ABSTRACT

BACKGROUND: Diabetes is the seventh leading cause of death in South Carolina. In 2006, three to four people died each day from diabetes, equating to one death from diabetes every seven hours and thirty minutes.

METHODS: We partnered with our community liaison, Dr. Carolyn Jenkins, the chair of the Outreach Council of the state legislated Diabetes Initiative of South Carolina, and principal investigator for a REACH grant to improve care for diabetics. Our goal is to decrease the incidence of hospital readmissions within a 30-day period by re-engineering discharge planning through patient education and follow up appointments to increase compliance with medications and clinical pathways. We created a standardized packet for diabetic patients so that they will easily be able to make better diet and exercise decisions. If diabetics are given concise information, they will be able to stay healthier and avoid the hospital, therefore reducing the risk of further complications of the disease.

RESULTS: Since our project is still in research and design stages, no statistical results have been obtained. We anticipate similar statistical results to those which were obtained by Project RED.

OBJECTIVE: Our goal is to decrease the amount of hospital readmissions by reforming discharge planning. We aim to reduce the incidence of hospital readmissions within a 30-day period by re-engineering discharge planning through patient education and follow up appointments to increase compliance with medications and clinical pathways.

DISCUSSION: In an effort to promote healthy development and healthy behaviors at every stage of life, our group identified our at risk population as diabetic patients recently discharged from an inpatient or outpatient facility.

As the seventh leading cause of death in South Carolina, a diagnosis of diabetes not only dramatically changes the lifestyle of an individual patient, but it also accounts for 3 to 4 deaths per day in the state of South Carolina alone. The CDC estimates that the economic burden of diabetes in the United States reaches $174 billion according to 2007 data.

Our research study is to commence in late 2010. By comparing our intervention with the similar intervention used by Project RED at Boston University, we expect to reduce hospital readmissions of diabetic patients.

By redesigning the method of discharge education, we expect to reduce not only the cost of life but also the cost of healthcare related to the diagnosis of diabetes in our experimental group.

Presented at: Presidential Scholars Day, Medical University of South Carolina Charleston, SC April 13, 2010

METHODS

Partnered with our community liaison, Dr. Carolyn Jenkins, the chair of the Outreach Council of the state legislated Diabetes Initiative of South Carolina, and principal investigator for a REACH grant to improve care for diabetics.

- Created a standardized packet for diabetic patients, so that they will easily be able to make better diet and exercise decisions. If diabetics are given concise information, they will be able to stay healthier and avoid the hospital, therefore reducing the risk of further complications of the disease.
- Attended the Diabetes Discharge Planning Meetings with team members from around the state to create a thorough yet simple discharge plan for newly diagnosed diabetics.
- We were given the assignment of presenting an exercise plan and a healthy diet for diabetics to include in the pamphlets (see figure 1).

DISCUSSION

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REFERENCES