the Remedi Pulse

DIABETES UPDATE

Remedi SeniorCare EDUCATION Rx

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

JULY 2016

Survey Solutions

with William Vaughan, BSN, RN VP of Education & Clinical Affairs

Finding the F-Tag: Diabetes

In the book *The Emperor of all Maladies* by Dr. Siddhartha Mukherjee, the profound impact that cancer has had on the human race is explored. In long-term care (LTC), the "emperor" may actually be diabetes, not cancer. Studies vary, but the prevalence of diabetes in nursing home residents is estimated at 30 percent. In terms of morbidity and mortality, diabetes is in a class all its own. And if ever there was a disease that deserved its very own F-Tag, diabetes would be it. (Note: there is no such F-Tag, federal regulations address processes of care, not specific disease states).

Given the complex nature of diabetes management, it's not surprising that multiple regulations come into play during the survey process. From drugs to nutrition to labs and even resident rights, solid processes, excellent communication, and attention to detail must be maintained to assure compliance and positive resident outcomes. Below we discuss several concepts that potentially increase clinical and regulatory risk related to diabetes care:

FIRST, DO NO HARM: Safely managing diabetes is a balancing act. Hyperglycemia is generally problematic in the long run, but hypoglycemia represents an immediate and potentially fatal consequence of diabetic management. Additionally, recurring episodes of hypoglycemia can negatively impact memory and cognition. Setting reasonable and realistic goals for diabetic control, then using medications and other interventions that have the most favorable safety profiles possible can reduce the likelihood of hypoglycemia. When hypoglycemia is identified, staff response must be prompt and robust. As part of their quality assurance plan, facilities should consider conducting unannounced hypoglycemia "drills" to assess the availability of resources (e.g., glucose gel, Glucagon, etc.) as well as staff's competency in addressing this medical emergency.

MORE IS NOT NECESSARILY BETTER: I recently visited a nursing facility where residents with diabetes were having their

continued on page 4

Studies vary, but the prevalence of diabetes in nursing home residents is estimated at 30 percent

FOR MORE INFORMATION
RemediRx.com

EDITORIAL STAFF

JENNIFER HARDESTY Pharm.D., FASCP
Chief Clinical Officer
Jennifer.Hardesty@RemediRx.com

ROB SHULMAN BS, R.Ph., CGP, FASCP
Director of Consultant Pharmacy Services
Rob.Shulman@RemediRx.com

REBECCA OGDEN BSN, RN, CRNI
Corporate Account Manager
Rebecca.Ogden@RemediRx.com

Please do not hesitate to contact your Remedi Consultant Pharmacist or Account Manager if you have any questions or concerns.

The Slippery Slope of Sliding Scale Insulin

Prepared by: Bethany Schultz, Pharm.D., Clinical Consulant R.Ph.

Organizations such as the American Diabetes Association, (ADA) American Medical Directors Association, and American Geriatrics Society, have long agreed that sliding scale insulin (SSI) as a primary means of regulating blood glucose should be avoided. Often times, residents are placed on a sliding scale regimen during hospital stays or transitional periods. While it is a very common practice, SSI regimens are a reactive way of controlling hyperglycemia and may in fact, do more harm than good. Strong evidence exists that SSI is neither effective in meeting the body's insulin needs nor is it efficient in the long-term care (LTC) setting.

CHALLENGES WITH SSI:

- Higher risk of hypoglycemia
- Limited improvement in hyperglycemia management
- Widely fluctuating blood glucose levels
- Greater resident discomfort, due to numerous injections and finger-sticks
- Increased nursing time, due to increased monitoring and number of injections administered

There are no "good" or "bad" medications, the key is using medications appropriately to address the resident's current condition. There are limited circumstances when SSI may be appropriate, and if used cautiously for a short period of time, may be an appropriate option.

