DSME for Older Adults:

Relative Utility of Selected

Assessment Tools

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AADE American Association of Diabetes Educators

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AADE American Association of Diabetes Educators

Background

Beyond Health Literacy

The Psychometrics of

Diabetes Self-management

In Aging Patients

DSME for Older Adults:

Relative Utility of Selected

Assessment Tools

Older adults with diabetes

I. Trends in prevalence, costs, delivery of care
II. Current guidelines and tools for assessing their DSM* needs, challenges, resources
III. Likely sources of DSM errors and non-adherence
IV. Criteria for evaluating quality and relevance of assessments
V. Most useful assessments for older adults

*DSM=diabetes self-management

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National Diabetes Statistics Report, 2014

Estimates of Diabetes and Its Burden in the United States

This document is intended to provide up-to-date scientific data and statistics on diabetes and its burden in the United States. Formerly referred to as the National Diabetes Fact Sheet, this consensus document is written for a scientific audience.

Fast Facts on Diabetes

29.1 million people or 9.3% of the U.S. population have diabetes.

Diagnosed
21.0 million people

Undiagnosed
8.1 million people
(27.8% of people with diabetes are undiagnosed).

All ages, 2012

Older adults are more likely to have diabetes

Diagnosed and undiagnosed diabetes among people aged 20 years or older, United States, 2012

	Number with diabetes (millions)	Percentage with diabetes (unadjusted)
Total		
20 years or older	28.9	12.3
By age		
20–44	4.3	4.1
45–64	13.4	16.2
65 years or older	11.2	25.9
By sex		
Men	15.5	13.6
Women	13.4	11.2

Source: 2009–2012 National Health and Nutrition Examination Survey estimates applied to 2012 U.S. Census data.

National Center for Chronic Disease Prevention and Health Promotion
Division of Diabetes Translation

New cases of DM in persons >65 will continue to increase

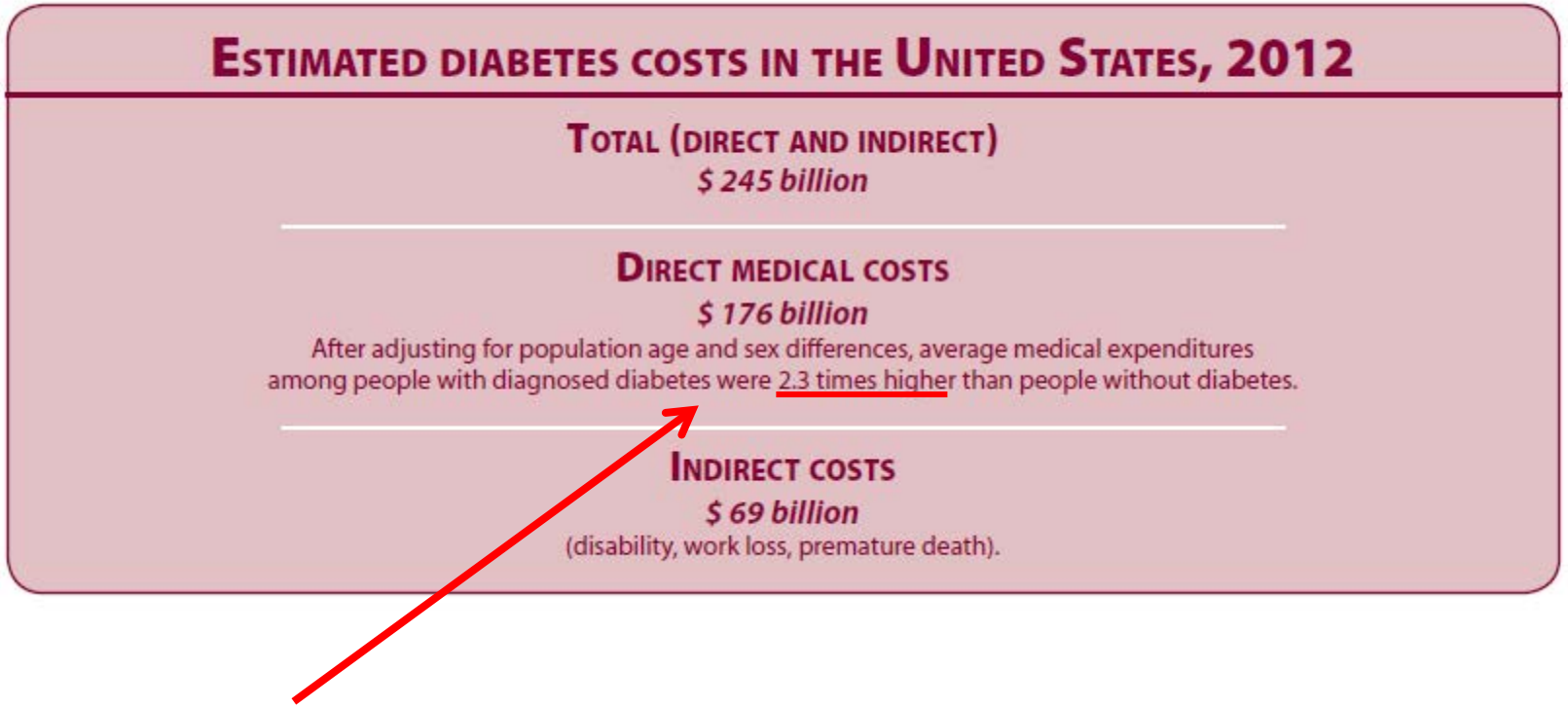
New Cases of Diagnosed Diabetes

New cases of diagnosed diabetes among people aged 20 years or older, United States, 2012

	Number of new diabetes cases	Rate of new diabetes cases per 1,000 (unadjusted)
Total		
20 years or older	1.7 million	7.8
By age		
20–44	371,000	3.6
45–64	892,000	12.0
65 years or older	400,000	11.5

Source: 2010–2012 National Health Interview Survey, 2009–2012 National Health and Nutrition Examination Survey, and 2012 U.S. Census data.

People with diabetes have higher health costs



Centers for Disease Prevention and Control
National Diabetes Statistics Report 2014

Forecast for 2025:
50% increase in prevalence and costs

Pre-Diabetes and Diabetes Trends[1] among Seniors in the United States

U.S. Seniors Diabetes Data and Forecasts	2010	2025
Population	40,229,000	63,907,000
Pre-diabetes	20,115,000	31,954,000
Diagnosed diabetes	7,901,000	12,551,300
Undiagnosed diabetes	2,920,600	4,639,700
Total with diabetes (diagnosed and undiagnosed)	10,821,600	17,191,000
Total with pre-diabetes or undiagnosed diabetes	23,035,600	36,593,700
Complications:		
Visual impairment	1,607,800	2,435,000
Renal failure	20,250	26,700
Leg amputations	27,180	31,400
Annual deaths attributable to diabetes	109,520	135,900
Total annual cost (2010 dollars)	$105.7 B	$168.0 B
Annual medical costs	$74.3 B	$118.1 B
Annual nonmedical costs	$31.4 B	$49.9 B

www.altfutures.org

65+ in the United States: 2010

Special Studies

Current Population Reports

By Loraine A. West, Samantha Cole, Daniel Goodkind, and Wan He

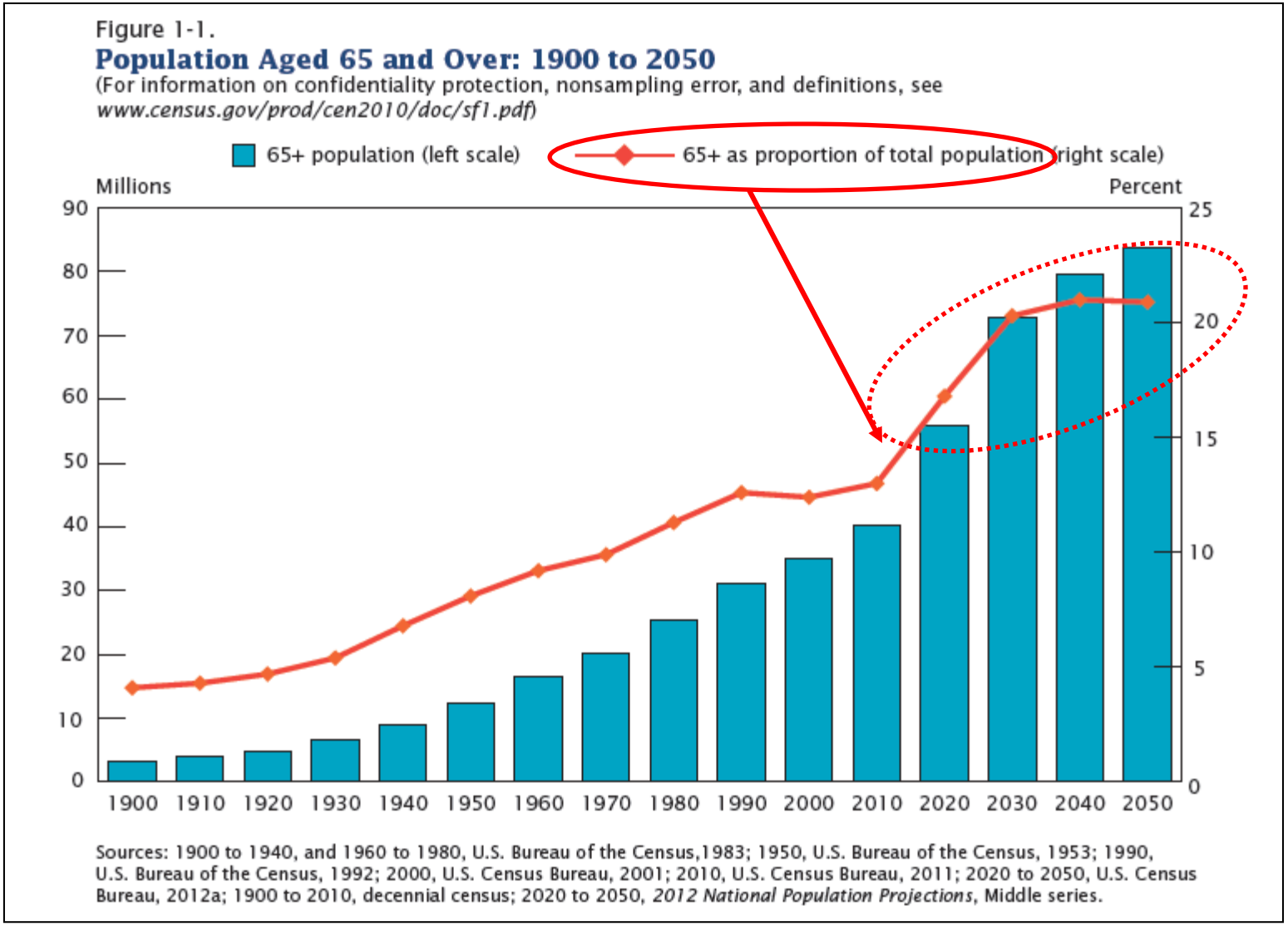
Issued June 2014
P23-212

U.S. Department of Health and Human Services
National Institutes of Health
NATIONAL INSTITUTE ON AGING

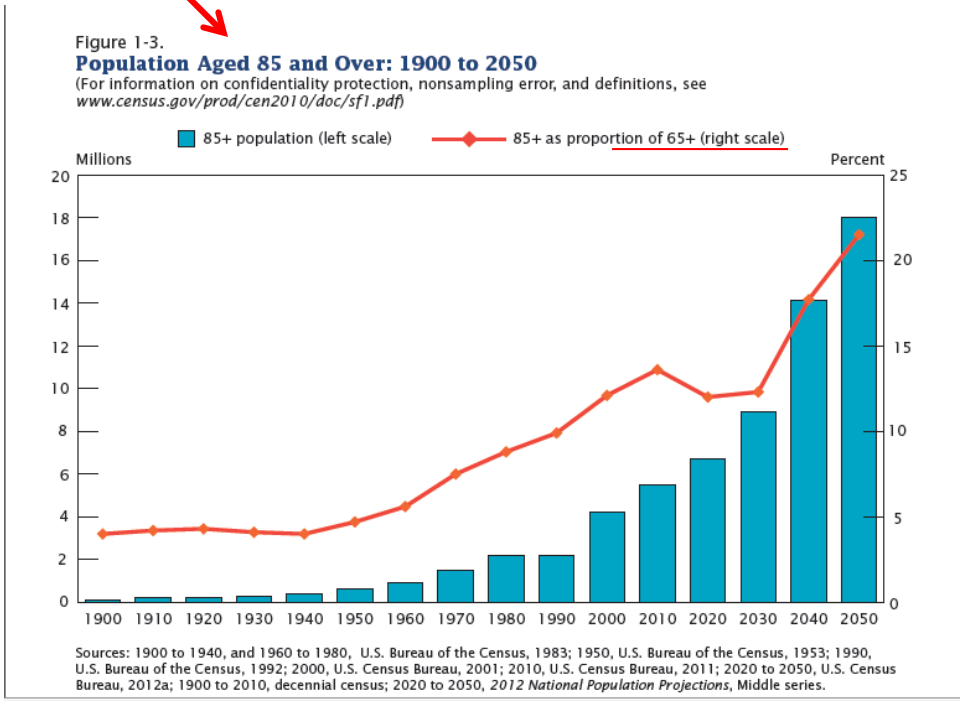
U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov

United States Census Bureau

Population getting older and older

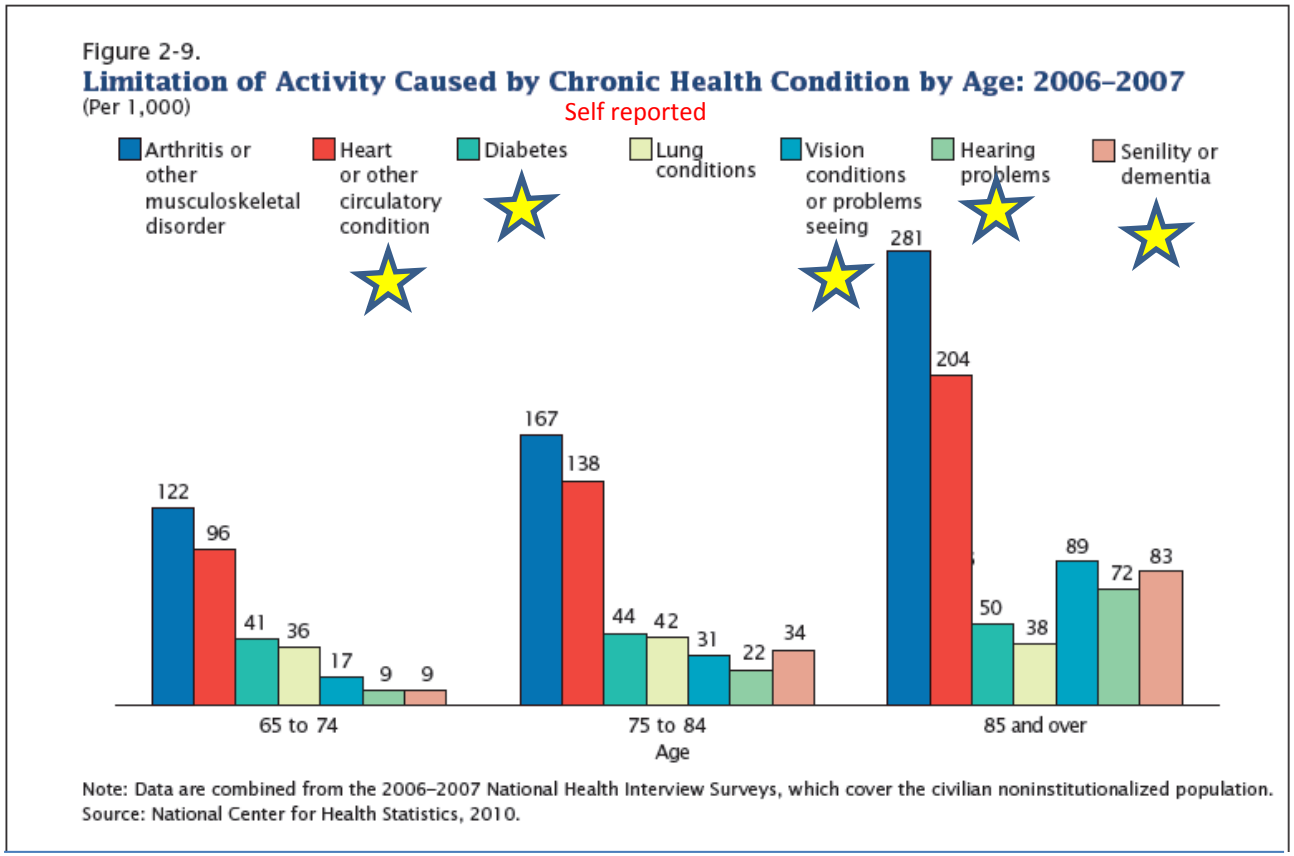


Source: U.S Census, *65+ in the United States: 2010*, Current Populations Reports, June 2014, p. 8.



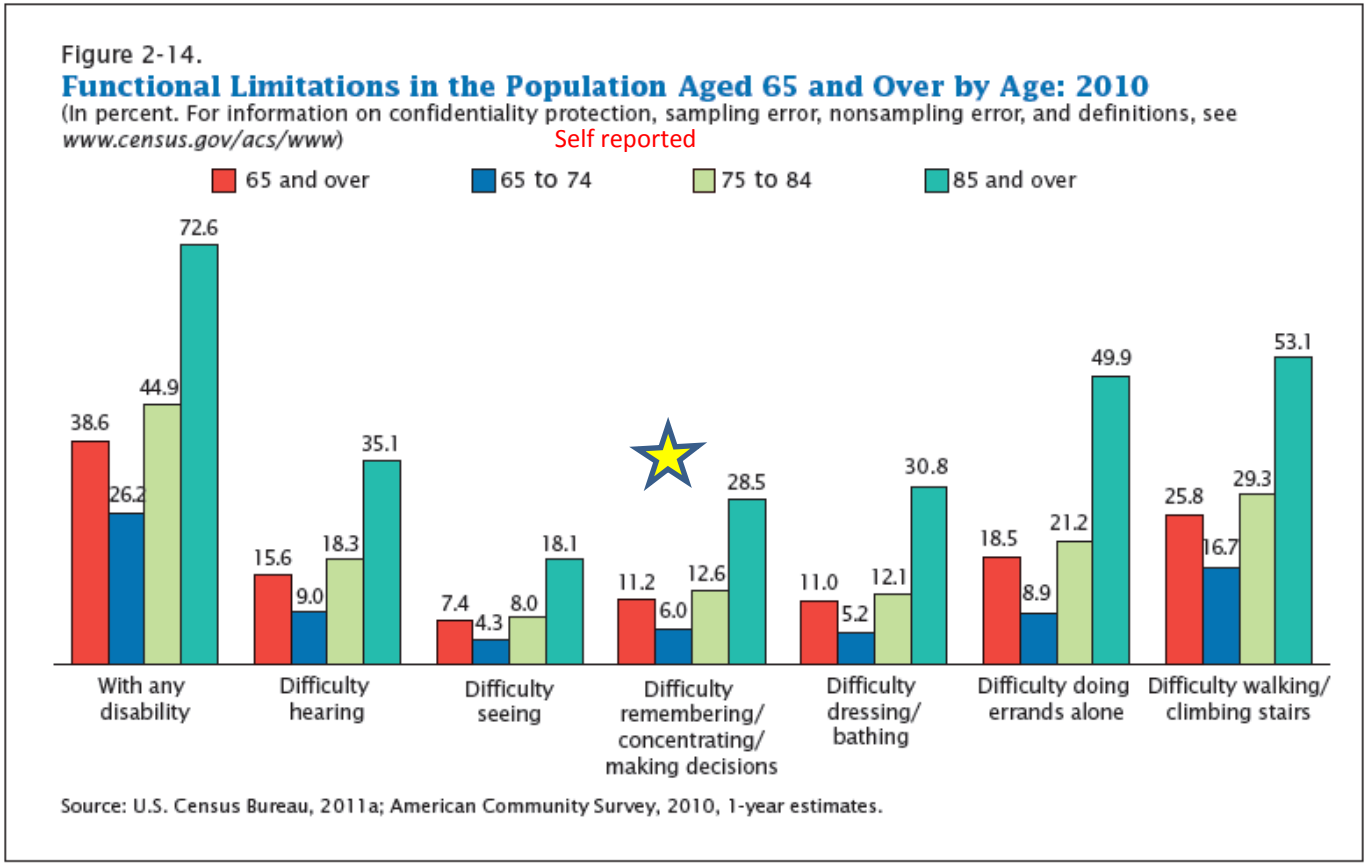
Source: U.S Census, *65+ in the United States: 2010*, Current Populations Reports, June 2014, p. 8.

