



Emergency Department Transfer to Outpatient Diabetes Education Prevents Readmissions

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Background/Significance

- ❖ The emergency department (ED) is highly over-utilized for treatable and preventable conditions such as diabetes and its complications.
- ❖ According to the Centers for Disease (CDC), approximately 17 million ED visits were reported with a diagnosis of diabetes.
- ❖ Readmissions of people with diabetes reflect the quality of healthcare delivery and cause an economic strain on the ED.
- ❖ The annual cost of diagnosed diabetes in America was \$327 billion, with more than half of the medical expenses spent only on two factors—hospitalizations (30%) and medicinal treatment for complications (30%).

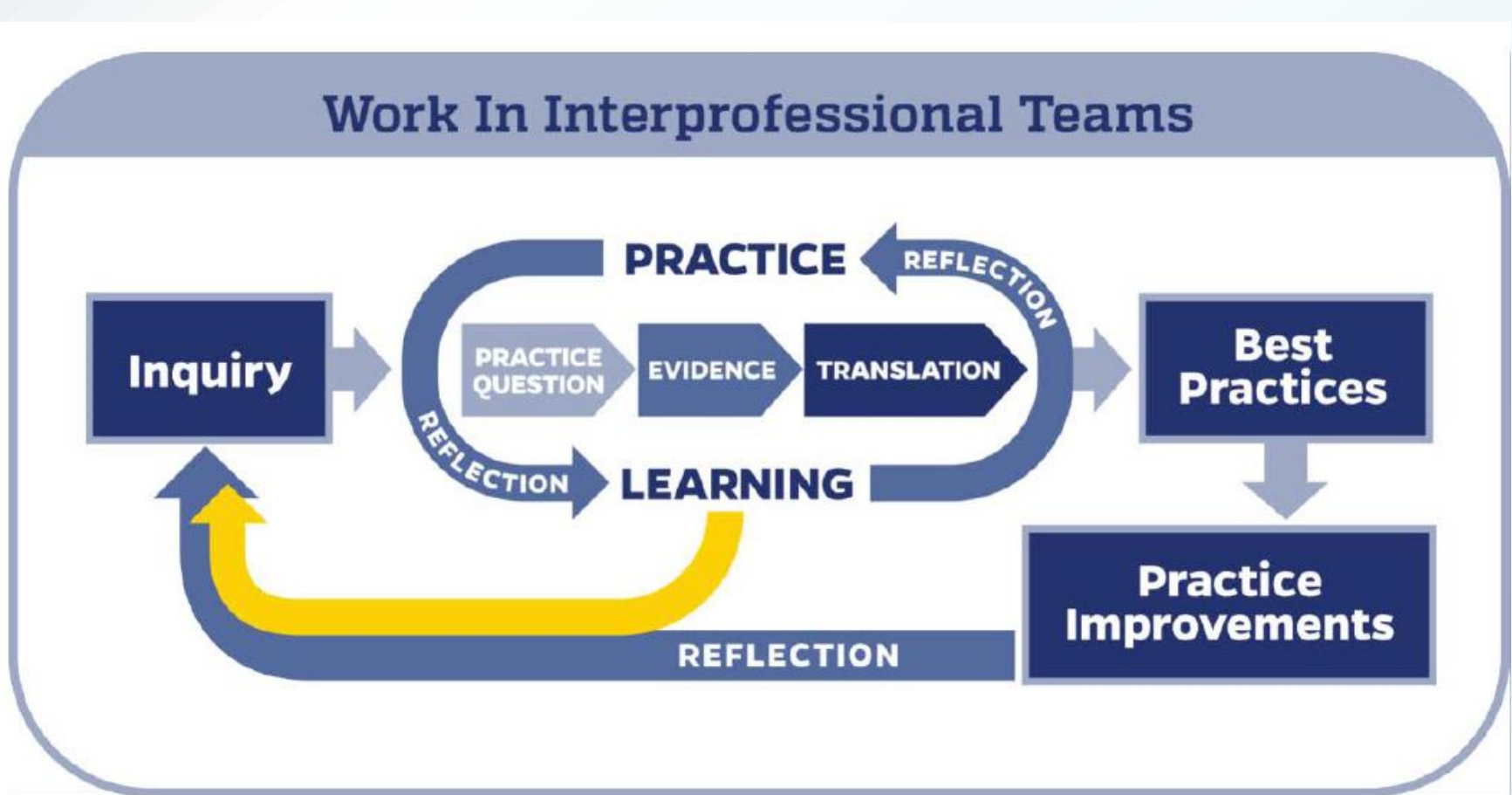
Purpose

- ❖ A Diabetes Education team from a large safety-net healthcare organization launched an evidence-based practice (EBP) study to determine the impact of receiving diabetes education and formal transition of care from an ED setting to an outpatient interdisciplinary team to decrease ED readmissions.

PICO Question

- ❖ Among people with type 2 diabetes (P), does diabetes education in the ED with care transition to primary care and community services (I), compared to standard ED medical management (C), reduce ED readmissions (O)?

Johns Hopkins Nursing EBP Model



Methodology

- ❖ Sources of Evidence: PubMed, CINAHL, EBSCOhost, and Elsevier Scientific Direct.
- ❖ The search yielded research and non-research articles (N=35); 8 articles met the specific inclusion criteria stipulated in the PICO.
- ❖ Johns Hopkins Nursing EBP criteria were used to appraise research and non-research articles critically.

Findings

<u>Research</u>	<u>Non-Research</u>
Level I: n = 2	Level IV: n=1
Level II: n= 3	Level V: n=1
Level III: n= 1	
<u>JHNEBP Strength of Evidence</u>	
❖ Level I: Randomized Controlled Trials (RCT); Meta-analysis of RCTs	
❖ Level II: Quasi-experimental	
❖ Level III: Non-experimental; Qualitative; Meta-synthesis	
❖ Level IV: Systematic Review; Clinical Practice Guidelines	
