

Project Title

Establish Transition of Care for High Risk Patients with Diabetes Related Admissions Post-Discharge

Problem

The readmission rate for all Cambridge Health Alliance (CHA) patients with diabetes is higher than the national average (14-20%)

- Transition of Care (TOC) model targeting patients with diabetes is not established at CHA

Readmission risk reduction suggested by the American Diabetes Association (ADA) guidelines:

- Post discharge support (phone or in person) visit within 1 week
- Additional close follow up within 1 month

Aims

- Establish TOC visits for diabetes patients (A1c > 9%) with a diabetes educator or a clinical pharmacist in the outpatient setting
- Reduce readmission rate for CHA patients with diabetes within 30 days
- Increase engagement and optimize diabetes care for uncontrolled patients (A1C > 9%)
- Identify barriers to reducing the readmission rate for CHA diabetes patients

Interventions

Patient with diabetes **A1C > 9%** discharged from CHA Hospital

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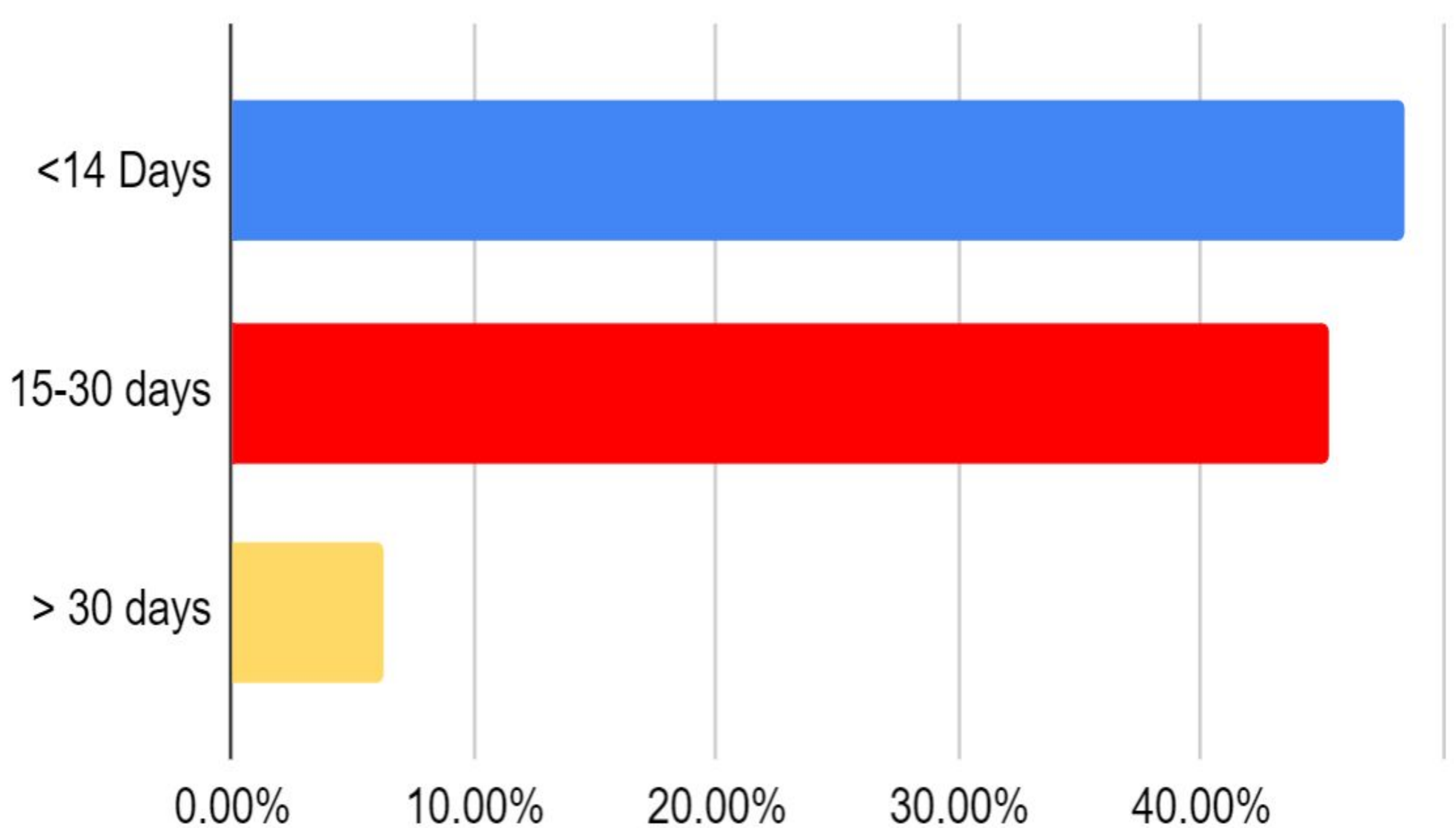
TOC Visit scheduled with diabetes educator or clinical pharmacist (3/6/23 - 5/5/23)