The older old have more chronic conditions that limit their activity



Source: U.S Census, *65+ in the United States: 2010*, Current Populations Reports, June 2014, p. 36.

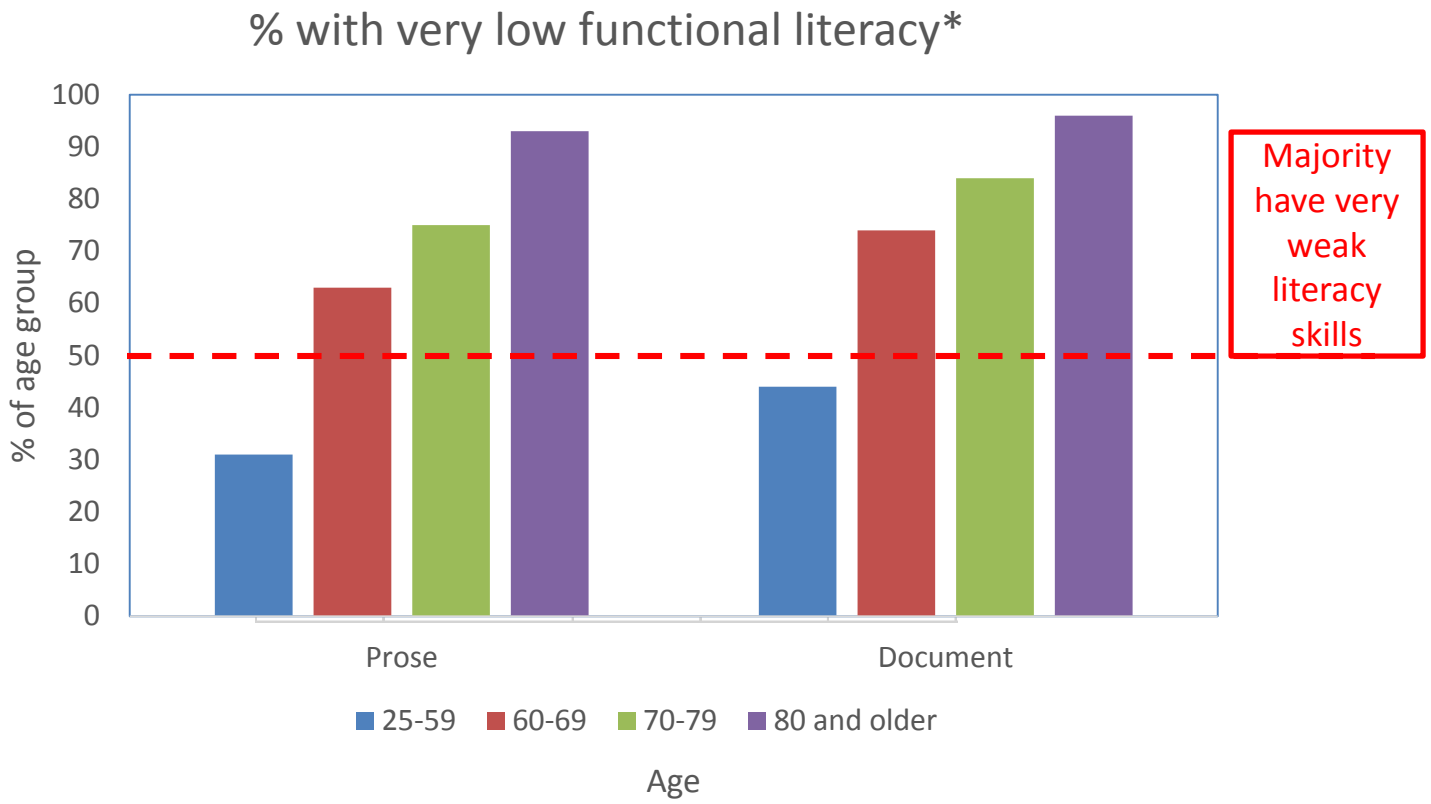
The older old have more functional limitations



Source: U.S Census, *65+ in the United States: 2010*, Current Populations Reports, June 2014, p. 43.

The older adults have less functional literacy

Objectively assessed



*Level 1 or 2 on NCES adult literacy survey's 5-level scale Source: Tables 1.2 and 1.3 of *Literacy of Older Adults in America*, 1996, http://nces.ed.gov/pubs97/97576.pdf (accessed 8/1/14)

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Patient-Centered Medical Home (PCMH)

Whole person orientation:

the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for

all stages of life;

acute care, chronic care, preventive services,

and end of life care.

Care is coordinated and/or integrated:

across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and

other means to assure that

patients get the indicated care when and where they need and want it

in a culturally and

linguistically appropriate manner.

http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

Diabetes PCMH

The care of individuals with diabetes—in particular,

those with diabetes

mellitus (type 2 diabetes)—provides one of the best opportunities to

illustrate the promise of the patient centered medical home.

The medical home offers patients a team-based model of care led by a provider that ensures high-quality, compassionate and coordinated care, superb access and communication, and is committed to quality and safety.

The evidence demonstrates that proper management of diabetes can reduce the risk of complications; well-designed care coordination interventions, delivered to the right individuals, can improve patient, provider and payer outcomes.

Patient-Centered Primary Care Collaborative

http://www.pcpcc.org/guide/practices-spotlight

Program of All-inclusive Care for the Elderly (PACE)

A team of health care professionals will give you the *coordinated care you need*.

These professionals are also experts in working with older people.

They will work together with you and your family (if appropriate) to develop your most effective plan of care.

http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html

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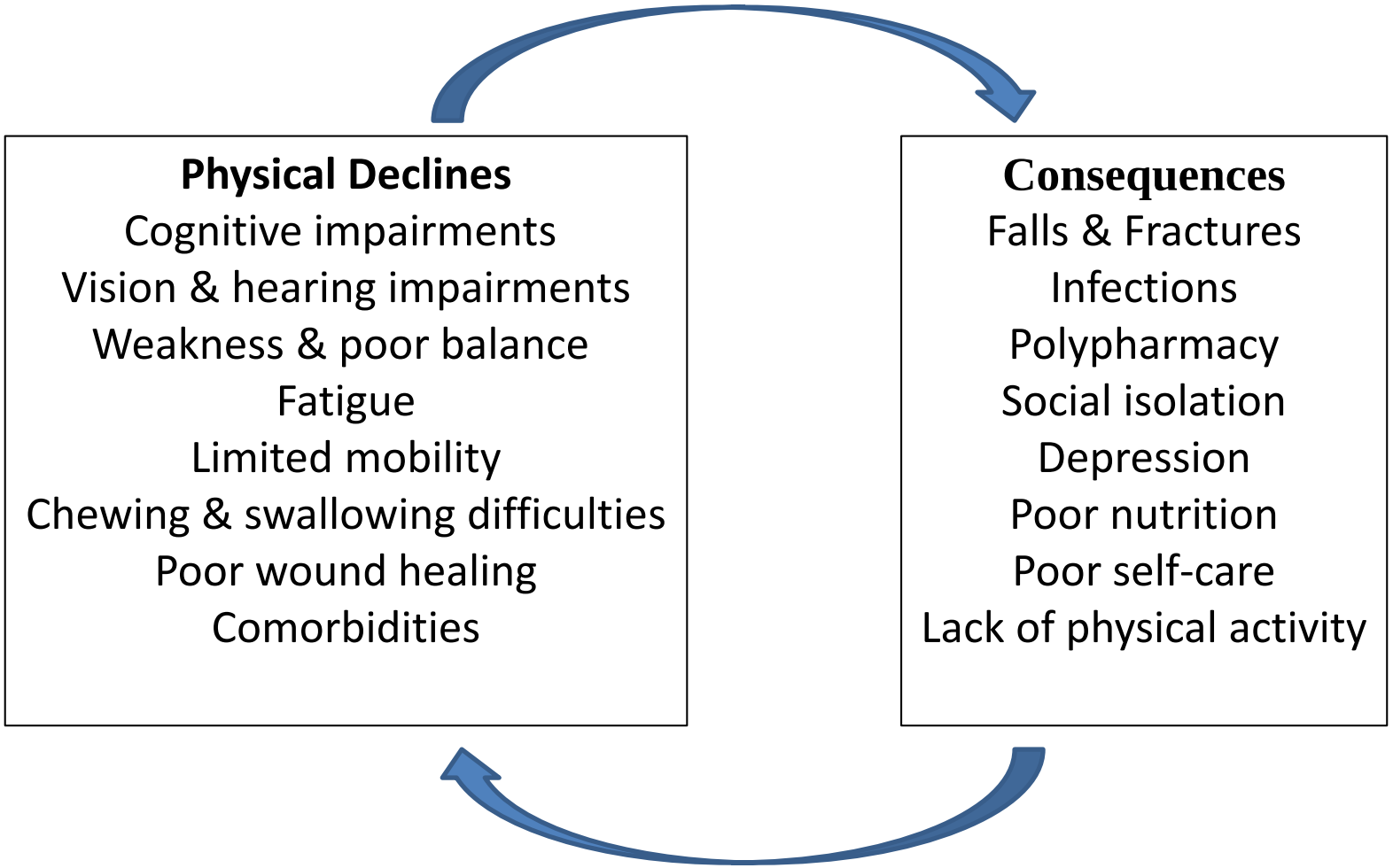
Geriatric syndromes

Biological syndromes unique to aging bodies:

Age-related biological declines
across multiple organ systems
which become increasingly vulnerable to dysregulation,
yield altered diagnostic signs and symptoms,
and often lead to a downward spiral in health & mobility.

Common elements in geriatric syndromes



Frailty Syndrome

Indicators

- Loss of appetite
- Loss of muscle loss
- Loss of bone mass
- Loss of mobility
- Fatigue
- Poor balance
- Risk of falls
- Poor physical health
- Homeostenosis*

Clinical diagnosis—
3 of the following

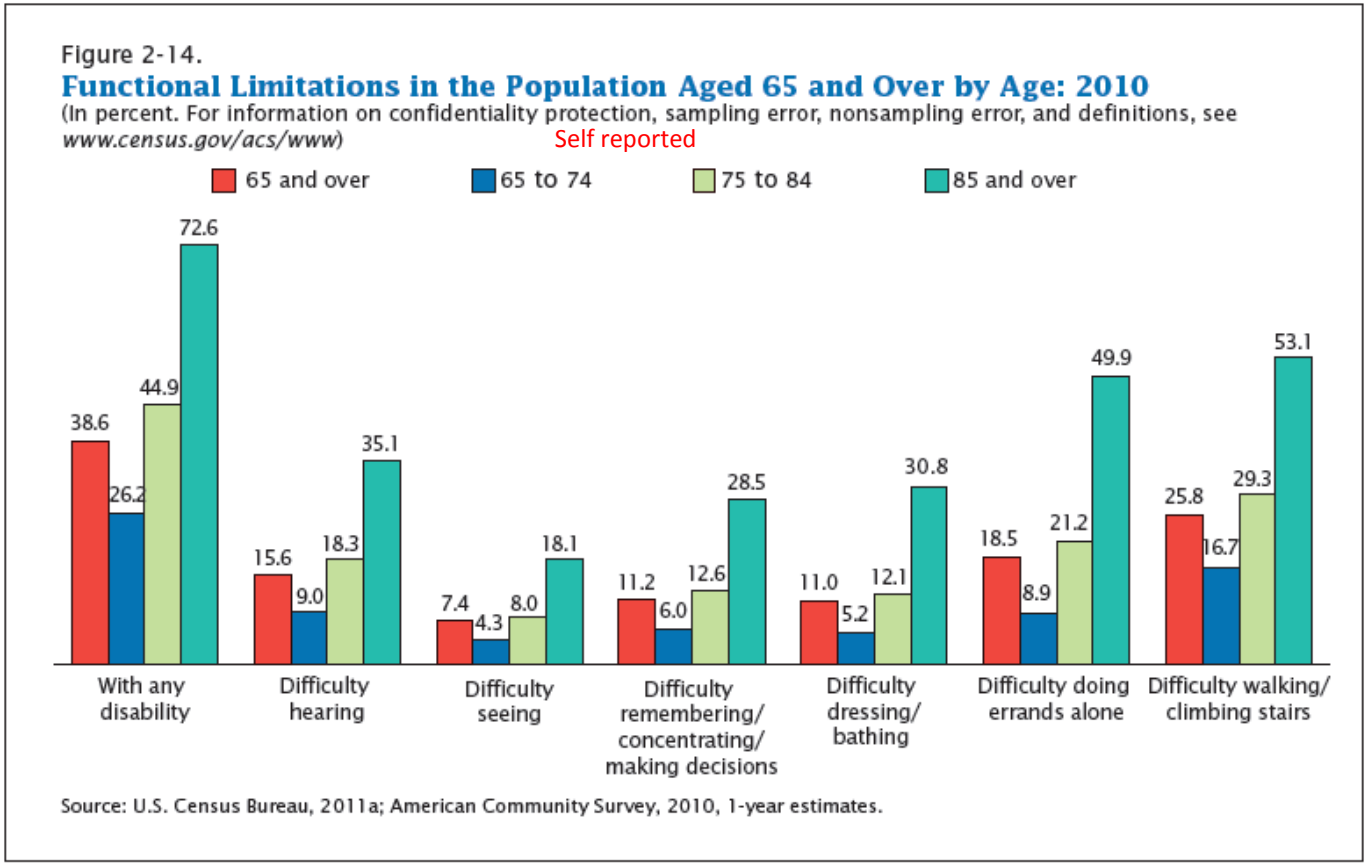
1. Unintentional weight loss (10 lbs. in past year)
2. Self-reported exhaustion
3. Weakness (Grip Strength)
4. Slow walking speed
5. Low physical activity

* Difficulty maintaining homeostasis under physiological stress

Todays' Geriatric Medicine. Jan/Feb 2014

Recall

The older old have more functional limitations



Source: U.S Census, *65+ in the United States: 2010*, Current Populations Reports, June 2014, p. 43.

Functional Categories of Older People with Diabetes

Category 1: Functionally Independent

Category 2: Functionally Dependent

- Sub-category A: Frail
- Sub-category B: Dementia

Category 3: End of Life

International Diabetes Federation:
Managing Older People with Type Diabetes.
Global Guideline. 2013

Diabetes Disaster Averted series:

http://www.diabetesincontrol.com/articles/practicum

Diabetes Disaster Averted #51: Careful Listening Saves Lives

A few years ago, I was working as a Nurse Practitioner in an endocrinology practice. One of my longstanding elderly patients, age 82, called me to report that the paramedics had to come to her house because she passed out....

I scheduled her for an appointment the next day, and took her history. She'd had diabetes for about 15 years, and was taking a long acting insulin at bedtime and rapid acting insulin before her meals. I reviewed her activities of the day (meal times, insulin doses and times, and activity level). She reported that she had her dinner, and then next thing she knew she was passed out at the dinner table. I performed a complete physical exam, which was normal. I was ready to order a battery of lab tests, and considering testing her for gastroparesis since it appeared that she'd had a severe hypoglycemic reaction so soon after eating.

I reviewed her recent episode with her again, stating "so you ate your dinner, and then you passed out..." at which point she interrupted with "no, I did not eat my dinner, I HAD it, it was right in front of me on the table, and then I passed out...." The conclusion was that she had a severe hypoglycemic reaction because she delayed her dinner.

Lesson learned: *Obtain a complete history from the patient,* ***choosing words carefully****, and make sure you and your patient are speaking the same language and have the same meaning! The lesson learned from this case saved a lot of time and money from unnecessary testing and work up.*

Louise DeRiso, MSN, CRNP, CCRC

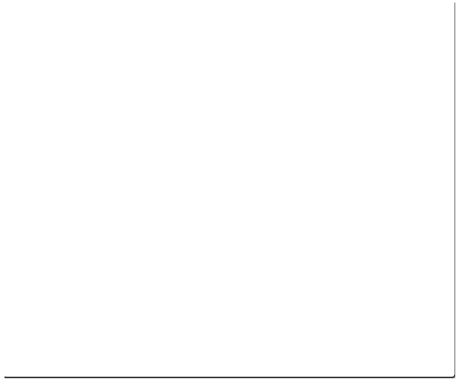
Coordinator, Vascular Clinical & Translational Research Center

University of Pittsburgh

"Do Not Crush, Chew or Cut"

From the Institute for Safe Medication Practices (ISMP): When a patient is prescribed a timed release medication such as Glucotrol XL or Glucophage XR, clinicians need to ensure that the patients understand that they should not crush, chew or cut these pills. The medications must be swallowed whole.

In one case an elderly patient was prescribed Glucotrol XL to treat elevated blood sugars. This is a specially formulated medication that releases an entire day's supply of the medication slowly over a 24-hour period. The pill was too large for the woman to swallow, so she chewed it. She soon complained of feeling dizzy, weak, listless, and lethargic. Chewing the drug caused it to be released all at once, causing dangerously low blood glucose levels, which could have been fatal....



In some cases pills are coated so the medication won't be released in the stomach where it may cause irritation. In other cases, special coatings or other properties slow the delivery of the medication into the body so that the drug is delivered over a period of time. This is more convenient than having to take a drug several times a day, but if these pills are crushed or chewed, the way they are supposed to work will be destroyed and the medication may go into the body too fast. If that happens, then a large amount of the drug will be released all at once, which could cause side effects or serious harm.

The Power and Dangers of Advertising

Recently a 69 year old man returned to see me after being started on a single bedtime dose of Levemir via the Flex pen along with a long acting sulfonylurea. He had received education about basal insulin action from the start. On return his morning glucose was terrible but I noticed that the rest of the day his glucose was near goal. I began to wonder if his sulfonylurea was working better with the addition of basal insulin but was puzzled by the worsening overnight rise. I was considering lowering the oral dose and increasing the basal dosing to balance glucose control better when he volunteered a critical piece of information nonchalantly....