❖ Level V: Organizational (e.g., Quality Improvement); Expert Opinion; Case Study; Literature Review	

Translation into Practice

- ❖ The diabetes transition of care program from the hospital includes patient-centered discharge education, hemoglobin A1C-based adjustment of diabetes therapy upon discharge, and post-discharge support, which decreases readmissions/ED visits among high-risk patients with diabetes (Rubin et al., 2022).
- ❖ A specialized diabetes team (SDT) member, such as the diabetes care and education specialist (DCES), provides a diabetes discharge/transition plan versus the primary service team to hospitalized diabetes patients. Patients are more likely to complete the transition of care to the PCP and/or endocrinologists and improve adherence to follow-up plans (Bansal et al., 2018).
- ❖ Outpatient diabetes education programs with an interdisciplinary approach can reduce ED visits among patients with diabetes (Bhalodkar et al., 2020; Gao et al., 2022).
- ❖ Programs aligned with the Chronic Care Model (CCM) and diabetes self-management education and support (DSMES) with an interdisciplinary approach. The interaction and collaboration are based on shared decision-making and flexible documentation process for healthcare professionals involved in the patient's diabetes care (Whitley et al., 2020).



Implications for Nursing

- ❖ The DCES will provide DSMES in the ED to patients with diabetes type 2 referred by the provider.
- ❖ The DCES will:
 - Complete an assessment
 - Provide education and problem-solving
 - Refer to the outpatient interdisciplinary team
 - Input the transition plan
 - Support successful transitions
- ❖ At discharge, the bedside nurse can provide appointment referral dates and addresses, prescriptions, and ensure diabetes medications and supplies are correct.
- ❖ Bedside nurses can reinforce diabetes education, such as blood glucose checks, insulin injection techniques, target levels for blood glucose, and sick day management at any teachable moment.

References

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