WHEN LIMITED SSI MAY BE APPROPRIATE:

- During acute illness
- As a result of irregular dietary intake

Although controlling glycemic levels is important, intensive glycemic control is not recommended in all situations. In LTC residents, older residents with a limited life expectancy, and residents with a high risk of hypoglycemia, previous cardiovascular disease or advanced microvascular disease, longer diabetes duration, or multiple comorbid conditions, there are limited benefits of intensive glycemic control. The ADA recommends a goal of HbA1c <8.5 percent and a focus on better quality of life. In residents at the end of life, it is not recommended to use invasive therapy and A1c testing has little benefit.

TRANSITIONING AWAY FROM SSI:

When a resident is receiving SSI, recommend the transition to a scheduled basal insulin, or basal insulin plus meal-time insulin (basal-bolus), as soon as possible. Basal insulin alone, or in combination with fast- acting insulin with meals, closely mimics the body's normal insulin production.

- When switching to basal-bolus insulin, the ADA recommends giving 50-75 percent of the average daily insulin requirement as basal insulin
- A rational approach includes a daily basal dose, plus a single bolus dose with the largest meal of the day
- Use increasing frequency of fixed-dose mealtime insulin for hyperglycemia after meals, if necessary

There are a variety of excellent resources available for prescriber and patient/resident education on diabetes and insulin therapy:

PRESCRIBER RESOURCES:

http://professional.diabetes.org/?loc=rp-slabnav
https://www.novomedlink.com/
https://www.healthforwardus.com/

PATIENT/RESIDENT EDUCATION:

https://www.cornerstones4care.com
http://www.diabetes.org

References:

1. Jan; 39 (Supplement 1): S4-S5. Available from: http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf
2. American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Available from: http://www.medscape.com/viewarticle/762283_5
3. Choosing Wisely: Don't use sliding scale insulin (SSI) for long-term diabetes management for individuals residing in the nursing home. Available from: http://www.aafp.org/afp/recommendations/viewRecommendation.htm?recommendationId=95
4. Munshi MN, Florez H, Huang ES, et al. Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association. Diabetes Care 2016 Feb; 39(2): 308-318. Available from: http://dx.doi.org/10.2337/dc15-2512

Rational Glucose Monitoring

Prepared by: Vincent Severn Pharm.D., Clinical Consultant R.Ph.

Diabetes should not be managed with one-size-fits all approach. Each resident should have an individualized monitoring plan which provides adequate clinical information, but minimizes resident risk and discomfort. For example, a patient having basal-bolus insulin therapy with QID finger-sticks could be poked eight times every day between finger-sticks and injections! While intensive blood glucose monitoring may be necessary at times, it should not be the standard for a majority of our residents.

THE AMERICAN DIABETES ASSOCIATION RECOMMENDS:

HbA1c Testing

- Upon admission
- At least twice yearly for stable residents at goal
- Quarterly for unstable residents not at goal or after therapy changes

Finger-Sticks

- For a simple basal-bolus regimen, finger-sticks may range from twice daily to once every few days, in a stable resident
- More frequent finger-sticks should occur when hypoglycemia is suspected or when hyperglycemia is likely (e.g., with corticosteroid use)
- Sliding scale insulin is generally not recommended, but do check pre-prandial and bedtime blood glucose, while on a sliding scale

Limitations of Testing

- The A1c is merely an average value of blood glucose levels for the last 60-90 days; residents may still experience extreme highs and lows – A1c values should be interpreted in the context of current finger-stick results
- Finger-stick measurements can be affected by activity, food/beverage, insulin administration, and contamination

Additional Considerations

- All finger-stick orders do not require accompanying sliding scale orders- if patterns of high or low blood glucose occur, the resident's overall therapy should be re-evaluated
- Alternatively, consider starting sliding scale insulin coverage at a higher threshold
- Does your facility have a standard hyper and hypoglycemia protocol to capture extreme highs and lows?
- What process is in place to re-evaluate the basal insulin dose if patients continue to require sliding scale insulin adjustments every day?

With roughly 30 percent of the long-term care (LTC) population living with diabetes, ensuring rational monitoring of blood glucose can have real efficiency and financial impacts on the facility, and can improve the quality of life for a significant group of residents.