He proudly announced that he had been listening to NovoNordisk commercials on TV and realized that when you use the Flex pen you need to eat a meal right afterwards. Since he was getting his insulin at bedtime, he decided he should add a fourth meal to the day. This was occurring after his bedtime dose of insulin and AFTER his glucose check.

It was then obvious he did not need a basal rate increase but instruction in the action of Levemir and the difference to the Novolog Flex pen action. If adjustments had been made without changing the dietary cause, this individual may have needed a very high basal dose to control this prandial problem and could have experienced increased hypoglycemia during the day.

Lesson Learned:

Many other sources of information through the media are now available and can be very confusing to a patient. Take time to re-evaluate a patient's understanding of their medications at subsequent visits.

Lynn White MS, FNP, CDE, BC-ADM

All Insulins Not the Same

I recently had a home care patient who had been discharged from a skilled nursing facility with a prescription for regular insulin, and who was put on a sliding scale dosage. The patient was experiencing hypoglycemic reactions. I was called to see him to find out why he was having multiple hypoglycemic reactions. When I asked to see how he and his wife were calibrating and injecting his insulin, she brought out a bottle of Lantus insulin....

The patient's wife had not filled the new prescription for the regular insulin because she thought that she already had insulin that her husband could use at home. She had the Lantus insulin which he was on prior to his hospitalization, and she wanted to use that insulin before purchasing any more. She was using Lantus for the sliding scale dosage instead of the regular insulin which was proving highly dangerous.

Lesson Learned:

Never take for granted that the patient is dosing properly or is using the insulin the doctor has prescribed.

Linda, RN, CDE

Patient's Method of Figuring Meal-time Insulin Doesn't Quite Work

Recently I assessed an 84 year old inpatient with diabetes for his insulin usage at home. In reporting his dosing he stated that after he checked his glucose before each meal he took the "first two numbers of the result," and made that his dosage for meal-time insulin. For example, if the glucose reading was 240, he would take 24 units of Humalog.

I asked him if this was his instruction per his provider and he said, "No, but it was the only thing that made sense to me that I could remember."...

A specific teaching plan with simple dosing was designed for him and a home health evaluation for medication administration safety was also made on his return home.

Lesson Learned:

This example once again reiterates the importance of having the patient give you a verbal and sometimes a practice demonstration of what they understand to be the practice for medication administration.

Janet Howard-Ducsay, RN, BA/BSN, CDE
Diabetes Nurse Educator

Most frail individuals have comorbidities, functional disabilities, or both

Relevance to DSME?
Critical tasks and complex burdens in self-care multiply with age.

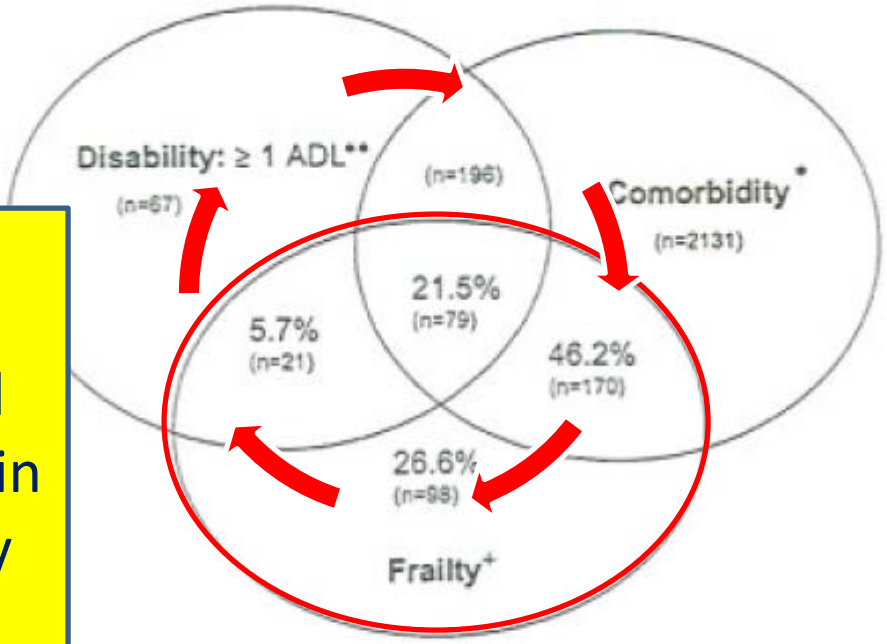


Figure 3. Venn diagram displaying extent of overlap of frailty with ADL disability and comorbidity (≥2 diseases). Total represented: 2,762 subjects who had comorbidity and/or disability and/or frailty. *n* of each subgroup indicated in parentheses. + Frail: overall *n* = 368 frail subjects (both cohorts). *Comorbidity: overall *n* = 2,576 with 2 or more out of the following 9 diseases: myocardial infarction, angina, congestive heart failure, claudication, arthritis, cancer, diabetes, hypertension, COPD. Of these, 249 were also frail. **Disabled: overall *n* = 363 with an ADL disability; of these, 100 were frail.

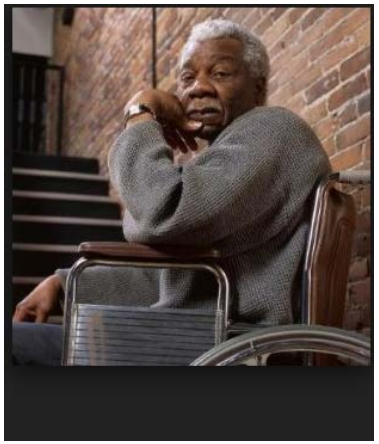
Journal of Gerontology: MEDICAL SCIENCES
2001, Vol. 56A, No. 3, M146–M156

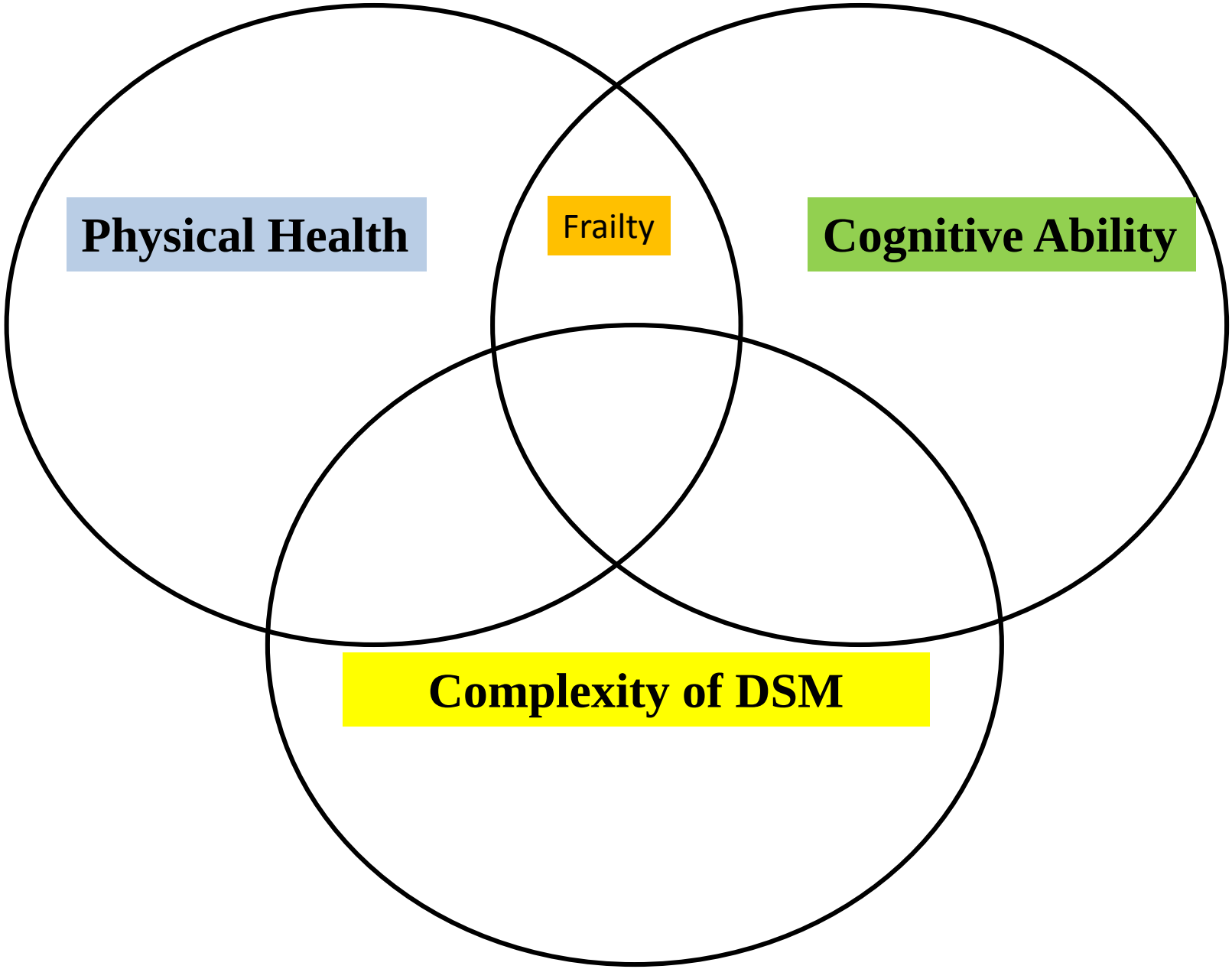
Frailty in Older Adults: Evidence for a Phenotype

To summarize……

- Many of your patients/clients will:
  - have complex medical problems,
  - experience heavy burdens in self-care,
  - but have fewer physical and cognitive reserves for effective self-care.

- Patients' physical and cognitive health trajectories will differ widely




Physical Health
Frailty
Cognitive Ability
Complexity of DSM

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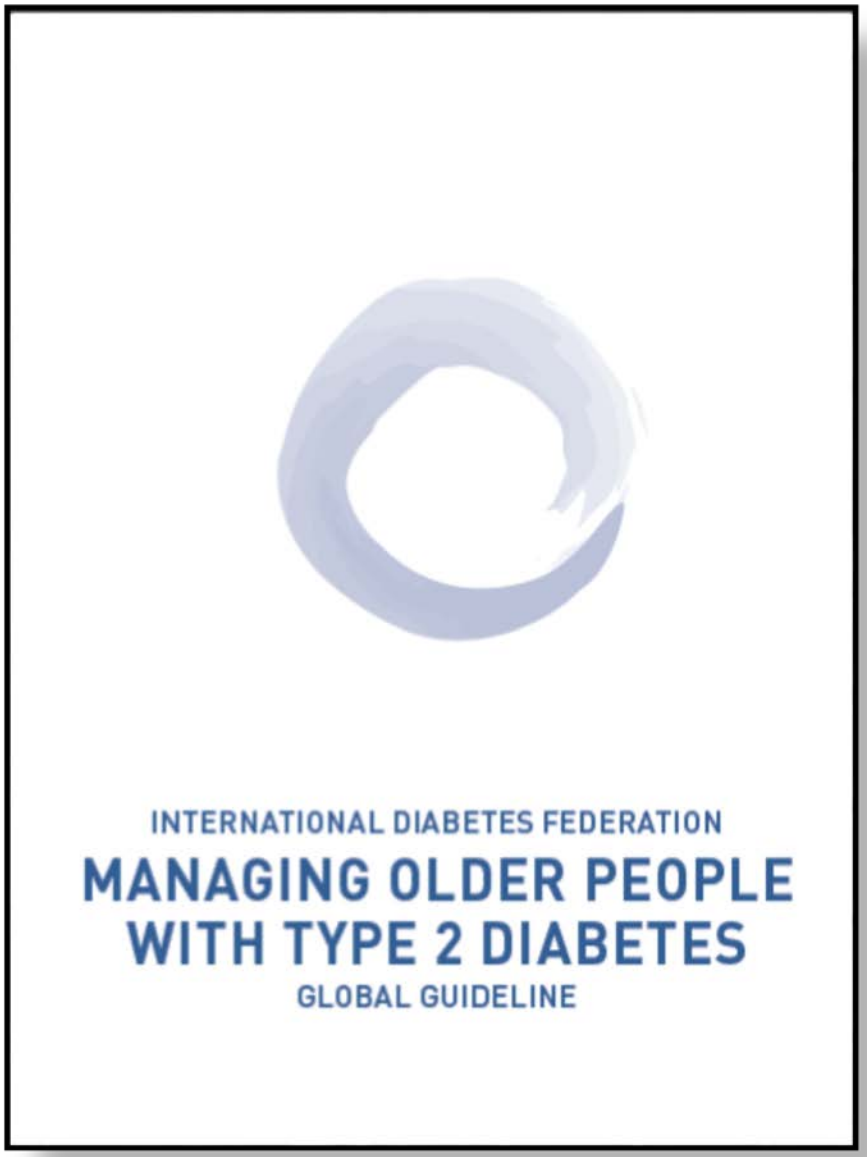
Appropriate assessment is essential for individualizing DSME.

To do that, CDEs will need to:

1. screen older adults for most critical DSM tasks

2. assess patient's major barriers to learning

(3. recognize the complexity levels of the DSM tasks: Bloom's Taxonomy)


INTERNATIONAL DIABETES FEDERATION
MANAGING OLDER PEOPLE WITH TYPE 2 DIABETES
GLOBAL GUIDELINE

IDF
Managing Older People with Diabetes
Global Guideline
2013

Examples of Assessment Tools and Procedures

Gait, balance & mobility

ADl & IADL

Cognition

Mood Level

Frailty Measures

Hypoglycemia Risk

Self-care Abilities

Nutritional Assessment

Pain

05

ASSESSMENT AND EVALUATION PROCEDURES FOR OLDER PEOPLE WITH DIABETES

Assessment of older people with diabetes should be a multidimensional and multidisciplinary process designed to collect information on medical, psychosocial and functional capabilities and how these may limit activities.

These data are important for:

- Organizing treatment plans.
- Arranging rehabilitative services where available.
- Conducting an annual review which should include a medicine review.
- Determining long-term care requirements.
- Planning end of life care.

The emphasis is on managing complexity and quality of life issues in older people. The assessment tests in Table 1 are designed to be routinely used in everyday clinical practice by nurses and doctors, require little training, and to be a basis for screening of functional deficits. It is not expected that most or all will be routinely undertaken but these tests should be considered as part of the annual assessment and when clinically indicated. As a minimum, the consultation should include enquiring about functional capacity and cognitive and mental health.

Table 1. Examples of assessment tools and procedures[13-21]*

Assessment domain	Examples of assessment tools and procedures	Comments
Gait, balance, and mobility	IDDP 3-steps package[22]	Easily adapted to guideline resource; contains information on assessing gait speed and balance ability
ADL and IADL	Barthal ADL and IADL	Universally used; minimal training required
Cognition	MiniCog or Montreal Cognitive Assessment Tool	Easy to use; good evidence as screening tools for cognitive impairment
Mood level	Geriatric Depression Score	Widespread use; little training required
Frailty measures	Clinical Frailty Scale or CHSA 9-point Scale	Can be used as a quick assessment for features of frailty
Hypoglycaemia risk	A comprehensive history to identify risk factors *(see Chapter 28.3: Hypoglycaemia)*	Requires a positive commitment to consider risk factors by the clinician
Self-care abilities	SCI-R	A 13-15 item self-completed questionnaire suitable for type 1 and type 2 diabetes
Nutritional assessment	MNA-SF tool or MUST Tool	Well validated tools in wide spread use; minimal training required
Pain	Pain thermometer[23] M-BNBPI[24]	For people with diabetes who have moderate to severe cognitive/communication disorder; easy to use but full validity has not yet been established[24]

ADL activities of daily living
CHSA Community Health Status Assessment
IADL instrumental activities of daily living
IDDP Institute for Diabetes in Old People
MNA-SF Mini Nutritional Assessment-Short Form
M-BNBPI Modified Residents' Verbal Brief Pain Inventory
MUST Malnutrition Universal Screening Tool
SCI-R Self-Care Inventory Revised

* Tools or procedures may from country to country.

The key purpose of these assessment tools is to identify one or more healthcare needs that can be addressed by clinician intervention. They require minimal training and their use is associated with additional nurse, therapist, or physician time. However, identifying early the need for mobility support, nutritional intervention, the presence of cognitive impairment, or increased support for diabetes self-care can be fundamentally important to each older person and may improve clinical outcome.

SPECIAL ARTICLE

Diabetes in Older Adults: A Consensus Report

M. Sue Kirkman, MD,[a] Vanessa Jones Briscoe, PhD, NP, CDE,[b] Nathaniel Clark, MD, MS, RD,[c] Hermes Florez, MD, MPH, PhD,[d] Linda B. Haas, PHC, RN, CDE,[e] Jeffrey B. Halter, MD,[f] Elbert S. Huang, MD, MPH,[g] Mary T. Korytkowski, MD,[h] Medha N. Munshi, MD,[i] Peggy Soule Odegard, BS, PharmD, CDE,[j] Richard E. Pratley, MD,[k] and Carrie S. Swift, MS, RD, BC-ADM, CDE[l]

More than 25% of the U.S. population aged ≥ 65 years has diabetes mellitus (hereafter referred

Consensus Development Conference on Diabetes and Older Adults (defined as those aged ≥ 65 years) in Feb-

Journal of the American Geriatrics Society 2012

Additional Consensus Recommendation

for Care of Older Adults

with Diabetes

"In order to develop and update an individualized treatment plan, screen older adults periodically for cognitive dysfunction, functional status and fall risk, using simple tools, such as those at

http://www.hospitalmedicine.org/geriresource/toolbox/determine.htm.

WHAT ISSUES NEED TO BE CONSIDERED IN INDIVIDUALIZING TREATMENT RECOMMENDATIONS FOR OLDER ADULTS?

Comorbidities and Geriatric Syndromes

Diabetes is associated with increased risk of multiple coexisting medical conditions in older adults. In addition to the classic cardiovascular and microvascular diseases, a group of conditions termed geriatric syndromes, described below, also occur at higher frequency in older adults with diabetes and may affect self-care abilities and health outcomes including quality of life.[58]

Cognitive Dysfunction

Alzheimer's-type and multi-infarct dementia are approximately twice as likely to occur in those with diabetes compared with age matched nondiabetic control subjects.[59] The

http://www.hospitalmedicine.org/geriresource/toolbox/determine.htm.

Consensus Recommendation

<u>for Research Question</u>

About Diabetes in Older Adults

"What is the impact of Geriatric Syndrome
on the management of diabetes
and the risk for
adverse treatment effects
and poor outcomes ?"

Journal of the American Geriatrics Society 2012

High rates of unidentified cognitive deficits in older adults suggest that it is important to periodically screen for cognitive dysfunction. Simple assessment tools can be accessed at www.hospitalmedicine.org/geriresource/toolbox/howto.htm. Such dysfunction makes it difficult for patients to perform complex self-care tasks such as glucose monitoring, changing insulin doses, or appropriately maintaining timing and content of diet. In older patients with cognitive dysfunction, regimens should be simplified, care-

Journal of the American Geriatrics Society 2012

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Journal of the American Geriatrics Society 2012

interactions. A challenge in treating type 2 diabetes is that polypharmacy may be intentional and necessary to control related comorbidities and reduce the risk of diabetes complications.[73,74] In one study, polypharmacy (defined as the use of 6 or more prescription medications) was associated with an increased risk of falling in older people.[75] The costs of multiple medications can be substantial, especially when older patients fall into the "doughnut hole" of Medicare Part D coverage. Medication reconciliation, ongoing assessment of the indications for each medication, and the assessment of medication adherence and barriers are needed at each visit.