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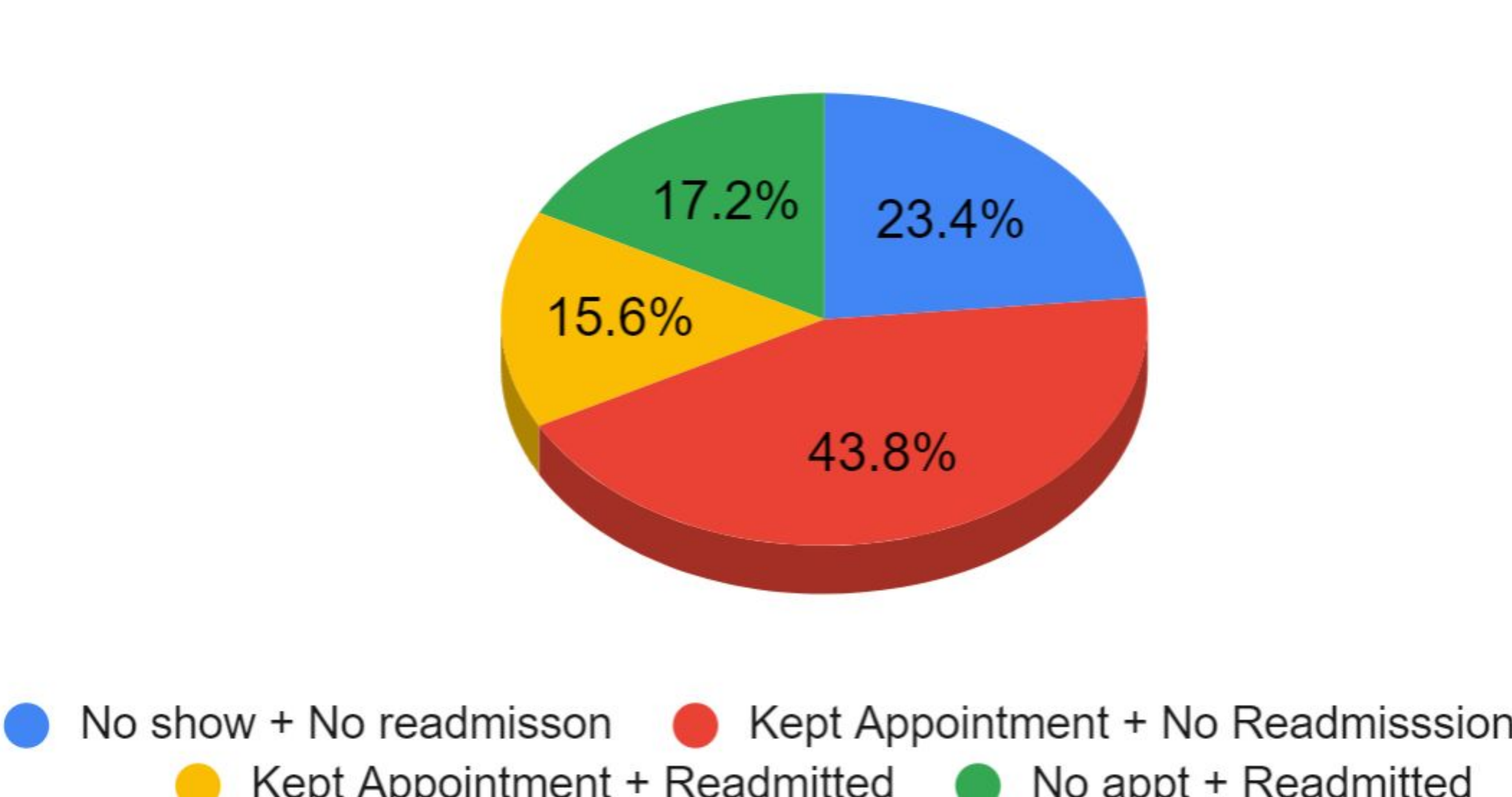
Engage patients in long term diabetes management to optimize evidence-based regimen and target A1C

Results

Time to TOC Appointment Post Discharge (n=64)



Relationship of TOC Appointment & Readmission (n=64)



Project Team Leads

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Scale up, spread, sustain

Barriers to Care: overdue or uncollected A1Cs, access to visits within 1 week, patients without CHA primary care, high no show rate (42%)

Improvement Opportunities: optimize ordering medications and diabetes supplies upon discharge, expand to emergency department visits/other diagnoses and specialties, dedicated sessions to improve time to access visit

Long-term follow-up: collect readmission rate, track A1C control for enrolled patients (90, 180, 270 days after discharge), collect patient feedback

Lessons Learned

- CHA Diabetes patient population has a high rate of suboptimal care:
 - Avg A1C= 11.2%**
 - 61 missed A1Cs during hospitalization
- Additional provider and patient support is needed to improve care of diabetes patients after hospitalization
- Expansion of TOC clinic to additional disease states would serve as a bridge to primary care and help optimize BG control