

# TYPE 2 DIABETES FACT SHEET: CARE COORDINATION

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*While improvements have been made in the number of patients achieving A1C goals, only 50% of patients achieved a goal of <7% in 2007-2010.<sup>1</sup> Effective coordination of care may impact the delivery of optimal care for patients with type 2 diabetes (T2D). The American Diabetes Association (ADA) has recommended strategies to help ensure continuity of care for patients with T2D.<sup>2</sup>*  
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## ADA RECOMMENDED STRATEGIES<sup>2</sup>

- Align care with components of the Chronic Care Model to ensure productive healthcare professional–patient interactions.
- Care systems should support team-based care, community involvement, patient registries, and decision support tools.
- Treatment decisions should be timely and follow evidence-based guidelines that are tailored to individual patient needs.
- A patient-centered communication style that addresses patient preferences, literacy and numeracy, and cultural barriers, should be employed.

### **Successful transition from inpatient to outpatient care is critical for the management of T2D<sup>3</sup>**

- Understand the patient’s daily life, including the living situation postdischarge
- Identify comorbidities before and at time of hospitalization
- Set goals for therapy and select antihyperglycemia regimen
- Provide nutritional counseling and recommendations for physical activity

### **People with diabetes are at high risk of complications at the time of discharge<sup>2</sup>**

- Discharge planning should begin upon admission<sup>2,4</sup>

### **The Agency for Healthcare Research and Quality recommends the following for discharge plans<sup>5</sup>:**

- **Medication reconciliation**
  - Ensure the safety of any new prescription and that no chronic medication was stopped.
- **Structure discharge communication**
  - Communicate medication changes, tests, and follow-up needs to outpatient physicians.
  - Transmit discharge summaries to primary physician.
  - Schedule outpatient follow-up prior to discharge to help ensure patients keep appointments.

### **Ongoing patient engagement is vital to effective care coordination**

Throughout the continuum of diabetes care, opportunities exist to provide effective care coordination and maintain patient engagement. Since hospitalization can be common in patients with diabetes, the efficient

transfer of care from the inpatient to outpatient setting may help to maintain appropriate diabetes care.

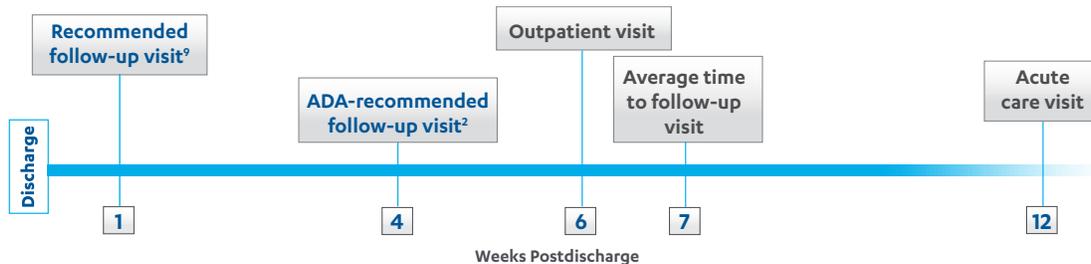
### The continuum of diabetes care

- Effective inpatient care can improve hospital outcomes in diabetes<sup>6-8</sup>
- Improved outcomes can reduce health service utilization and hospitalizations<sup>7</sup>
- Integrated outpatient care works with a goal of achieving good glycemic control<sup>7</sup>
- Patients who are lost to follow-up have more severe hyperglycemia and are at greater risk of complications<sup>8</sup>

### Postdischarge follow-up presents opportunities to improve care coordination

- Healthcare reform provisions promote patient follow-up visits to an appropriate physician within the first week following hospital discharge<sup>9</sup>
- The ADA recommends a follow-up visit with a primary care provider, an endocrinologist, or a diabetes educator within one month of discharge<sup>2</sup>

### The length of time between discharge and recommended follow-up visit vs actual follow-up visit for patients with diabetes discharged from a municipal hospital<sup>9</sup>



\*A retrospective analysis conducted in 2001 of records for 658 patients from one municipal hospital to examine the pattern of immediate postdischarge visits and patient characteristics.

*Opportunities in care coordination can improve diabetes care and reduce costs.<sup>2,10,11</sup>*  
*Effective transitions of care and ongoing patient engagement can reduce risk at hospital discharge and improve patient self-management.<sup>2,12</sup>*

**References:** **1.** Casagrande SS, Fradkin JE, Saydah SH, et al. The prevalence of meeting A1C, blood pressure, and LDL goals among people with diabetes, 1988-2010. *Diabetes Care.* 2013;36(8):2271-2279. **2.** American Diabetes Association. Standards of medical care in diabetes—2017. *Diabetes Care.* 2017;40(suppl 1):S1-S135. **3.** Peterson G. Transitioning from inpatient to outpatient therapy in patients with in-hospital hyperglycemia. *Hosp Pract.* 2011;39(4):87-95. **4.** Moghissi ES, Korytkowski MT, DiNardo M, et al. American Association of Clinical Endocrinologists and American Diabetes Association consensus statement on inpatient glycemic control. *Diabetes Care.* 2009;32(6):1119-1131. **5.** Agency for Healthcare Research and Quality. Adverse events after hospital discharge. <http://psnet.ahrq.gov/primer.aspx?primerID=11>. Accessed July 7, 2020. **6.** Van den Berghe G, Wouters P, et al. Intensive insulin therapy in critically ill patients. *N Engl J Med.* 2001;345(19):1359-1367. **7.** Wagner EH, Sandhu N, Newton KM, et al. Effect of improved glycemic control on health care costs and utilization. *JAMA.* 2001;285(2):182-189. **8.** Graber AL, Davidson P, Brown AW, et al. Dropout and relapse during diabetes care. *Diabetes Care.* 1992;15(11):1477-1483. **9.** California Healthcare Foundation. Issue brief. The post-hospital follow-up visit: A physician checklist to reduce readmissions. October 2010. **10.** National Committee for Quality Assurance. Standards for Patient-Centered Medical Home (PCMH) 2011. February 1, 2011:1-28. **11.** Muhlestein D, Croshaw A, Merrill T, Peña C. Growth and dispersion of accountable care organizations: June 2012 update. Center for Accountable Care Intelligence. June 2012. **12.** Shah M, Norwood CA, Farias S, Ibrahim S, Chong PH, Fogelfeld L. Diabetes transitional care from inpatient to outpatient setting: pharmacist discharge counseling. *J Pharm Pract.* 2012;26(2):120-124.