Depression

Diabetes is associated with a high prevalence of depression.[76] Untreated depression can lead to difficulty with self-care and with implementing healthier lifestyle choices[77] and is associated with a higher risk of mortality and dementia in patients with diabetes.[78,79] In older adults, depression may remain undiagnosed if screening is not performed. Clinical tools such as the Geriatric Depression Scale[80] can be used to periodically screen older patients with diabetes.

Journal of the American Geriatrics Society 2012

to standard assessments and treatments for incontinence, clinicians should remember that uncontrolled hyperglycemia can increase the amount and frequency of urination.

Unique Nutrition Issues

Nutrition is an integral part of diabetes care for all ages, but there are additional considerations for older adults with diabetes. Though energy needs decline with age, macronutrient needs are similar throughout adulthood. Meeting micronutrient needs with lower caloric intake is challenging; therefore older adults with diabetes are at higher risk for deficiencies. Older adults may be at risk for undernutrition due to anorexia, altered taste and smell, swallowing difficulties, oral/dental issues, and functional impairments leading to difficulties in preparing or consuming food. Overly restrictive eating patterns, either self-imposed or provider-directed, may contribute additional

risk for older adults with diabetes. The Mini-Nutritional Assessment, specifically designed for older adults, is simple to perform and may help determine whether referral to a registered dietitian for medical nutrition therapy (MNT) is needed (http://www.mna-elderly.com/).

MNT has proven to be beneficial in older adults with diabetes.[84] Recommendations should take into account the patient's culture, preferences, and personal goals and abilities. When nutrition needs are not being met with usual intake, additional interventions may include encouraging smaller more frequent meals, fortifying usual foods, changing food texture, or adding liquid nutrition supplements (either regular or diabetes-specific formulas) between meals. For nutritionally vulnerable older adults, identifying community resources such as Meals on Wheels, senior centers, and the U.S. Department of Agriculture's Older Americans Nutrition Program may help maintain independent living status.

Vulnerability to Hypoglycemia

intervention arms had ~50% higher rates of severe hypoglycemia (hypoglycemia requiring third-party assistance) than participants under age 65 years (M. Miller, personal communication). In a population analysis of Medicaid enrollees treated with insulin or sulfonylureas, the incidence of serious hypoglycemia (defined as that leading to emergency department visit, hospitalization, or death) was approximately 2 per 100 person-years,[103] but clearly studies based on administrative databases miss less catastrophic hypoglycemia.

The risk factors for hypoglycemia in diabetes in general (use of insulin or insulin secretagogues, duration of diabetes, antecedent hypoglycemia, erratic meals, exercise, renal insufficiency)[104] presumably apply to older patients as well. In the Medicaid study cited above, independent risk factors included hospital discharge within the prior 30 days, advanced age, black race, and use of five or more concomitant medications.[103] Assessment of risk factors for hypoglycemia is an important part of the clinical care of older adults with hypoglycemia. Education of both patient and caregiver on the prevention, detection, and treatment of hypoglycemia is paramount.

****

brain function.[61] Cross-sectional studies have shown an association between hyperglycemia and cognitive dysfunction.[62] Hypoglycemia is linked to cognitive dysfunction in a bidirectional fashion: cognitive impairment increases the subsequent risk of hypoglycemia,[60] and a history of severe hypoglycemia is linked to the incidence of dementia.[63]

High rates of unidentified cognitive deficits in older adults suggest that it is important to periodically screen for cognitive dysfunction. Simple assessment tools can be accessed at www.hospitalmedicine.org/geriresource/toolbox/howto.htm. Such dysfunction makes it difficult for patients to perform complex self-care tasks such as glucose monitoring, changing insulin doses, or appropriately maintaining timing and content of diet. In older patients with cognitive dysfunction, regimens should be simplified, care-

Journal of the American Geriatrics Society 2012

Hospital admissions for hyper- or hypoglycemia Medicare PWDs, ages 65+, 1999-2011

Retrospective observational study

- Both types of admission are relatively rare, so data capture most severe cases
- 279,937 patients had 302,095 hospitalizations for hyperglycemia
- 404,467 patients had 429,850 admissions for hypoglycemia
- Over the 12 years, rates of admission for:
  - ↓ – hyperglycemia dropped by 38.6 percent
  - ↑ – hypoglycemia rose by 11.7 percent

Lipska, K. L., MD. JAMA Internal Medicine. Published online May 17, 2014.

American Geriatrics Society

Guidelines for

Improving the Care of Older Adults

With Diabetes Mellitus

2013 Update

OBJECTIVES

- Incorporate high-quality new evidence with significant effect on diabetes mellitus (DM) care that has become available since the 2003 "Guidelines for Improving the Care of the Older Person with Diabetes Mellitus" into a new 2013 Guideline update.
- Improve the care of older people with DM by providing an updated set of evidence-based recommendations individualized to adults with DM aged 65 and older.

Ten years ago, the California Health Care Foundation (CHCF)/American Geriatrics Society (AGS) Panel published some of the first patient-centered clinical guidelines to assist clinicians with the complex and individualized care of older adults with DM.[1] The abstracted set of recommendations presented here provides essential guidance in the care of older adults with DM and is based on the 2013 AGS Guidelines, which have incorporated new evidence available since 2003. The full version of the updated guidelines, *American Geriatrics Society (AGS) Guidelines for Improving the Care of the Older Adult with Diabetes Mellitus: 2013 Update*, is available at www.GeriatricsCareOnline.org.

COMPONENTS OF CARE

The components of the 2003 guidelines were aspirin, tobacco cessation, glucose control, blood pressure management, lipids management, eye care, foot care, and DM self-management education and support (DSME/S). Specific geriatric syndromes that have been included and emphasized in the updated 2013 guidelines are depression, polypharmacy, cognitive impairment, urinary incontinence, injurious falls, and persistent pain.

Clinical and functional heterogeneities in older adults with DM that were also addressed in the 2013 guidelines are differences in general health status, age and duration of disease at diagnosis, number of years of treatment, comorbidities and underlying chronic conditions, range of complications, degree of frailty, limits in physical or cognitive function, and differences in life expectancy (time horizon for benefit).

PATIENT-CENTERED CARE AND INDIVIDUALIZED GOALS

The 2013 guidelines update recommends DM care that is customized and prioritized to the individual person with DM, with attention to quality of life and personal and caregiver choices related to health care. The 2013 guidelines update:

- No longer recommends aspirin for the primary prevention of cardiovascular disease (CVD).
- Renews the emphasis on treating dyslipidemias with statins but not to target levels.
- Continues to support glycemic control recommendations customized to burden of comorbidity, functional status, and life expectancy.
- Presents stronger, more-prescriptive, patient-centered recommendations for lifestyle modification because of increased evidence of its importance for healthy older adults with DM.

EVIDENCE

The guidelines were updated by reviewing the existing peer-reviewed literature (2002–2012) and guidelines on each DM topic. PubMed was searched for relevant studies published in the peer-reviewed literature from 2002 to 2012. Randomized clinical trials and systematic reviews or meta-analyses were reviewed. When reasonable, the expert panel extrapolated findings to older adults with DM. Evidence tables (available at http://www.GeriatricsCareOnline.org) were constructed summarizing new evidence.

An expert panel consisting of general internists, family practitioners, geriatricians, clinical pharmacists, health services researchers, and certified DM educators was con-

American Geriatrics Society Guidelines for Improving the Care of Older Adults With Diabetes Mellitus

2013 Update

Depression

1. Older adults with DM are at greater risk of major depression and should be screened for depression during the initial evaluation period (first 3 months) and if there is any unexplained decline in clinical status. (IIB)

On initial presentation of an older adult with DM, a healthcare professional should assess the individual for symptoms of depression using a standardized short screener,[14] such as the Geriatric Depression Scale, Patient Heath Questionnaire (PHQ-9), or other available instruments.[15] Expert opinion suggests screening for depression when there is new-onset cognitive decline.

Psychosocial problems other than depression, such as attitudes about DM, quality of life, DM-related distress, and lack of financial resources, are also important for older adults with type 2 DM.

2. Older adults with DM who present with new-onset

Cognitive Impairment

instrument during the initial evaluation period and with any significant decline in clinical status. Increased difficulty with self-care should be considered a change in clinical status. (IIIA)

Systematic review and meta-analyses of up to 15 studies found that dementia was more likely in persons with DM and suggested that DM was associated with faster cognitive decline in older adults.[24–26]

Simple tools are available to clinicians (http://www.hospitalmedicine.org/geriresource/toolbox/mental_status_page.htm). The Montreal Cognitive Assessment tool is available in several languages and is easily accessible for clinical and education purposes (http://www.mocatest.org/).

2. If there is evidence of cognitive impairment in an older adult with DM and delirium has been excluded as a cause, then an initial evaluation designed to identify reversible conditions that may cause or exacerbate cognitive impairment should be performed within the first 3 months after diagnosis and with any significant change in clinical status. (IIIA)

The American Academy of Neurology guidelines recommend screening older adults with evidence of cognitive impairment for depression, B_{12} deficiency, and hypothyroidism; structural neuroimaging to identify lesions is also recommended for those recently diagnosed.[27] If the cognitive impairment is due to delirium, urgent assessment for etiology and management is indicated.

Urinary Incontinence

http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=108

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC Centers for Disease Control and Prevention

NIH National Institute of Diabetes and Digestive and Kidney Diseases

NDEP National Diabetes Education Program

NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations.

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Guiding Principles for Diabetes Care

This evidence-based booklet outlines important patient-centered principles of diabetes care, helping health care professionals identify people with prediabetes and undiagnosed diabetes for treatment aimed at preventing long-term complications.

For the most recent diagnostic criteria for diabetes and prediabetes in non-pregnant adults, see NDEP's Diabetes Numbers At-a-Glance 2011. This pocket guide is based on the American Diabetes Association Standards of Medical Care for Diabetes - 2011.

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Last reviewed: 04/01/2009

Contents

Regular monitoring of diabetes management enables the diabetes team to assess achievement of treatment goals and to adjust therapy as necessary. Regular checking for long-term complications can help detect problems at a time when they can be treated and managed successfully. The physical examination, laboratory tests, and other assessments that the team conducts to monitor management and to identify complications early should be performed during routine diabetes visits, and at quarterly and annual visits.

At each diabetes visit:

- Measure weight, blood pressure, and calculate BMI.
- Inspect feet for lesions or abnormalities if one or more high-risk foot conditions are present.
- Review self-monitoring glucose record.
- Review/adjust medications to control glucose, lipids, blood pressure. Include regular use of low dose aspirin (if there are not contraindications) for cardiovascular disease prevention, as appropriate.
- Review self-management skills, progress toward behavior change goals, dietary needs, and physical activity as indicated.
- Assess for coping, depression, or other mood disorder.
- Counsel on smoking cessation and alcohol use.
- Review interventions for weight loss.

Older adults with diabetes

I. Trends in prevalence, costs, delivery of care
II. Current guidelines and tools for assessing their DSM* needs, challenges, resources
III. Likely sources of DSM errors and non-adherence
IV. Criteria for evaluating quality and relevance of assessments
V. Most useful assessments for older adults

*DSM=diabetes self-management

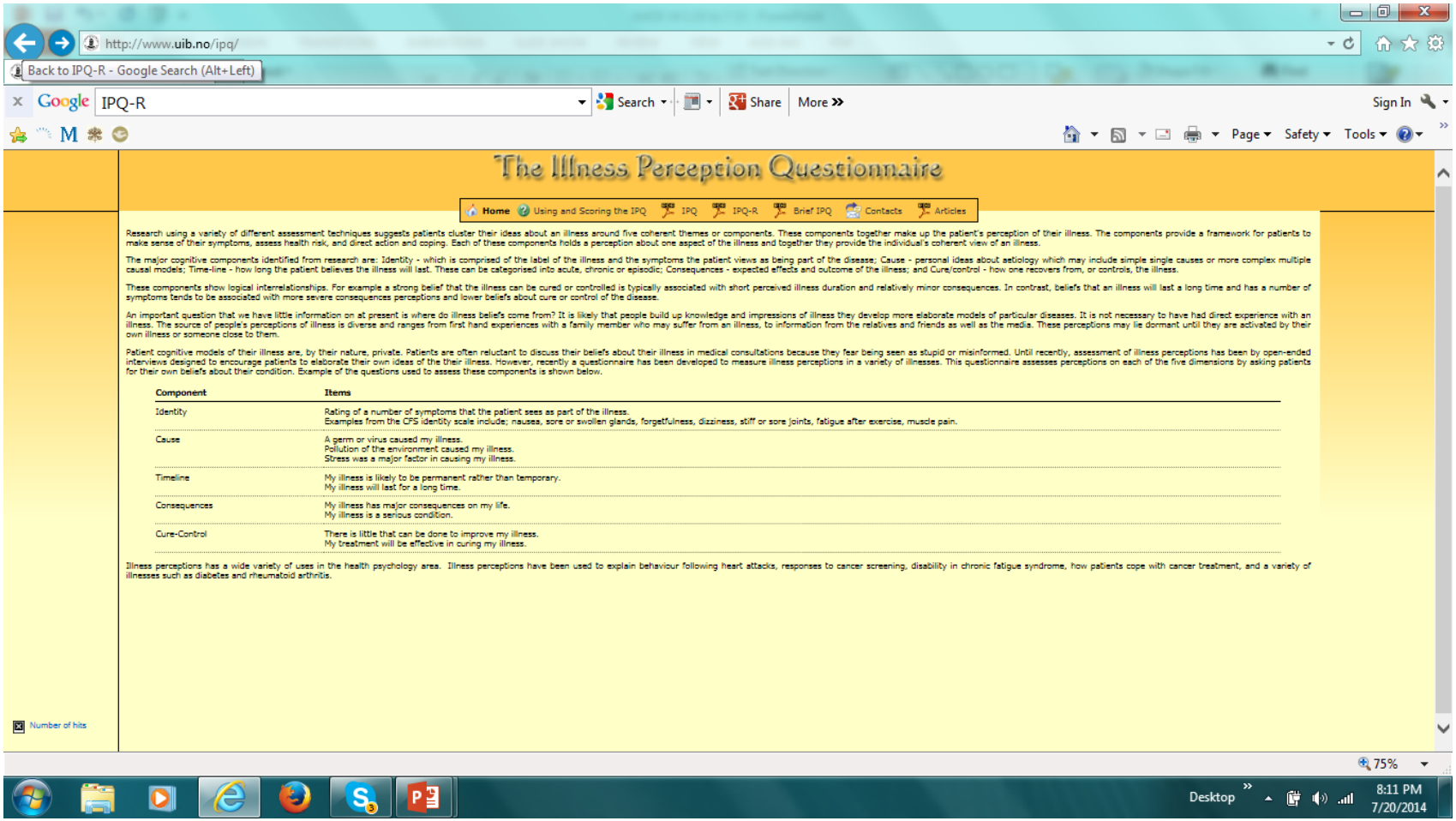
Single Item Literacy Screen (SILS)

"How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

1-Never
2-Rarely
3-Sometimes
4-Often
5-Always

Difficulty reading
and understanding
printed health related material.

BMC Family Practice 2006, **7**:21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Research using a variety of different assessment techniques suggests patients cluster their ideas about an illness around five coherent themes or components. These components together make up the patient's perception of their illness. The components provide a framework for patients to make sense of their symptoms, assess health risk, and direct action and coping. Each of these components holds a perception about one aspect of the illness and together they provide the individual's coherent view of an illness.
The major cognitive components identified from research are: Identity - which is comprised of the label of the illness and the symptoms the patient views as being part of the disease; Cause - personal ideas about aetiology which may include simple single causes or more complex multiple causal models; Time-line - how long the patient believes the illness will last. These can be categorised into acute, chronic or episodic; Consequences - expected effects and outcome of the illness; and Cure/control - how one recovers from, or controls, the illness.
These components show logical interrelationships. For example a strong belief that the illness can be cured or controlled is typically associated with short perceived illness duration and relatively minor consequences. In contrast, beliefs that an illness will last a long time and has a number of symptoms tends to be associated with more severe consequences perceptions and lower beliefs about cure or control of the disease.
An important question that we have little information on at present is where do illness beliefs come from? It is likely that people build up knowledge and impressions of illness they develop more elaborate models of particular diseases. It is not necessary to have had direct experience with an illness. The source of people's perceptions of illness is diverse and ranges from first hand experiences with a family member who may suffer from an illness, to information from the relatives and friends as well as the media. These perceptions may lie dormant until they are activated by their own illness or someone close to them.
Patient cognitive models of their illness are, by their nature, private. Patients are often reluctant to discuss their beliefs about their illness in medical consultations because they fear being seen as stupid or misinformed. Until recently, assessment of illness perceptions has been by open-ended interviews designed to encourage patients to elaborate their own ideas of the their illness. However, recently a questionnaire has been developed to measure illness perceptions in a variety of illnesses. This questionnaire assesses perceptions on each of the five dimensions by asking patients for their own beliefs about their condition. Example of the questions used to assess these components is shown below.
Component
Items
Identity
Rating of a number of symptoms that the patient sees as part of the illness.
Examples from the CFS identity scale include; nausea, sore or swollen glands, forgetfulness, dizziness, stiff or sore joints, fatigue after exercise, muscle pain.
Cause
A germ or virus caused my illness.
Pollution of the environment caused my illness.
Stress was a major factor in causing my illness.
Timeline
My illness is likely to be permanent rather than temporary.
My illness will last for a long time.
Consequences
My illness has major consequences on my life.
My illness is a serious condition.
Cure-Control
There is little that can be done to improve my illness.
My treatment will be effective in curing my illness.
Illness perceptions has a wide variety of uses in the health psychology area. Illness perceptions have been used to explain behaviour following heart attacks, responses to cancer screening, disability in chronic fatigue syndrome, how patients cope with cancer treatment, and a variety of illnesses such as diabetes and rheumatoid arthritis.
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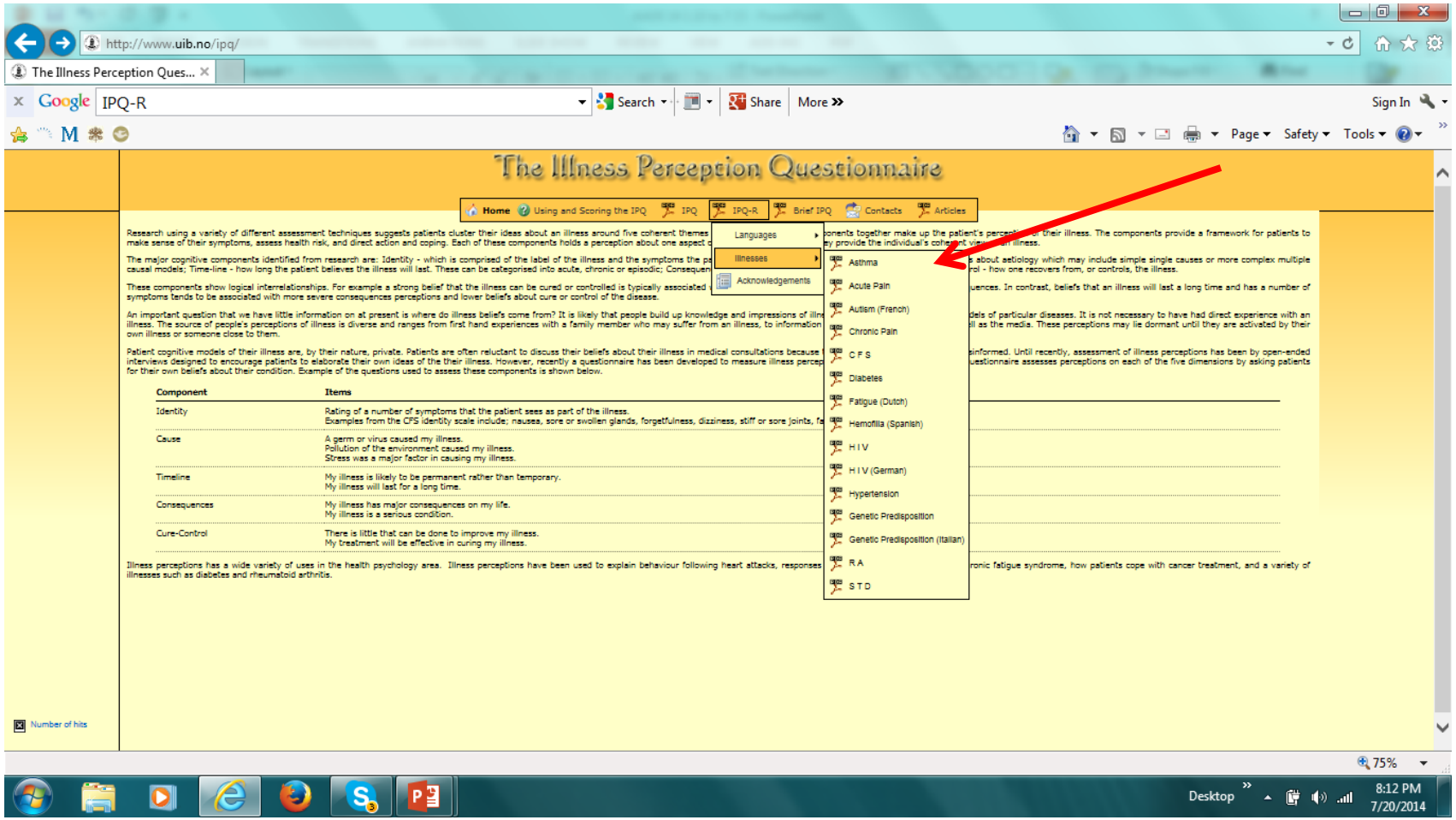
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Hypertension
Genetic Predisposition
Genetic Predisposition (Italian)
R A
S T D
Component
Items
Identity
Rating of a number of symptoms that the patient sees as part of the illness.
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A germ or virus caused my illness.
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Consequences
My illness has major consequences on my life.
My illness is a serious condition.
Cure-Control
There is little that can be done to improve my illness.
My treatment will be effective in curing my illness.
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Illness Perception Questionnaire (IPQ-R)

