

Continuity of care after hospital discharge in type 2 diabetic polymorbid patients

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Background

The **transition of care** between hospital and ambulatory settings is a complex and high-risk period for patients who experience potential discontinuity of care and difficulties in medication management and care organization.

The prevalence of **patients hospitalized with type 2 diabetes** can exceed 40%. These patients are at risk of re-hospitalization in case of diabetes complication or previous hospitalization and were taken as an example in this study.

This study seeks to better **understand the post-hospital context** and to identify the difficulties and needs of patients with type 2 diabetes and polymorbidities during this transition phase. It is the first phase to the implementation of an interprofessional post-hospital intervention.

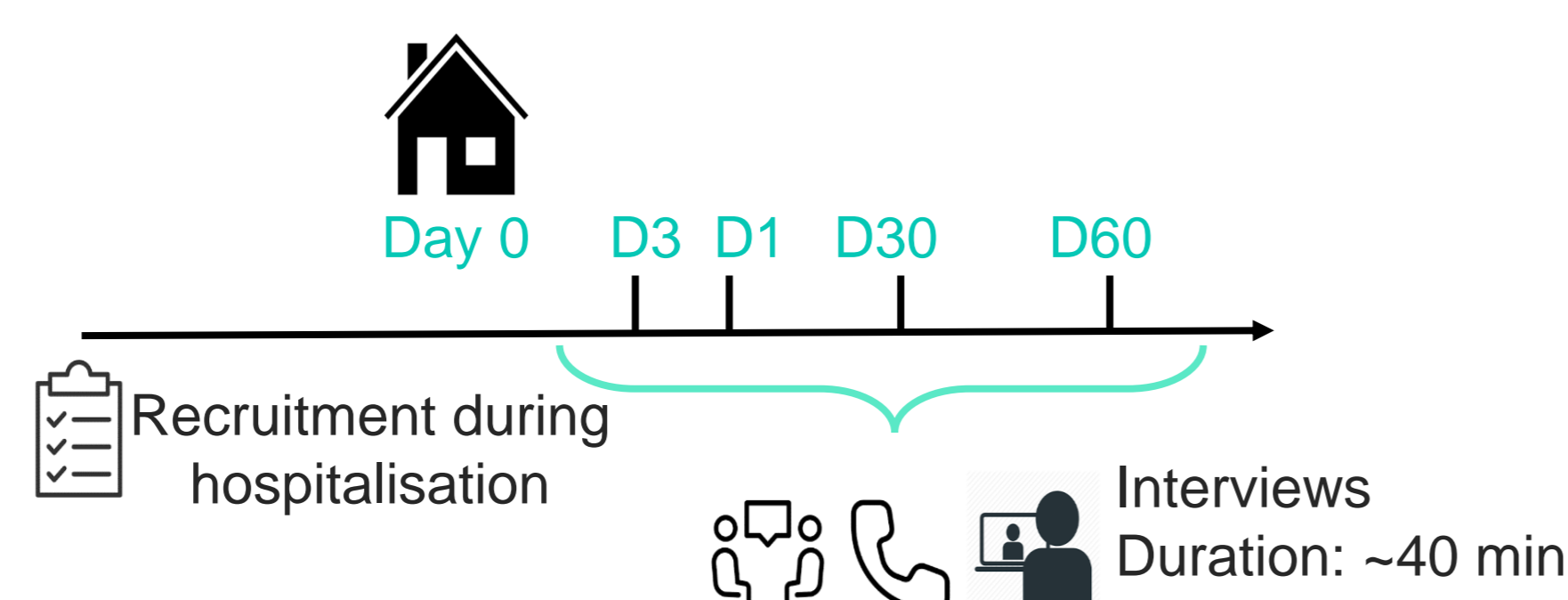
Methods

Objectives : describe:

- patients' journey after hospital discharge in the health care system
- changes in prescribed medications during the study
- factors influencing medication management and adherence

Study Design:

Qualitative, longitudinal research based on 4 semi-structured interviews per patient



Population:

- patients with type 2 diabetes
- with at least 2 other co-morbidities
- returning home after hospitalization

Duration of the study: October 2020 - September 2021

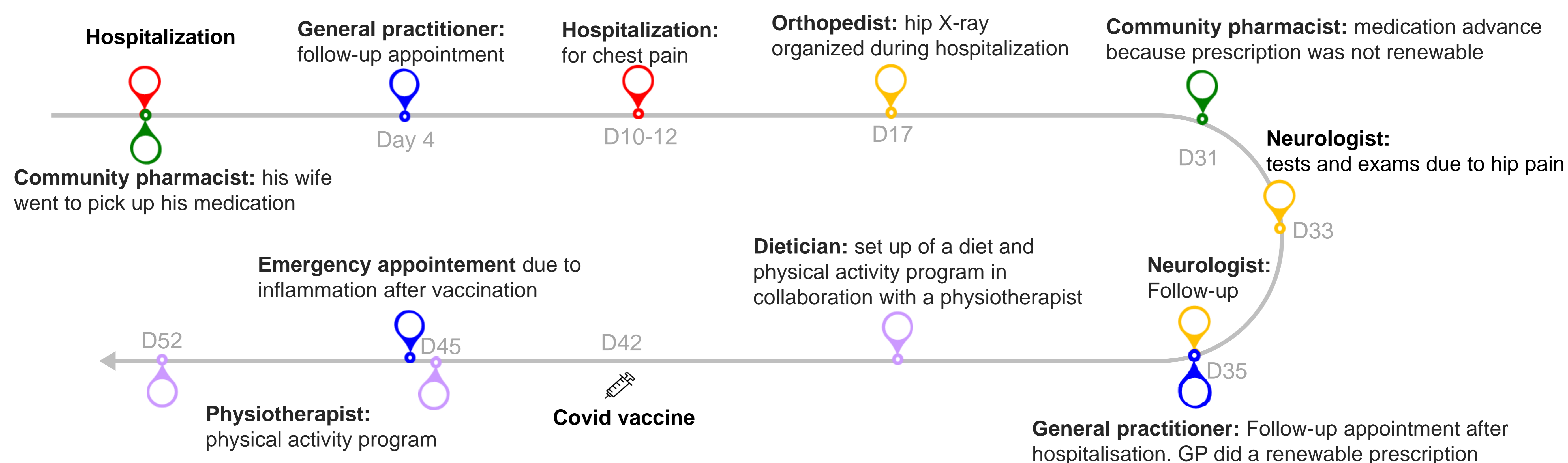
Qualitative analysis method:

transcription of interviews → thematic analysis of verbatims
→ double coding until a common codes are obtained

Example of a Patient Journey Mapping

55 year-old man hospitalized for a myocardial infarction for 4 days

Comorbidities: type 2 diabetes, hypertension, obesity, sleep apnea, coxarthrosis



Preliminary results

Participants	
- Number	21
- Female	9
- Age (mean ± SD), years	65 ± 9
Interviews	
- Number	75
- Duration (median, IQR), minutes	41, 34-49
Raison for hospitalisation	
- Type 2 diabetes	9
- Myocardial infarction	4
- Other cardiac reasons	5
- Other reasons	3
Medication	
- Number of medication at discharge (median, IQR)	9, 7-12

Example of themes expressed by participants

Difficulty in medication management :

"I used to manage my diabetes very well. Now with the heart medication and everything, it's a lot..." P22.2

Generic medication:

"The name [of the medication] changes all the time...so maybe I have it but I don't know...Names [of medications] are a problem for me" .P13.4

Facilitator in medication management:

"I prepare a pill organizer. In the morning, I don't ask myself any more questions." P10.3

Medication non-adherence:

"I regularly forget to take it in the evening." P6.4

Conclusion

Preliminary results show that patients are seen at discharge by several caregivers such as home care nurses, pharmacists, general practitioners, medical specialists or nutritionists.

Patients' verbatims were subdivided into three key moments: the hospitalization, the transition period and the ambulatory follow-up. The analysis is ongoing.

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