**Inpatient to Outpatient Transfer of Diabetes Care: Perceptions of Barriers to Postdischarge Followup in Urban African American Patients**

**Objectives:** To determine potential obstacles to postdischarge followup of hospitalized diabetes patients and to inform planning to better ensure continuity of service when care is transferred from inpatient to outpatient settings.

**Design:** Surveys of hospital inpatients

**Setting:** Urban hospital

**Patients:** Inpatients with diabetes mellitus

**Main Outcome Measures:** Identification of barriers to postdischarge followup in relation to age, sex, race, marital status, employment status, educational level, health insurance status, date of admission, date of diagnosis, admission and discharge glucose values, and hyperglycemia medications at discharge.

**Results:** Of 303 respondents (average age 50 years, 46% women, 91% African American), 95% indicated that they planned to use follow-up services. Fifty percent of these patients anticipated encountering barriers to keeping outpatient appointments. The primary reasons were transportation problems (59%), inability to afford the visit (34%), and lack of health insurance (24%). Among persons expecting difficulty with follow-up care, significantly more were uninsured \( (P = 0.025) \) and a greater proportion had prior trouble accessing medical care \( (P < 0.001) \). The odds of anticipating a barrier to postdischarge followup were higher for persons without health insurance (odds ratio [OR] 2.62, \( P = 0.040 \)) and for persons with prior healthcare access problems (OR 5.94, \( P < 0.001 \)). Women also had a greater chance of reporting an obstacle (OR 2.30, \( P = 0.024 \)).

**Conclusion:** New discharge planning programs that emphasize the need for long-term followup and that assist persons with access to postdischarge medical services should be developed, particularly for minority populations at particular risk for diabetes and its complications. (Ethn Dis. 2007;17:238–243)

**Key Words:** Diabetes Mellitus, Health Services Accessibility, Hospitalization

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**Introduction**

Hospitalization is a frequent occurrence among diabetes patients, 30% of whom require readmission, and it is a substantial component of the economic impact of the disease. The importance of effective inpatient care to improve hospital outcomes is increasingly apparent, but ambulatory settings are the most common sites of diabetes care. Diabetes patients who receive intensive, integrated outpatient management of multiple metabolic risk factors achieve better outcomes. Thus, establishing contact with an outpatient care team after a hospital event can help diabetes patients maintain care.

Despite the large economic burden attributable to hospital admissions and the importance of outpatient management of diabetes, little is known about the transfer of care from inpatient to outpatient settings. We reported recently on patterns of postdischarge followup in a cohort of urban diabetes patients and identified patient characteristics associated with having ambulatory visits. Developing interventions that facilitate the transition from the hospital to the ambulatory care site requires better understanding of the potential barriers to posthospitalization care.

Successful transfer of patients from inpatient to outpatient settings for diabetes care is particularly relevant in minority patient populations such as African Americans, who have a high prevalence of diabetes, worse glycemic control, and more complications but who can clearly benefit from integrated outpatient care. However, we know little about obstacles this population faces that might prevent posthospital care. Therefore, we surveyed hospitalized urban diabetes patients to identify the follow-up problems they believed they would experience and to determine the variables associated with barriers to postdischarge care.

**Materials and Methods**

**Data Collection**

The study was conducted in a downtown Atlanta public hospital, which is part of a large two-county public healthcare system that includes outpatient specialty clinics (including a specialty diabetes clinic adjacent to the hospital), hospital-based and neighborhood primary care sites, and an emergency department/urgent care center. The mission of this healthcare system is to provide care to the underserved residents in the referral area.

Hospitaized diabetes patients who were referred to the endocrinology service or inpatient nurse educators for consultative care were surveyed. Recorded data included demographic