YOUR VIEWS ABOUT YOUR ILLNESS

Listed below are a number of symptoms that you may or may not have experienced since your illness. Please indicate by circling *Yes* or *No*, whether you have experienced any of these symptoms since your illness, and whether you believe that these symptoms are related to your illness.

	I have experienced this symptom *since my illness*	**This symptom is *related to my illness***
Pain	**Yes No**	**Yes No**
Sore Throat	**Yes No**	**Yes No**
Nausea	**Yes No**	**Yes No**

Brief Illness Perception Questionnaire (Brief-IPQ)

The Brief Illness Perception Questionnaire

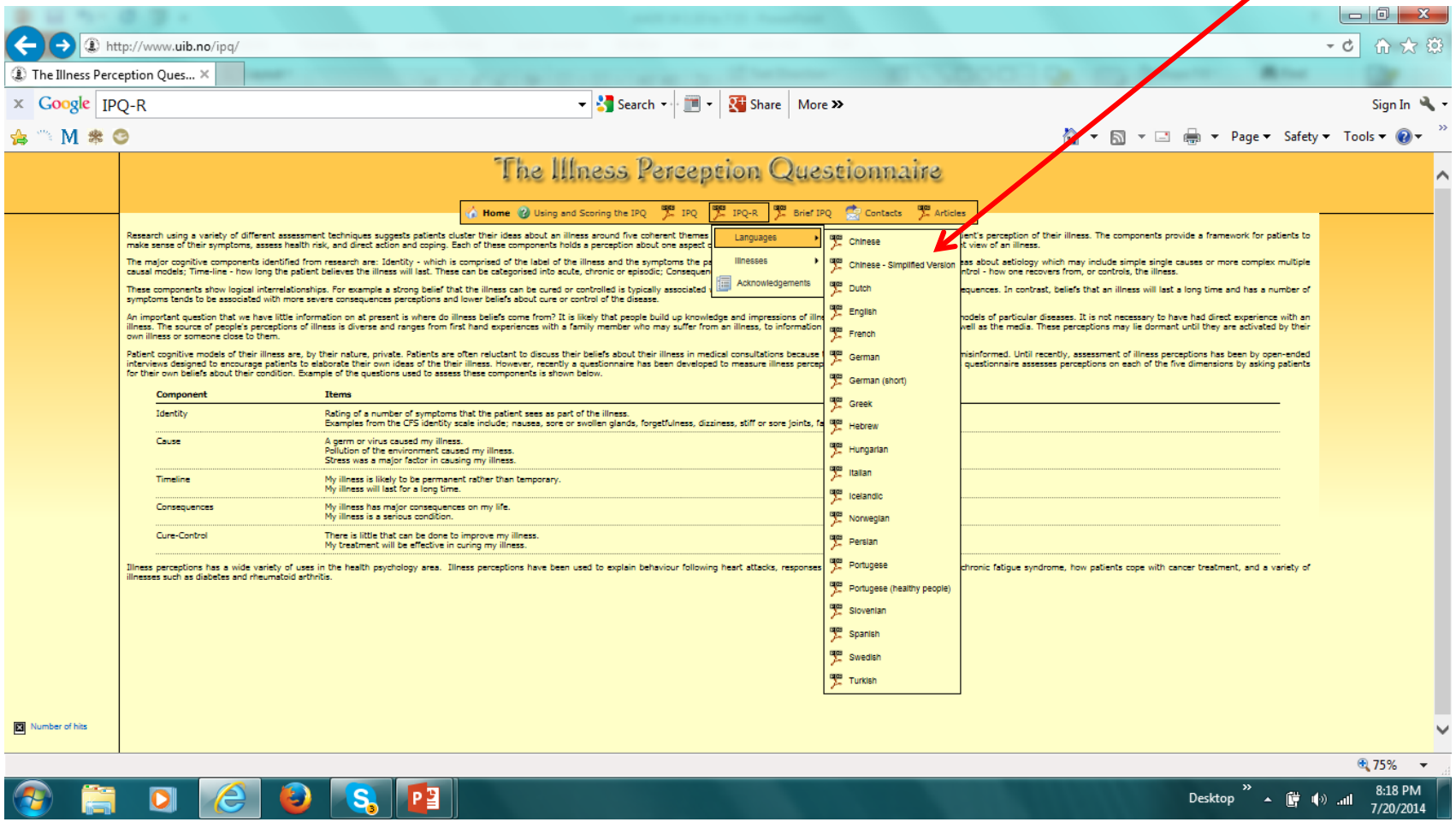
For the following questions, please circle the number that best corresponds to your views:

How much does your illness affect your life?											
	0	1	2	3	4	5	6	7	8	9	10
	no affect at all										severely affects my life
How long do you think your illness will continue?											
	0	1	2	3	4	5	6	7	8	9	10
	a very short time										forever
How much control do you feel you have over your illness?											
	0	1	2	3	4	5	6	7	8	9	10
	absolutely no control										extreme amount of control
How much do you think your treatment can help your illness?											
	0	1	2	3	4	5	6	7	8	9	10
	not at all										extremely helpful
How much do you experience symptoms from your illness?											
	0	1	2	3	4	5	6	7	8	9	10
	no symptoms at all										many severe symptoms
How concerned are you about your illness?											
	0	1	2	3	4	5	6	7	8	9	10
	not at all concerned										extremely concerned
How well do you feel you understand your illness?											
	0	1	2	3	4	5	6	7	8	9	10
	don't understand at all										understand very clearly
How much does your illness affect you emotionally? (e.g. does it make you angry, scared, upset or depressed?											
	0	1	2	3	4	5	6	7	8	9	10
	not at all affected emotionally										extremely affected emotionally

Please list in rank-order the three most important factors that you believe caused your illness. ***The most important causes for me:-***

1. _____
2. _____
3. _____

IPQ-R-DM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Greek
Hebrew
Hungarian
Italian
Icelandic
Norwegian
Persian
Portugese
Portugese (healthy people)
Slovenian
Spanish
Swedish
Turkish
Component
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Pollution of the environment caused my illness.
Stress was a major factor in causing my illness.
Timeline
My illness is likely to be permanent rather than temporary.
My illness will last for a long time.
Consequences
My illness has major consequences on my life.
My illness is a serious condition.
Cure-Control
There is little that can be done to improve my illness.
My treatment will be effective in curing my illness.
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IPQ-R-DM

Listed below are a number of symptoms that you may or may not have experienced since your diabetes. Please indicate by circling *Yes* or *No*, whether you have experienced any of these symptoms since your diabetes, and whether you believe that these symptoms are related to your diabetes.

	I have experienced this symptom *since my diabetes*			This symptom is *related to my diabetes*	
Pain	Yes	No	_____	Yes	No
Sore Throat	Yes	No	_____	Yes	No
Nausea	Yes	No	_____	Yes	No
Breathlessness	Yes	No	_____	Yes	No
Weight Loss	Yes	No	_____	Yes	No
Fatigue	Yes	No	_____	Yes	No
Stiff Joints	Yes	No	_____	Yes	No
Sore Eyes	Yes	No	_____	Yes	No
Wheeziness	Yes	No	_____	Yes	No
Headaches	Yes	No	_____	Yes	No
Upset Stomach	Yes	No	_____	Yes	No
Sleep Difficulties	Yes	No	_____	Yes	No
Dizziness	Yes	No	_____	Yes	No
Loss of Strength	Yes	No	_____	Yes	No

We are interested in your own personal views of how you now see your current diabetes.

Please indicate how much you agree or disagree with the following statements about your diabetes by ticking the appropriate box.

	VIEWS ABOUT YOUR DIABETES	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
IP1	My diabetes will last a short time					
IP2	My diabetes is likely to be permanent rather than temporary					
IP3	My diabetes will last for a long time					

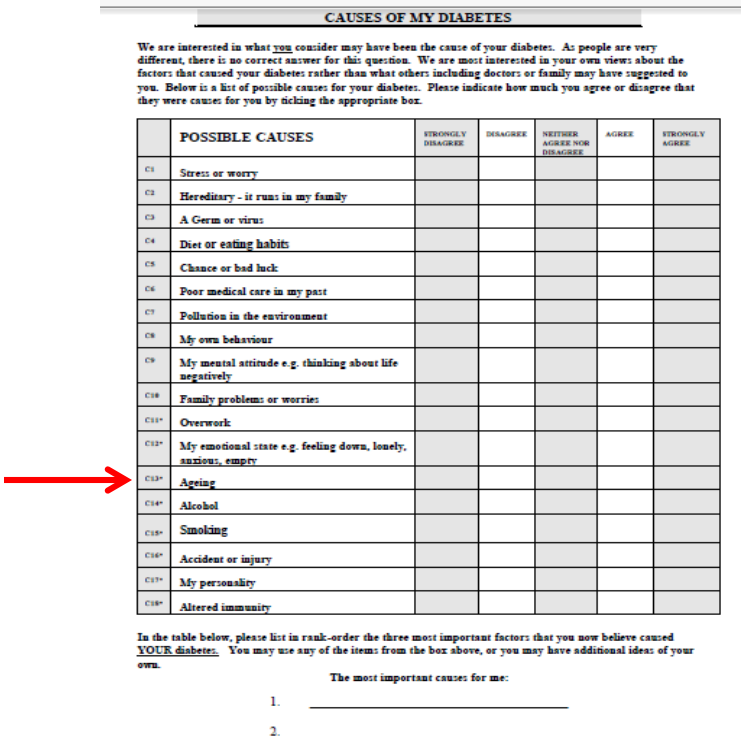
IPQ-R-DM

	VIEWS ABOUT YOUR DIABETES	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
D4*	This diabetes will pass quickly					
D5*	I expect to have this diabetes for the rest of my life					
D6	My diabetes is a serious condition					
D7	My diabetes has major consequences on my life					
D8*	My diabetes does not have much effect on my life					
D9	My diabetes strongly affects the way others see me					
D10	My diabetes has serious financial consequences					
D11	My diabetes causes difficulties for those who are close to me					
D12	There is a lot which I can do to control my symptoms					
D13	What I do can determine whether my diabetes gets better or worse					
D14	The course of my diabetes depends on me					
D15*	Nothing I do will affect my diabetes					
D16	I have the power to influence my diabetes					
D17*	My actions will have no affect on the outcome of my diabetes					
D18*	My diabetes will improve in time					
D19*	There is very little that can be done to improve my diabetes					
D20	My treatment will be effective in curing my diabetes					
D21	The negative effects of my diabetes can be prevented (avoided) by my treatment					
D22	My treatment can control my diabetes					
D23*	There is nothing which can help my condition					
D24	The symptoms of my condition are puzzling to me					
D25	My diabetes is a mystery to me					

IPQ-R-DM

IP26	I don't understand my diabetes					
IP27	My diabetes doesn't make any sense to me					
IP28*	I have a clear picture or understanding of my condition					
IP29	The symptoms of my diabetes change a great deal from day to day					
IP30	My symptoms come and go in cycles					
IP31	My diabetes is very unpredictable					
IP32	I go through cycles in which my diabetes gets better and worse.					
IP33	I get depressed when I think about my diabetes					
IP34	When I think about my diabetes I get upset					
IP35	My diabetes makes me feel angry					
IP36*	My diabetes does not worry me					
IP37	Having this diabetes makes me feel anxious					
IP38	My diabetes makes me feel afraid					

IPQ-R-DM



CAUSES OF MY DIABETES

We are interested in what you consider may have been the cause of your diabetes. As people are very different, there is no correct answer for this question. We are most interested in your own views about the factors that caused your diabetes rather than what others including doctors or family may have suggested to you. Below is a list of possible causes for your diabetes. Please indicate how much you agree or disagree that they were causes for you by ticking the appropriate box.

	POSSIBLE CAUSES	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
C1	Stress or worry					
C2	Hereditary - it runs in my family					
C3	A Germ or virus					
C4	Diet or eating habits					
C5	Chance or bad luck					
C6	Poor medical care in my past					
C7	Pollution in the environment					
C8	My own behaviour					
C9	My mental attitude e.g. thinking about life negatively					
C10	Family problems or worries					
C11*	Overwork					
C12*	My emotional state e.g. feeling down, lonely, anxious, empty					
C13*	Ageing					
C14*	Alcohol					
C15*	Smoking					
C16*	Accident or injury					
C17*	My personality					
C18*	Altered immunity					

In the table below, please list in rank-order the three most important factors that you now believe caused YOUR diabetes. You may use any of the items from the box above, or you may have additional ideas of your own.

The most important causes for me:

1. _____
2.

Beacon Patient-Reported Outcome Quality-of-Life Tool

- Providers in 11 southeast Minnesota counties have their patients with diabetes complete a real-time, easy-to-use assessment tool that helps in identifying and addressing their biggest quality-of-life concerns.
- Completed just before each visit, the tool asks patients to identify their biggest concern, complete a checklist that helps define specific aspects of that concern, and rank various aspects of their perceived well-being.
- Based on the patient's responses, the tool generates a list of interventions that could help the patient (tailored to the site using the tool), including treatment modifications and referrals to locally available resources.
- The electronic version also generates a graphic depiction of trends in patient responses over time. Although a formal, survey-based evaluation of the program is not yet complete, it has generated overwhelmingly positive feedback from patients and clinicians.
- **Evidence Rating** : Suggestive: The evidence consists of anecdotal feedback from patients and clinicians who have used the assessment tool.

Cited by AHRQ

http://www.innovations.ahrq.gov/content.aspx?id=3760

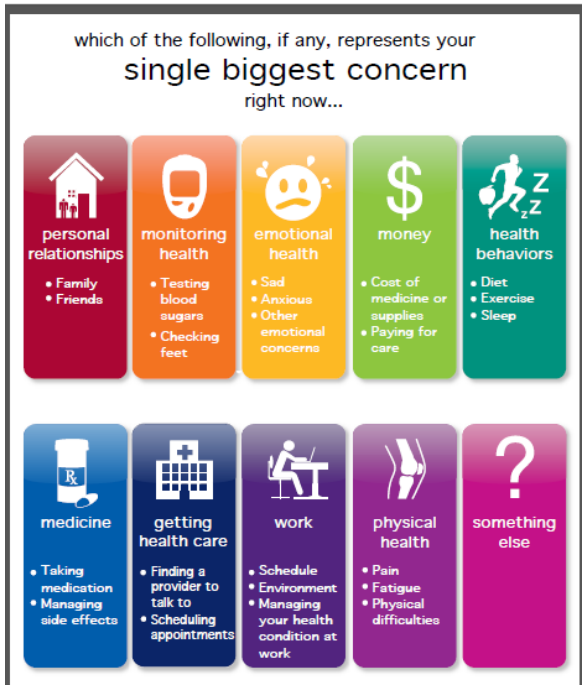
On the next few screens please tell us about a concern that you would like to discuss with your diabetes care team today and answer a few questions about how you are feeling.

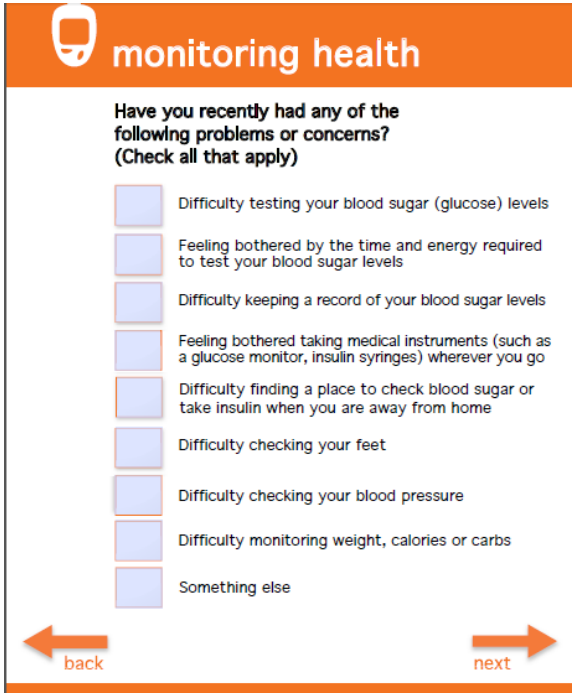
This information will become part of your medical chart. This will **not** replace your regular discussion with your health care team. They will still talk to you today about test results or other health-related issues.

