Helping Diabetic Patients Achieve Glycemic Control: Barriers to the Transition of Care from an Inpatient to an Outpatient Setting

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Introduction

Achieving glycemic control in patients with diabetes can be a challenging task. This is especially true when patients become ill and require admission to an acute care facility, and subsequent discharge. The transition of care between the inpatient and outpatient setting can be difficult to navigate, for patients and providers, and can result in poor blood glucose control as well as other complications.

Purpose

The purpose of this study was to identify barriers to the transition of care for patients with diabetes from the inpatient to outpatient setting.

Methods

Hospitalist and primary care providers were surveyed to identify if barriers existed in the transition of care and if so, what specific barriers they have identified. The 16 question survey using BlueQ, a survey program through Creighton University, was emailed to the providers

Setting & Sample

A convenience sample of health care providers in a large Mid-Western healthcare facility were sent the survey. The healthcare providers included 21 hospitalists, 50 family practice, and 19 internal medicine providers.

N=7 (included five MDs, one DO and one nurse practitioner.)

Results

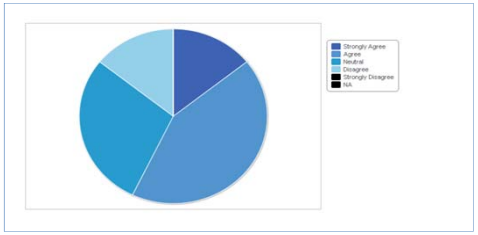
All of the survey respondents strongly agreed that the transition of care between the inpatient and outpatient setting is important for patients with diabetes.

Barriers exist in the transition of care: 100% agreed or strongly agreed

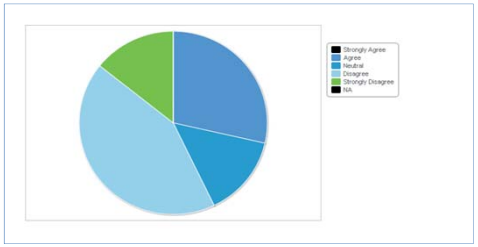
Use of a discharge coordinator or team would help improve the process of discharge transition for diabetic patients (90%)

Suggested improvements to the transition of care included: better communication, a more proactive role of diabetes educators and health coaches in discharge planning and patient education, and a timely follow up appointment with the primary care provider

There are times when I feel as though I do not have an accurate picture of my diabetic patient's hospital course and discharge plan



My patients seem to have a good understanding of their hospital discharge instructions during their follow-up appointment with me



Conclusions

- Communication and utilization of nursing resources is important in the transition of care of diabetic patients
- Barriers to the transition of care do exist in the process
- Lack of communication was identified as the greatest barrier
- The use of CNSs and CNPs may help to reduce these barriers
- A diabetic educator and health coach may also assist in reducing these barriers

Limitations

- The sample size was small and non-diverse
- Subjects were recruited from only one health care facility in a small mid-western community
- The time frame for returning surveys was brief due to restraints related to the project

Discussion and Implications

- Improving diabetic outcomes may be achieved by improved communication between acute care and primary care providers
- The use of the electronic medical record has improved continuity of care (this is a new statement – no mention of EMR yet)
- Utilization of resources such as CNS, CNP, health coach, and diabetic educator may assist in the transition
- Further research could be completed reviewing the role of a diabetes education team, health coach and discharge coordinator on the discharge transition. Outcomes could include rate of timely follow up, patient understanding of hospital discharge instructions, medication compliance, medication reconciliation and actions taken once poor glucose control is identified.

Acknowledgements

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