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General Guidelines for Discharge Planning According to Specific HbA_{1c} Values

HbA_{1c} <5.2

New hyperglycemia: These patients do not have diabetes. Repeat screening should be done in the future with fasting blood glucose or OGTT.

Known diabetes: Continue home regimen if no significant hypoglycemia or new contraindications.

HbA_{1c} 5.2-6

New hyperglycemia: May have diabetes. Repeat screening in the near future with fasting blood glucose or OGTT.

Known diabetes: Continue home regimen if no significant hypoglycemia or new contraindications.

HbA_{1c} 6-7

New hyperglycemia: Likely will have diabetes diagnosed in the future but should be discharged home on a diabetic diet and have fasting blood glucose or OGTT as soon as metabolically stable.

Known diabetes: Continue home regimen if no significant hypoglycemia or new contraindications.

HbA_{1c} 7-8

New hyperglycemia: Likely will have diabetes diagnosed in the future. Possible treatment options include diet and exercise or a low-dose oral agent (in general, each oral agent can decrease the HbA_{1c} by 1%-2%).

Known diabetes: Increase dose of home oral agents, add a third agent, or add basal insulin at bedtime.

HbA_{1c} >8

New hyperglycemia: Same as for HbA_{1c} 7-8.

Known diabetes: If already on two oral agents at home, add once-a-day basal insulin at bedtime. If adding insulin to thiazolidinediones, only pioglitazone is approved by the FDA, so the patient will need to be switched to this particular agent.

Once **HbA_{1c} >9-10**, most patients should be on basal/bolus insulins at discharge.

Note: The values used here were demonstrated in the study by Greci et al. (Greci LS, Kailasam M, Malkani S, et al. Utility of HbA_{1c} levels for diabetes case finding in hospitalized patients with hyperglycemia. *Diabetes Care*. 2003;26:1064-1068.)

Adapted from SHM Glycemic Control Task Force. *Workbook for Improvement: Improving Glycemic Control, Preventing Hypoglycemia, and Optimizing Care of the Inpatient with Hyperglycemia and Diabetes*. Society of Hospital Medicine Web site, Glycemic Control Quality Improvement Resource Room. <http://www.hospitalmedicine.org>. Accessed May 6, 2009.

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Restarting Oral Antidiabetic Drugs

- If patients are going to be discharged on basal insulin in addition to oral agents, discontinue mealtime bolus insulin but continue the same dose of basal insulin and correction factor.
- The dose of basal insulin should be no more than 50% of the total daily dose of insulin.
- If recent changes have occurred in nutritional intake or medical condition that place the patient at increased risk for hypoglycemia, this basal insulin dose may need to be reduced and gradually titrated back up.
- Once the patient is discharged, the long-acting insulin dose can be safely increased in patients with creatinine <2 mg/dL every 3 days by 2 units if blood glucose is still >100 mg/dL.¹
- Other dose titration regimens with proven safety start at 10 units of NPH insulin or glargine at bedtime and increase weekly based on the average fasting morning glucose. In this regimen, for the following fasting blood glucose levels, increase the total dose by the units shown²:
 - 100 to 120 mg/dL: 2 units
 - 140 to 180 mg/dL: 6 units
 - 120 to 140 mg/dL: 4 units
 - >180 mg/dL: 8 units
- If patients are discharged on oral agents only, discontinue the basal insulin 12 to 24 hours prior to restarting the oral diabetic medications and discontinue the scheduled nutritional insulin at the same time pills are started.
- Continuing a low dose of the rapid-acting correction-factor insulin until discharge will ensure that extreme excursions in blood glucose levels that might occur during the transition do not persist.

1. Greci LS, Kailasam M, Malkani S, et al. Utility of HbA_{1c} levels for diabetes case finding in hospitalized patients with hyperglycemia. *Diabetes Care*. 2003;26:1064-1068.

2. Davies M, Storms F, Shutler S, Bianchi-Biscay M, Gomis R. Improvement of glycemic control in subjects with poorly controlled type 2 diabetes. *Diabetes Care*. 2005;28:1282-1288.

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