Not only will this allow your health care team to assist you, but it will also help us identify areas where more community resources are needed.

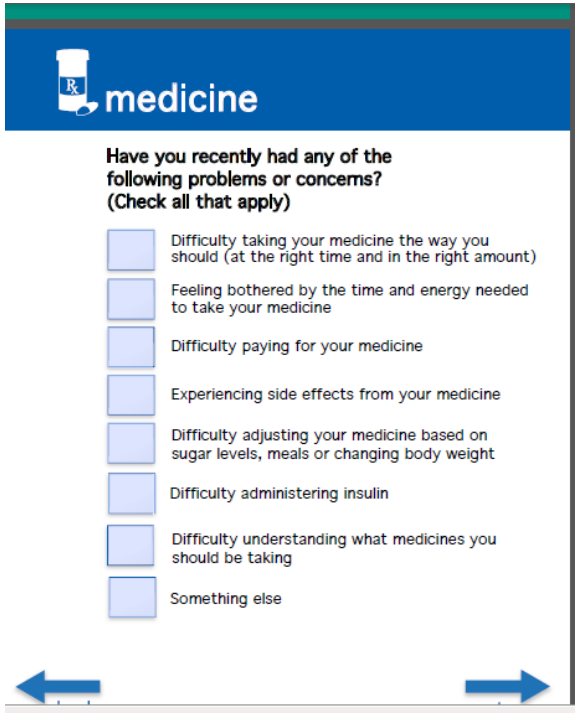
Please click the button below to get started. It will take about 5 minutes to complete.

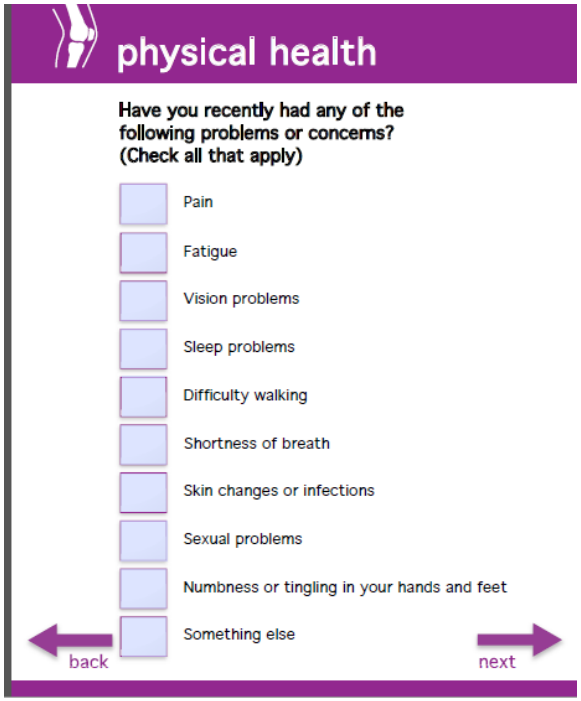
BEGIN


which of the following, if any, represents your
single biggest concern
right now...
personal relationships
• Family
• Friends
monitoring health
• Testing blood sugars
• Checking feet
emotional health
• Sad
• Anxious
• Other emotional concerns
money
• Cost of medicine or supplies
• Paying for care
health behaviors
• Diet
• Exercise
• Sleep
medicine
• Taking medication
• Managing side effects
getting health care
• Finding a provider to talk to
• Scheduling appointments
work
• Schedule
• Environment
• Managing your health condition at work
physical health
• Pain
• Fatigue
• Physical difficulties
something else


monitoring health
Have you recently had any of the following problems or concerns? (Check all that apply)
Difficulty testing your blood sugar (glucose) levels
Feeling bothered by the time and energy required to test your blood sugar levels
Difficulty keeping a record of your blood sugar levels
Feeling bothered taking medical instruments (such as a glucose monitor, insulin syringes) wherever you go
Difficulty finding a place to check blood sugar or take insulin when you are away from home
Difficulty checking your feet
Difficulty checking your blood pressure
Difficulty monitoring weight, calories or carbs
Something else
back
next


health behaviors
Have you recently had any of the following problems or concerns? (Check all that apply)
Eating too much or too little
Not sticking to your meal plan
Not exercising the right amount
Difficulty doing everyday physical activities such as walking, climbing stairs, carrying groceries
Not sleeping enough to feel well-rested
Feeling you should cut down on the amount of alcohol you drink
Feeling you should quit smoking or using tobacco
Something else
back
next


medicine
Have you recently had any of the following problems or concerns? (Check all that apply)
Difficulty taking your medicine the way you should (at the right time and in the right amount)
Feeling bothered by the time and energy needed to take your medicine
Difficulty paying for your medicine
Experiencing side effects from your medicine
Difficulty adjusting your medicine based on sugar levels, meals or changing body weight
Difficulty administering insulin
Difficulty understanding what medicines you should be taking
Something else


physical health
Have you recently had any of the following problems or concerns? (Check all that apply)
Pain
Fatigue
Vision problems
Sleep problems
Difficulty walking
Shortness of breath
Skin changes or infections
Sexual problems
Numbness or tingling in your hands and feet
Something else
back
next


www.diabetesinitiative.org/resources/resources.html
DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation
Home · What is Self Management · Build A Program · Support Your Program · Program Models · Resources · Lessons Learned · Search
Resources
Materials By Type
Materials By Topic
Diabetes Initiative Tools
Record of Grantee Meetings
Resources
Grantees of the Diabetes Initiative have adapted and developed materials useful to project implementation, training, education and assessment activities. We are making them available on this Web site for others to use or adapt in their own organizations. If you use or adapt these please give credit to the developing organization.
Materials By Type
Assessment Materials, Forms & Instruments
Patient Education Materials
Presentations
Program Management & Implementation
Spanish Materials
Staff Training Materials & Methods
Template Recruitment & Marketing Materials
Materials By Topic
Community Health Workers (including Lay Health Workers & Educators, Coaches & Promotoras)
Follow-up and Support
General Administration
Goal Setting
Healthy Coping
Healthy Eating
Individual Assessment
Linking to Quality Clinical Care
Multiple Self Management Behaviors
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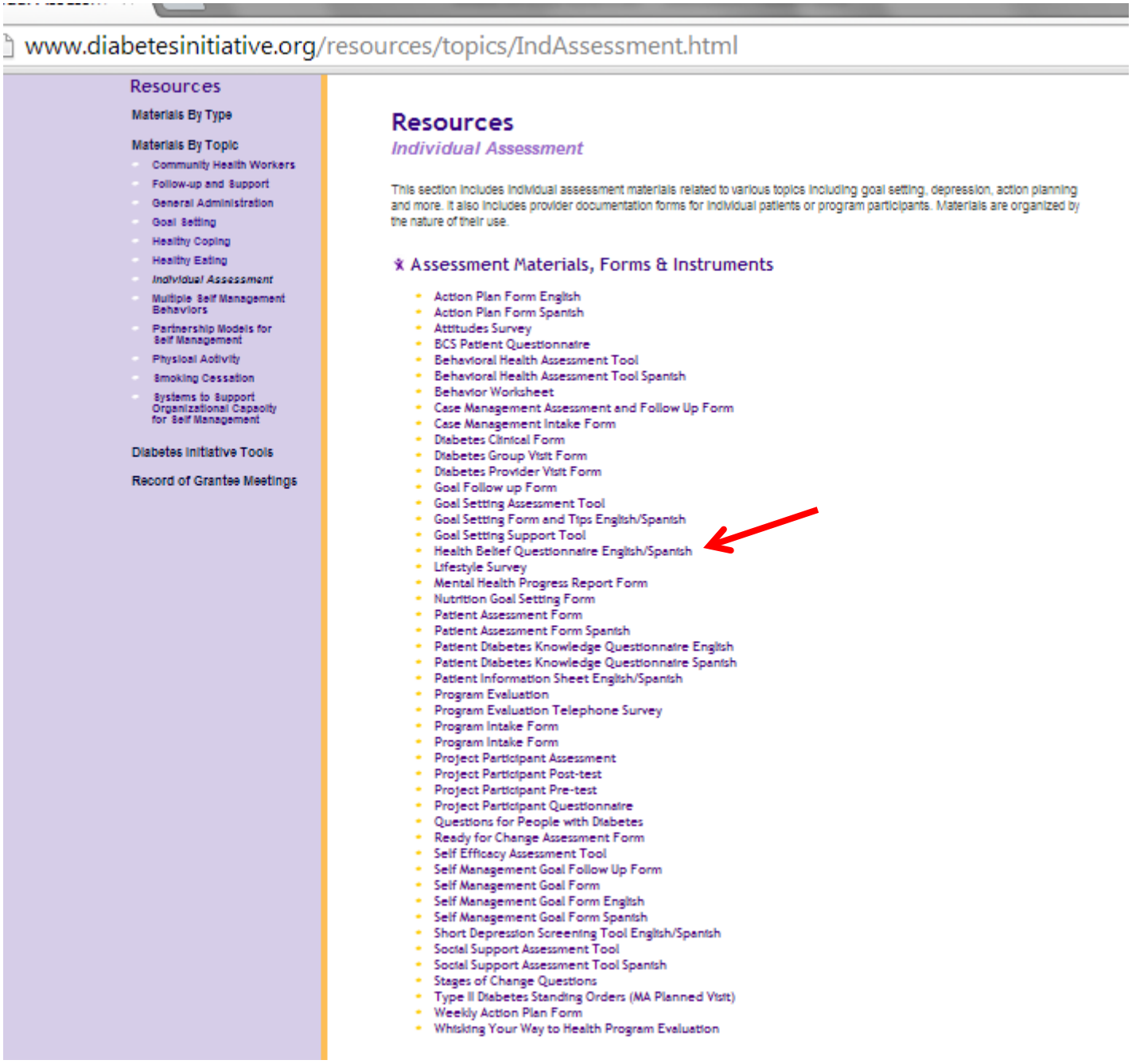

www.diabetesinitiative.org/resources/topics/IndAssessment.html
Resources
Materials By Type
Materials By Topic
Community Health Workers
Follow-up and Support
General Administration
Goal Setting
Healthy Coping
Healthy Eating
Individual Assessment
Multiple Self Management Behaviors
Partnership Models for Self Management
Physical Activity
Smoking Cessation
Systems to Support Organizational Capacity for Self Management
Diabetes Initiative Tools
Record of Grantee Meetings
Resources
Individual Assessment
This section includes individual assessment materials related to various topics including goal setting, depression, action planning and more. It also includes provider documentation forms for individual patients or program participants. Materials are organized by the nature of their use.
Assessment Materials, Forms & Instruments
Action Plan Form English
Action Plan Form Spanish
Attitudes Survey
BCS Patient Questionnaire
Behavioral Health Assessment Tool
Behavioral Health Assessment Tool Spanish
Behavior Worksheet
Case Management Assessment and Follow Up Form
Case Management Intake Form
Diabetes Clinical Form
Diabetes Group Visit Form
Diabetes Provider Visit Form
Goal Follow up Form
Goal Setting Assessment Tool
Goal Setting Form and Tips English/Spanish
Goal Setting Support Tool
Health Belief Questionnaire English/Spanish
Lifestyle Survey
Mental Health Progress Report Form
Nutrition Goal Setting Form
Patient Assessment Form
Patient Assessment Form Spanish
Patient Diabetes Knowledge Questionnaire English
Patient Diabetes Knowledge Questionnaire Spanish
Patient Information Sheet English/Spanish
Program Evaluation
Program Evaluation Telephone Survey
Program Intake Form
Program Intake Form
Project Participant Assessment
Project Participant Post-test
Project Participant Pre-test
Project Participant Questionnaire
Questions for People with Diabetes
Ready for Change Assessment Form
Self Efficacy Assessment Tool
Self Management Goal Follow Up Form
Self Management Goal Form
Self Management Goal Form English
Self Management Goal Form Spanish
Short Depression Screening Tool English/Spanish
Social Support Assessment Tool
Social Support Assessment Tool Spanish
Stages of Change Questions
Type II Diabetes Standing Orders (MA Planned Visit)
Weekly Action Plan Form
Whisking Your Way to Health Program Evaluation

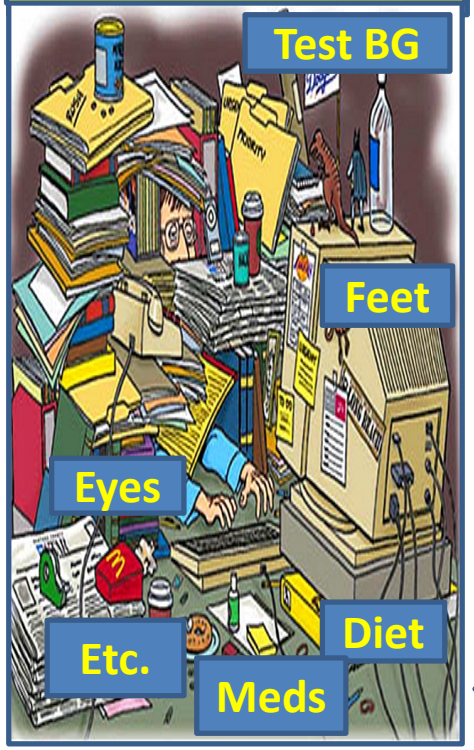
Appendix B: Health Belief Questionnaire

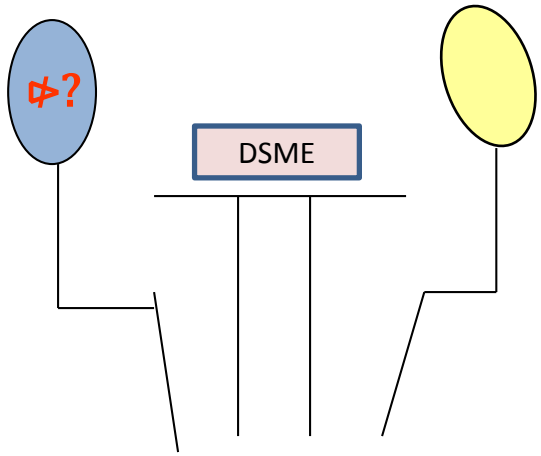
Key: 5 = Strongly Agree; 4 = Agree; 3 = Not Sure; 2 = Disagree; 1 = Strongly Disagree *Clave: 5=Totalmente Deacuerdo; 4=Deacuerdo; 3=No estoy seguro; 2=Desacuerdo; 1=Totalmente en desacuerdo*		
1. 1.	*Mi diabetes esta bien controlada* My diabetes is well controlled	
2. 2.	*Tendria que cambiar demasiadas costumbres para seguir mi dieta (comidas de diabeticos)* I would have to change too many habits to follow my diet (diabetic foods)	
3. 3.	*Ha sido dificil seguir la dieta (comidas de diabeticos) que me receto el doctor* It has been difficult following the diet (diabetic foods) the doctor ordered for me	
4. 4.	*Estoy confundido por todo el medicamento que el doctor me ha dado* I am confused by all the medication the doctor has given me	
5. 5.	*Tendria que cambiar muchos habitos para tomar mi medicamento* I would have to change too many habits to take my medication	
6. 6.	*Tomar mi medicamento interfiere con mis actividades diarias normales* Taking my medication interferes with my normal daily activities	
7. 7.	*Tengo otras personas alrededor de mi que me recuerdan de comer los alimentos adecuados* I have others around me who remind me to eat the right foods	
8. 8.	*Puedo contar con mi familia cuando necesito ayuda para seguir mi dieta (comidas de diabeticos)* I can count on my family when I need help following my diet (diabetic foods)	
9. 9.	*Mi esposo/esposa me ayuda a seguir mi dieta (comidas de diabeticos)* My husband /wife helps me follow my diet (diabetic foods)	
10. 10.	*Si cambiara de "trabajo" seria mas facil seguir mi dieta (comidas de diabeticos)* If I changed "jobs" I would be easier to follow my diet (diabetic foods)	
11. 11.	*Me cansa tanto mi trabajo que es dificil seguir mi dieta (comidas de diabeticos)* My work makes me so tired that it's hard to follow my diet (diabetic foods)	
12. 12.	*Podria controlar mi peso si las presiones de mi trabajo no fueran tan grandes* I could control my weight if the pressures of my job weren't so great	

How do CDEs prioritize ?

Much to teach.

DSM behaviors





Many standards to meet.

American Guidelines: DSME &/or **Elderly**

- ADA/Endo Soc 2013
- ACOG 2011
- Joslin 2007 2009
- ADA/AGS 2012
- AAFP 2009
- ADA/EASD 2012
- ADA 2014
- APA 2004,2012
- AGS 2012 2013
- Others
- AACE/ACE/OS 2011
- AACE 2013
- IDF 2013

Older adults with diabetes

I. Trends in prevalence, costs, delivery of care
II. Current guidelines and tools for assessing their DSM* needs, challenges, resources
III. Likely sources of DSM errors and non-adherence
IV. Criteria for evaluating quality and relevance of assessments
V. Most useful assessments for older adults

*DSM=diabetes self-management

Patient's Method of Figuring Meal-time Insulin Doesn't Quite Work

Recently I assessed an 84 year old inpatient with diabetes for his insulin usage at home. In reporting his dosing he stated that after he checked his glucose before each meal he took the "first two numbers of the result," and made that his dosage for meal-time insulin. For example, if the glucose reading was 240, he would take 24 units of Humalog.

I asked him if this was his instruction per his provider and he said, "No, but it was the only thing that made sense to me that I could remember."...

A specific teaching plan with simple dosing was designed for him and a home health evaluation for medication administration safety was also made on his return home.

Lesson Learned:

This example once again reiterates the importance of having the patient give you a verbal and sometimes a practice demonstration of what they understand to be the practice for medication administration.

Janet Howard-Ducsay, RN, BA/BSN, CDE
Diabetes Nurse Educator

Diabetes Disaster Averted #51: Careful Listening Saves Lives

A few years ago, I was working as a Nurse Practitioner in an endocrinology practice. One of my longstanding elderly patients, age 82, called me to report that the paramedics had to come to her house because she passed out....

I scheduled her for an appointment the next day, and took her history. She'd had diabetes for about 15 years, and was taking a long acting insulin at bedtime and rapid acting insulin before her meals. I reviewed her activities of the day (meal times, insulin doses and times, and activity level). She reported that she had her dinner, and then next thing she knew she was passed out at the dinner table. I performed a complete physical exam, which was normal. I was ready to order a battery of lab tests, and considering testing her for gastroparesis since it appeared that she'd had a severe hypoglycemic reaction so soon after eating.

I reviewed her recent episode with her again, stating "so you ate your dinner, and then you passed out..." at which point she interrupted with "no, I did not eat my dinner, I HAD it, it was right in front of me on the table, and then I passed out...." The conclusion was that she had a severe hypoglycemic reaction because she delayed her dinner.