References:
1. Munshi MN, Florez H, Huang ES, et al. Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association. Diabetes Care 2016 Feb; 39(2): 308-318. Available from: http://dx.doi.org/10.2337/dc15-2512
2. American Diabetes Association. Glycemic targets. Sec. 5. In Standards of Medical Care in Diabetes – 2016. Diabetes Care 2016;39(Suppl. 1): S39–S46. Available from: http://care.diabetesjournals.org/content/suppl/2015/12/21/39.Supplement_1.DC2/2016-Standards-of-Care.pdf

REMEDI SUPERSTAR NURSE

MOLLIE HOOVER, RN, DON
Covington Skilled Nursing and Rehabilitation, East Palestine, OH

CONGRATULATIONS to Mollie Hoover RN, DON, Covington Skilled Nursing and Rehabilitation, East Palestine, OH for being chosen as the Remedi Superstar Nurse! Mollie has been a nurse and employed at Covington for six years. She was nominated by one of her nurses, Debra Leininger, LPN. Per Debra, "Mollie is a great team leader as well as an inspiration to all of us. She is always willing to help where needed, and her door is open for personal/professional advice. Mollie has the ability to absorb much information and shares what she has learned with her team. She is not afraid to admit when she has a lack of knowledge, but at the same time, she is relentless in finding the answer and sharing it with all of us. Mollie is always thinking of areas on which to improve regarding patient care and ways to eliminate stress for her floor staff. Residents and family members appreciate her kind and compassionate demeanor. Mollie does her best to handle all matters in a fair and impartial manner. She encourages team members to offer solutions/input to problems and makes it a group effort to reach a solution. Mollie is truly a team player and fantastic leader."

The Remedi Superstar Nurse exemplifies excellence in nursing practice. Email your Superstar Nurse nomination(s) to Rebecca.Ogden@RemediRx.com. Nurses Rock!!

Survey Solutions

continued from page 1

blood glucose assessed via finger-stick four times a day. Most were clinically stable and their diabetic medications had rarely undergone any adjustments during the preceding six months. It was a cultural norm in this facility to closely monitor the blood glucose of all diabetic residents (HbA1c was also obtained every 3-6 months). While F329 requires "adequate" monitoring of all drugs, facilities should avoid over-monitoring residents. According to the American Diabetes Association, "in most patients residing in LTC facilities with type 2 diabetes, a high frequency of capillary monitoring of blood glucose should only be considered under special circumstances (e.g., starting corticosteroids) and where the danger of hypoglycemia is particularly high (e.g., with significant nutritional problems)." [1] Unnecessary finger-stick monitoring creates opportunities for error and may rise to the level of an actual harm deficiency, when viewed in the context of the recently revised CMS guidance to surveyors regarding psychosocial harm.[2]

BEST PRACTICES: FTag 281 requires facilities to provide services "according to accepted standards of clinical practice." In February of 2016, the American Diabetes Association (ADA) published a position statement titled "Management of Diabetes in Long-term Care and Skilled Nursing Facilities." While the regulation at FTag 281 does not require strict compliance with any specific set of guidelines, facilities should review the ADA position statement as many of the concepts discussed represent current, accepted standards of clinical practice in LTC.

PERSON-CENTERED CARE: Lastly, the management of diabetes provides ample opportunities to implement systems which promote person-centered care. The timing of medications, food choices, selection of activities, and even assistance with the development of advance directives are but a few areas which are often particularly important to residents with diabetes. Since person-centered care is a theme incorporated throughout the highly anticipated CMS final rule reforming nursing home requirements, now is the time for facilities to view their diabetic management practices in this context.

The baby boomers are coming, and lots of them are bringing all the clinical and regulatory challenges associated with diabetes to a facility near you. Leaders in nursing homes need to act now and make diabetic management a priority … the numbers simply demand it.

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.

References
1. Diabetes Care 2016 Feb; 39(2): 308-318: Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association
2. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-15.pdf

Stay tuned for the next quarterly edition of The Pulse - Managing High Risk Drugs.