Lesson learned: *Obtain a complete history from the patient,* ***choosing words carefully****, and make sure you and your patient are speaking the same language and have the same meaning! The lesson learned from this case saved a lot of time and money from unnecessary testing and work up.*

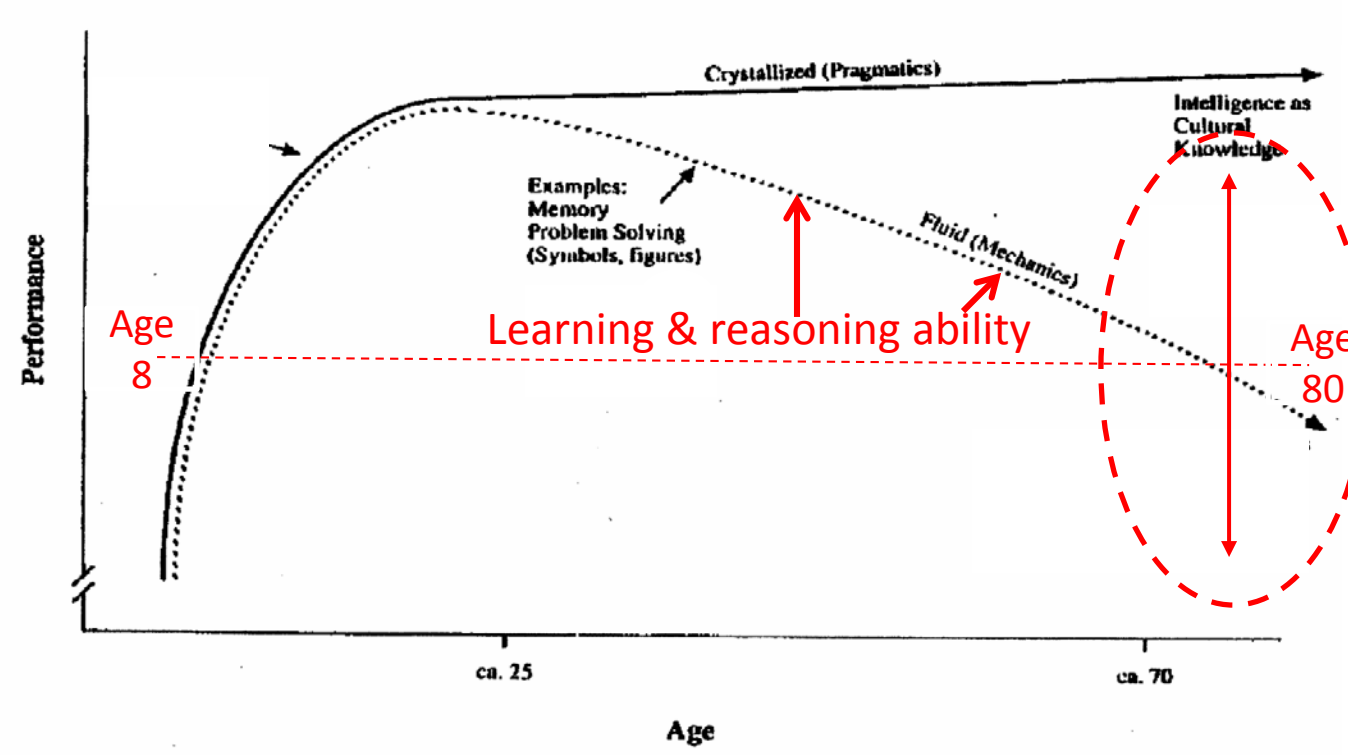
Louise DeRiso, MSN, CRNP, CCRC

Coordinator, Vascular Clinical & Translational Research Center

University of Pittsburgh

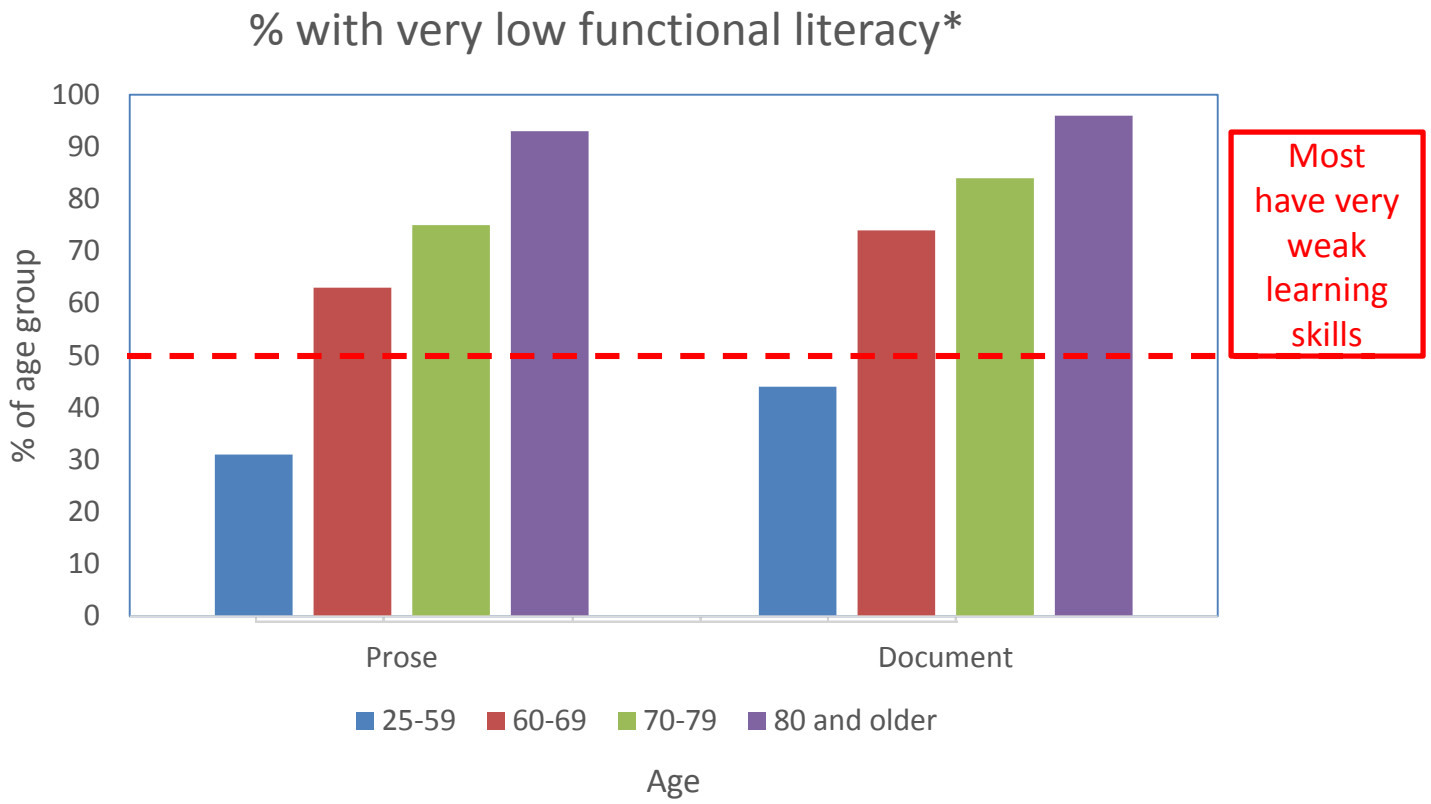
Normal age-related cognitive decline

How important?
Cognitive ability ≈ ability to learn & reason well ≈ functional literacy Cognitive ability ⇒ better DSM Functional literacy ⇒ better adherence



Recall: older adults have less functional literacy

How handicapping? VERY!



*Level 1 or 2 on NCES adult literacy survey's 5-level scale Source: Tables 1.2 and 1.3 of *Literacy of Older Adults in America*, 1996, http://nces.ed.gov/pubs97/97576.pdf (accessed 8/1/14)

Typical literacy items, by difficulty level

National Adult Literacy Survey (NALS), 1993

Community dwelling

NALS difficulty level	% US adults peaking at this level: Prose scale				Simulated everyday tasks
	Age				Daily self-maintenance in modern literate societies
	16-59	60-69	70-79	80+	
5	4	1	1	0	▪ Use calculator to determine cost of carpet for a room ▪ Use table of information to compare 2 credit cards
4	20	8	5	1	▪ Use eligibility pamphlet to calculate SSI benefits ▪ Explain difference between 2 types of employee benefits
3	35	27	19	6	▪ Calculate miles per gallon from mileage record chart ▪ Write brief letter explaining error on credit card bill
2	25	33	22	27	▪ Determine difference in price between 2 show tickets ▪ Locate intersection on street map
1	16	30	42	66	▪ Total bank deposit entry ▪ Locate expiration date on driver's license

Includes normal cognitive decline

Typical literacy items, by difficulty level

National Adult Literacy Survey (NALS), 1993

NALS difficulty level	% US adults peaking at this level: Prose scale				Simulated everyday tasks
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3	35	27	19	6	▪ Calculate miles per gallon from mileage record chart ▪ Write brief letter explaining error on credit card bill
2	25	33	22	27	▪ Determine difference in price between 2 show tickets ▪ Locate intersection on street map
1	16	30	42	66	▪ [illegible] ▪ Locate expiration date on driver's license

NOT reliable informants!

Typical literacy items, by difficulty level

National Adult Literacy Survey (NALS), 1993

NALS difficulty level	% US adults peaking at this level: Prose scale				Simulated everyday tasks
	Age				Daily self-maintenance in modern literate societies
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2	25	33	22	27	▪ …nce in price between 2 show tickets ▪ …on street map
1	16	30	42	66	▪ Total bank deposit entry ▪ Locate expiration date on driver's license

a b i l i t y

The "simple" becomes harder or impossible to do

Typical literacy items, by difficulty level

National Adult Literacy Survey (NALS), 1993

NALS difficulty level	% US adults peaking at this level: Prose scale				Simulated everyday tasks
	Age				Daily self-maintenance in modern literate societies
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5	4	1	1	0	▪ Use calculator to determi ▪ Use table of information t
4	20	8	5	1	▪ Use eligibility pamphlet to ▪ Explain difference betwee
3	35	27	19	6	▪ Calculate miles per gallon ▪ Write brief letter explaini
2	25	33	22	27	▪ Determine difference in p ▪ Locate intersection on str
1	16	30	42	66	▪ Total bank deposit entry ▪ Locate expiration date on driver's license

complexity

Elements of "process complexity"

- number of features to match
- level of inference
- abstractness of info
- distracting info

Task difficulty level is *not* about readability, but about "problem solving"

Document1 - Microsoft Word

File Home Insert Page Layout References Mailings Review View PDF

Spelling & Grammar | Research | Thesaurus | Word Count — Proofing
Translate | Language — Language
New Comment | Delete | Previous | Next — Comments
Track Changes | Final: Show Markup | Show Markup | Reviewing Pane — Tracking
Accept | Reject | Previous | Next — Changes
Compare — Compare
Block Authors | Restrict Editing — Protect

Readability doesn't make a complex task easy

To be or not to be, that is the question.

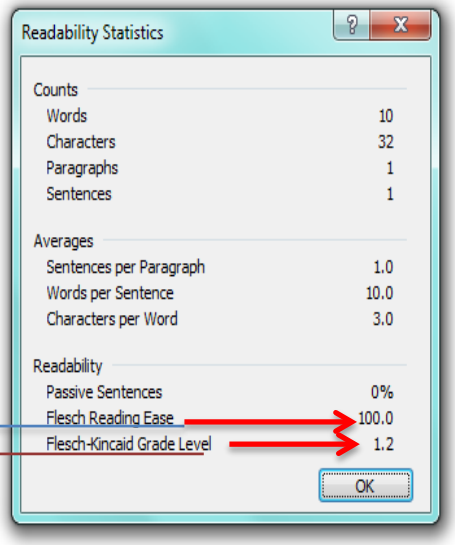
Ingredients of readability:

ASW: Average syllables per word

ASL: Average words per sentence

206.835- (84.6 * ASW) - (1.015 * ASL)

(0.39 * ASL) + (11.8 * ASW) -15.59



Page: 1 of 1 | Words: 10 | 160%

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Recall

Appropriate assessment is essential for individualizing DSME.

To do that, CDEs will need to:

1. screen older adults for most critical DSM tasks

2. assess patient's major barriers to learning

3. recognize the complexity levels of the DSM tasks (Bloom's Taxonomy)

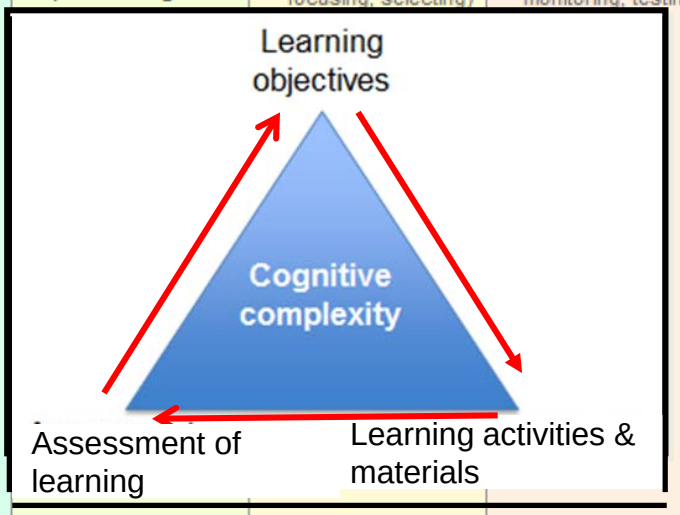
Bloom's Taxonomy of Learning Objectives (2001 revision)

Bloom's levels = continuum of cognitive complexity

Table 1. The cognitive processes dimension — categories, cognitive processes (and alternative names)

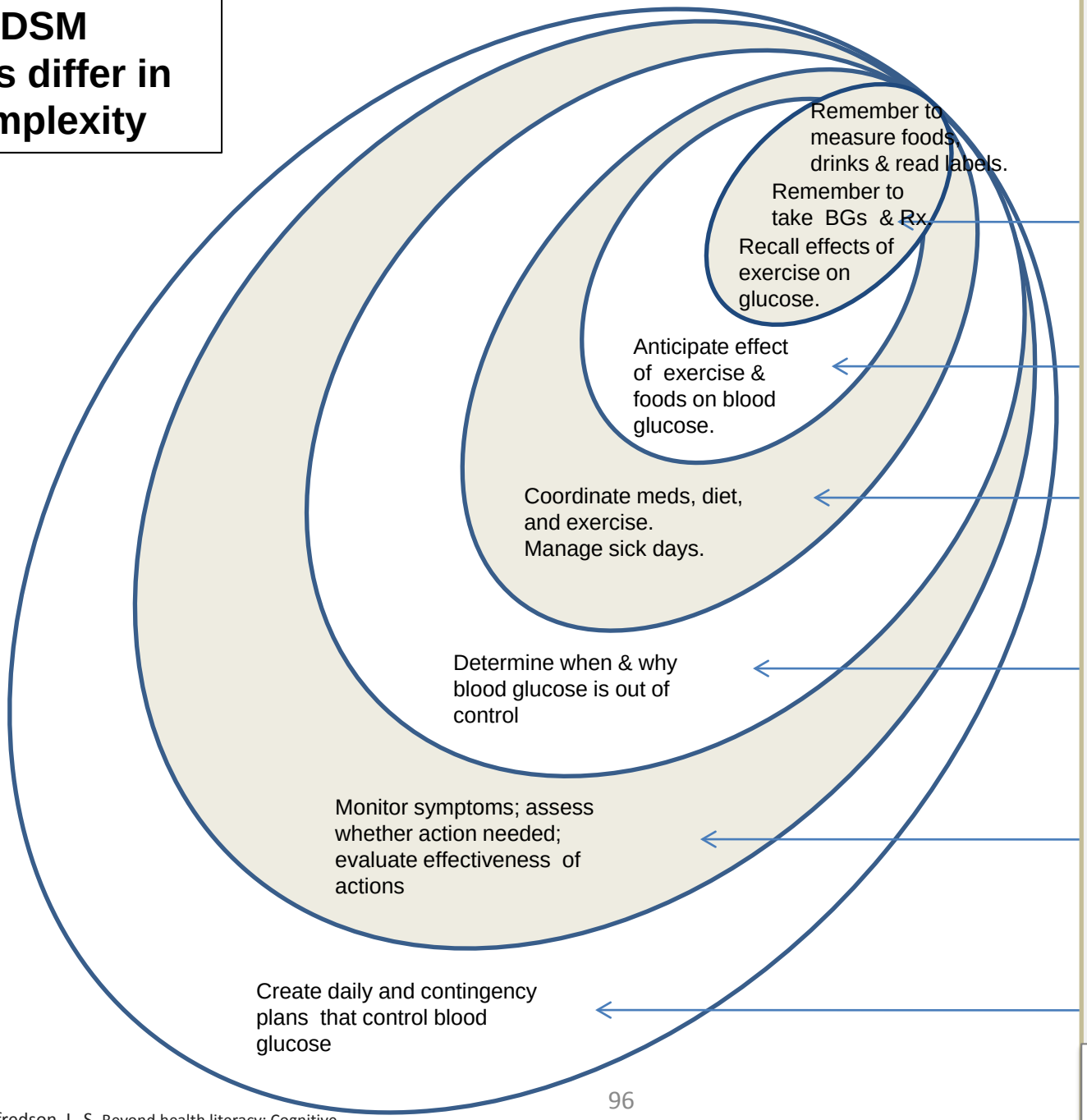
lower order thinking skills → higher order thinking skills

remember	understand	apply	analyze	evaluate	create
recognizing (identifying) recalling (retrieving)	interpreting (clarifying, paraphrasing, representing, translating) exemplifying (illustrating, instantiating) classifying (categorizing, subsuming) summarizing (abstracting, generalizing) inferring (concluding, extrapolating, interpolating, predicting) comparing (contrasting, mapping, matching) explaining (constructing models)	executing (carrying out) implementing	differentiating (discriminating, distinguishing, focusing, selecting)	checking (coordinating, detecting, monitoring, testing)	generating (hypothesizing) planning (designing) producing (construct)



(Table 1 adapted from Anderson and Krathwohl, 2001, pp. 67–68.)

DSM tasks differ in complexity



Bloom's taxonomy of educational objectives (cognitive domain)*

Simplest tasks

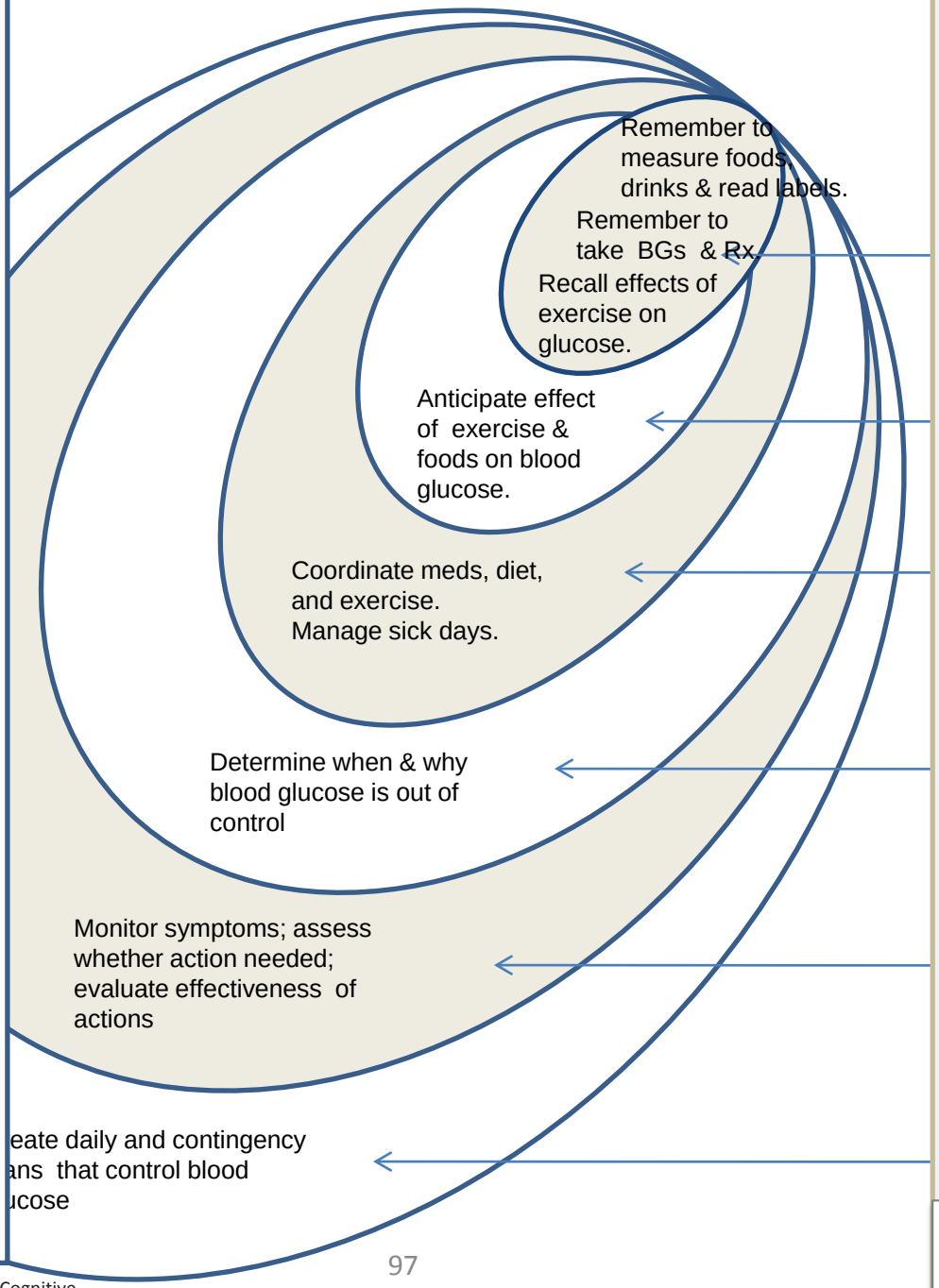
1. **Remember**
   recognize, recall, Identify, retrieve
2. **Understand**
   paraphrase, summarize, compare, predict, infer
3. **Apply**
   execute familiar task,, apply procedure to unfamiliar task
4. **Analyze**
   distinguish, focus, select, integrate, coordinate
5. **Evaluate**
   check, monitor, detect inconsistencies, judge effectiveness
6. **Create**
   hypothesize, plan, invent, devise, design

Most complex tasks

*Revised 2001: Anderson, L. W., & Krathwohl,D. R. *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives.* NY: Addison Wesley Longman.

Instructional strategy—minimize *unnecessary* cognitive load

- Teach essential DSM tasks first, one at a time
- Sequence instruction from simple to complex ideas & skills
- Adjust speed and abstractness of instruction to accommodate individual's learning needs
- **Never** assume that something is "simple" or obvious
- Confirm mastery before moving on
- Don't squander individual's cognitive resources by teaching non-essential skills and content, using too-complex materials, etc.



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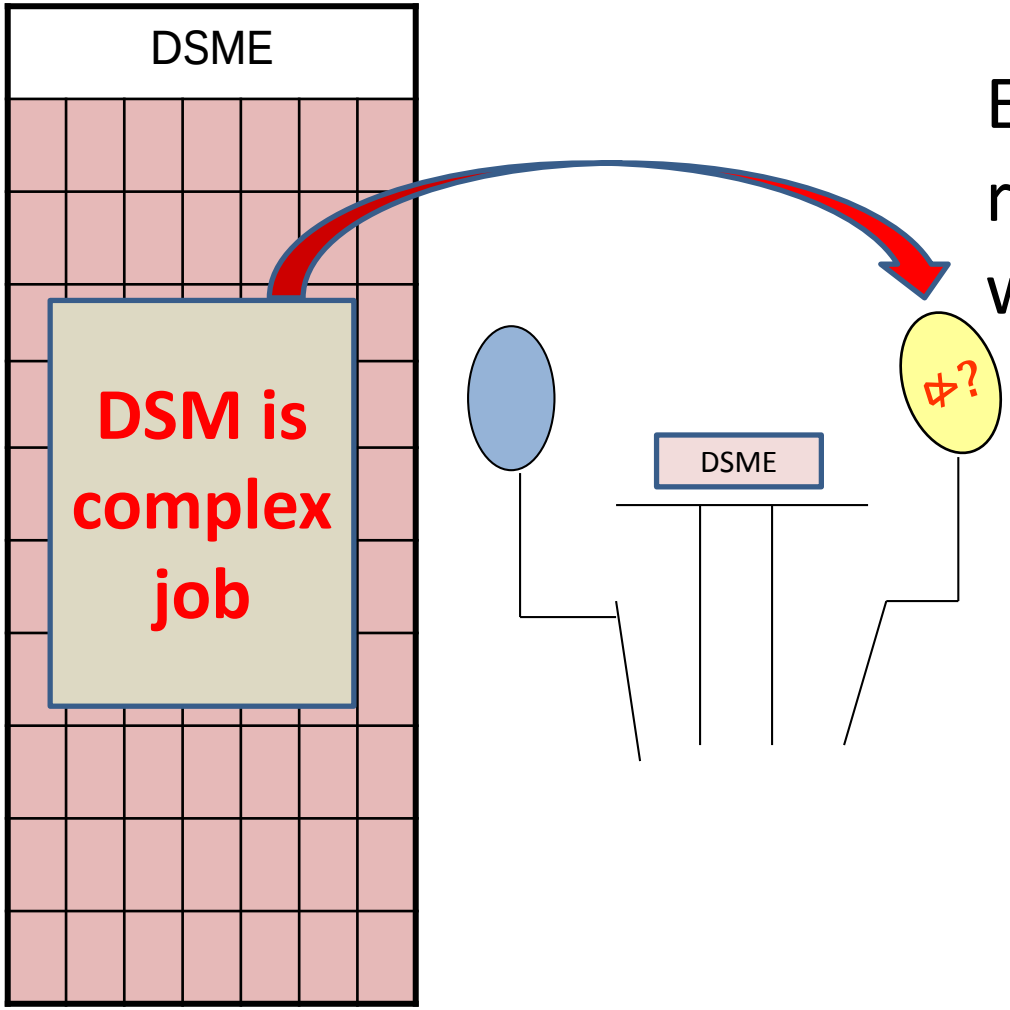
6. **Create**
   hypothesize, plan, invent, devise, design

Most complex tasks

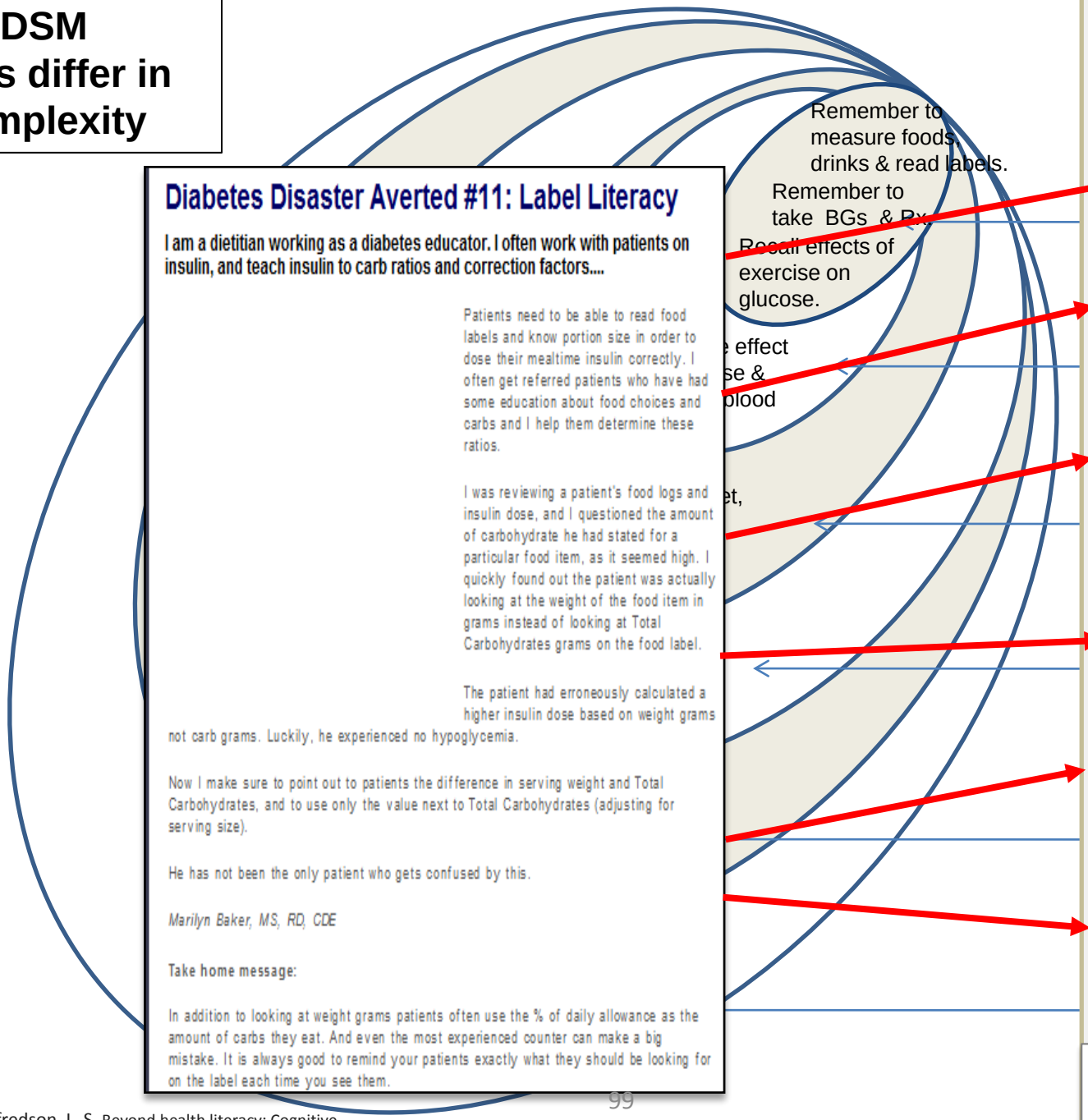
*Revised 2001: Anderson, L. W., & Krathwohl,D. R. *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives.* NY: Addison Wesley Longman.

Risk of cognitive overload!

Especially when cognitive resources are weak or declining



DSM tasks differ in complexity



Diabetes Disaster Averted #11: Label Literacy

I am a dietitian working as a diabetes educator. I often work with patients on insulin, and teach insulin to carb ratios and correction factors....

Patients need to be able to read food labels and know portion size in order to dose their mealtime insulin correctly. I often get referred patients who have had some education about food choices and carbs and I help them determine these ratios.

I was reviewing a patient's food logs and insulin dose, and I questioned the amount of carbohydrate he had stated for a particular food item, as it seemed high. I quickly found out the patient was actually looking at the weight of the food item in grams instead of looking at Total Carbohydrates grams on the food label.

The patient had erroneously calculated a higher insulin dose based on weight grams not carb grams. Luckily, he experienced no hypoglycemia.

Now I make sure to point out to patients the difference in serving weight and Total Carbohydrates, and to use only the value next to Total Carbohydrates (adjusting for serving size).

He has not been the only patient who gets confused by this.

Marilyn Baker, MS, RD, CDE

Take home message:

In addition to looking at weight grams patients often use the % of daily allowance as the amount of carbs they eat. And even the most experienced counter can make a big mistake. It is always good to remind your patients exactly what they should be looking for on the label each time you see them.

Bloom's taxonomy of educational objectives (cognitive domain)*

Simplest tasks

1. **Remember**
   recognize, recall, Identify, retrieve
2. **Understand**
   paraphrase, summarize, compare, predict, infer
3. **Apply**
   execute familiar task,, apply procedure to unfamiliar task
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5. **Evaluate**
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I scheduled her for an appointment the next day, and took her history. She'd had diabetes for about 15 years, and was taking a long acting insulin at bedtime and rapid acting insulin before her meals. I reviewed her activities of the day (meal times, insulin doses and times, and activity level). She reported that she had her dinner, and then next thing she knew she was passed out at the dinner table. I performed a complete physical exam, which was normal. I was ready to order a battery of lab tests, and considering testing her for gastroparesis since it appeared that she'd had a severe hypoglycemic reaction so soon after eating.

I reviewed her recent episode with her again, stating "so you ate your dinner, and then you passed out..." at which point she interrupted with "no, I did not eat my dinner, I HAD it, it was right in front of me on the table, and then I passed out...." The conclusion was that she had a severe hypoglycemic reaction because she delayed her dinner.

Lesson learned: *Obtain a complete history from the patient,* ***choosing words carefully****, and make sure you and your patient are speaking the same language and have the same meaning! The lesson learned from this case saved a lot of time and money from unnecessary testing and work up.*

Louise DeRiso, MSN, CRNP, CCRC

Coordinator, Vascular Clinical & Translational Research Center

University of Pittsburgh

She did not accurately remember ("eat dinner") the DM ed,
She did not understand ("eat vs *had* meal"),
Could not apply instructions appropriately,
Could not analyze her situation
Could not evaluate what she did wrong

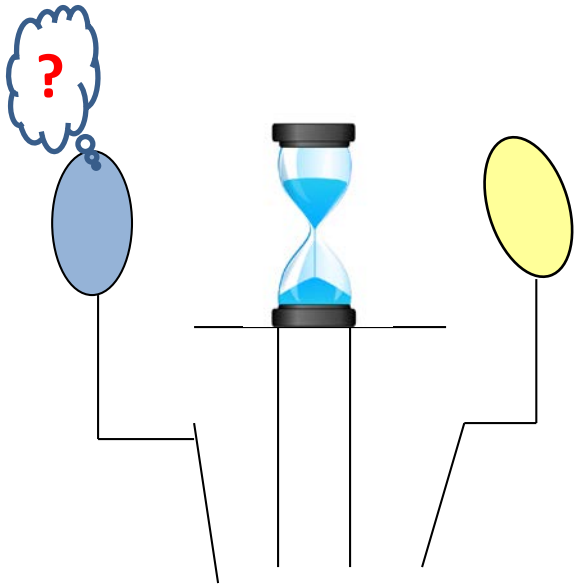
Older adults with diabetes

I. Trends in prevalence, costs, delivery of care
II. Current guidelines and tools for assessing their DSM* needs, challenges, resources
III. Likely sources of DSM errors and non-adherence
IV. Criteria for evaluating quality and relevance of assessments
V. Most useful assessments for older adults

*DSM=diabetes self-management

What is most important to know

- about this patient
  - right now
  - and *why*?



Is the assessment tool

Clinically relevant ?
Valid ?
Reliable ?
Useful ?

For your elderly patient ?

Criteria for evaluating assessment tools

- **Clinical relevance:** Is what you intend to measure, really worth measuring?
  - In *this* population*
  - For *my* purposes
- **Validity:** Does this tool really measure it?
  - In *this* population
- **Reliability:** Does it provide results precise and consistent enough for my purposes?
  - In *this* population
- **Utility:** Do the benefits of using it outweigh the costs/harm?
  - In *this* population

*Here, older adults with diabetes

Single Item Literacy Screen (SILS)

"How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

1-Never
2-Rarely
3-Sometimes
4-Often
5-Always

Difficulty reading
and understanding
printed health related material.

BMC Family Practice 2006, **7**:21

1. Clinical relevance

Is what you intend to measure,

really worth measuring?

- ❑ High priority patient behavior or outcome?
- ❑ A big causal influence?
- ❑ Malleable? (fixable)
- ❑ In my intended population?
- ❑ Results would guide instructional decisions

How do you know that?
Good evidence, or mostly supposition?

2. Validity

Does the tool really measure what it claims to?

- ❑ Am I really clear about what I want to measure ?
- ❑ Does this tool really measure it?
  - o Solid *evidence*?
  - o Label is poor guide
    - – Same label often means different things (e.g., “quality of life”)
    - – Different labels often mean same thing (e.g., “literacy” & “cognitive ability”)
  - o Testimonials are poor guide
- ❑ Any validation for <u>older adults</u>?

3. Reliability

How precise and consistent are the results this tool provides?

- ❑ Margin of error (if “continuous” variable)?
- ❑ Or, rate of false positives and false negatives (if categorical)?
- ❑ Accurate enough for my intended use?
- ❑ Any evidence for older adults?

Evidence matters, popularity does not.

4. Utility

Do the benefits outweigh the costs/harm of using this tool?

- ❑ Acceptable to patients & providers?
- ❑ Comprehensible to users?
- ❑ Feasible for practical use?
  - o Expense; time to administer, score and record; flow of work; staff
- ❑ Consequences of collecting and using the info?
  - o Benefits of true positives and negatives
  - o Harm of false positives and negatives

Evidence matters, wishful thinking does not

Older adults with diabetes

I. Trends in prevalence, costs, delivery of care
II. Current guidelines and tools for assessing their DSM* needs, challenges, resources
III. Likely sources of DSM errors and non-adherence
IV. Criteria for evaluating quality and relevance of assessments
V. Most useful assessments for older adults

*DSM=diabetes self-management

Assessment Realities

- Myriad assessments, but few validated for older adults
- Older adults have a more complicated DSM job
- Older adults tend to have fewer cognitive resources for learning and doing DSM well
- But they differ enormously—one size does not fit all

The most useful assessment tools for the elderly answer these questions:

1. What is most important, right now, for this patient to *learn to do DSM?*
2. What are the *major barriers* to this patient learning to *do DSM?*
3. What is the most effective way to *teach* this patient ?

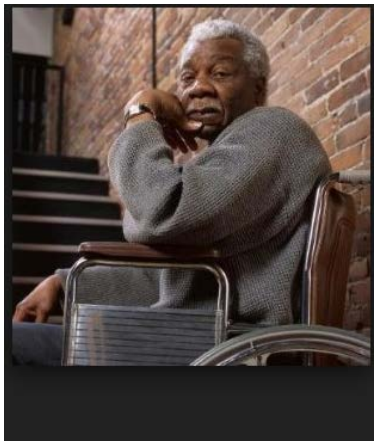
And **meet these criteria**:

Clinically relevant
Valid
Reliable
Useful

Recall……..

- Many of your patients/clients will:
  - have complex medical problems,
  - experience heavy burdens in self-care,
  - but have fewer physical and cognitive reserves for effective self-care.

- Patients' physical and cognitive health trajectories will differ widely



Good Assessment Matters!

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