




REVIEW

Transition of care to the home for individuals with Diabetes Mellitus: a concept analysis based on Rodgers

HIGHLIGHTS

1. Improved coordination between levels of healthcare.
2. Longitudinal care to meet the needs of people with diabetes.
3. Promotion of effective and safe care transition strategies.

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ABSTRACT

Objective: To analyze the concept of transition from care to home for people with diabetes mellitus from Rodgers' evolutionary perspective. **Method:** This is a conceptual analysis based on Rodgers' evolutionary model. Data collection was carried out in October 2024, through online access to data sources using the Decs/Mesh/EMTREE descriptors: "Cuidado transicional/Transitional care/Home transition", "Diabetes Mellitus" and "Alta do paciente/Patient Discharge/Discharge Planning" connected by boolean operators AND e OR. **Results:** After selection, 34 studies were included in the analysis. Essential characteristics of the transition of care to the home for people with diabetes and its significance were identified, contributing to a better understanding of the aspects that identify this care, the conditions for its occurrence, and its results. **Conclusion:** The concept contributes to better identification of challenges for its implementation in clinical practice and post-discharge follow-up, aiming to improve coordination between levels of health care and safe longitudinal care.

KEYWORDS: Transitional Care; Diabetes Mellitus; Patient Discharge; Hospital to Home Transition; Models, Theoretical.

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INTRODUCTION

Diabetes *mellitus* (DM) and its complications are the leading cause of premature death in several countries, accounting for 3.4 million deaths in people aged 20 to 79 in 2024. It is an important global challenge because it affects the health of individuals, families, society, and health systems through its impact on people's quality of life, disabilities, loss of productivity, and chronic complications arising from the disease¹⁻².

Sometimes, hospitalization of these patients is necessary, mainly due to a worsening of their health condition, with severity that requires therapeutic or diagnostic intervention or careful monitoring. Intrinsic to this, hospital discharge is a complex process, fraught with challenges³⁻⁴.

To this end, discharge management is an essential tool that requires planning and systematization to promote more effective and targeted interventions, with a view to integration with other points of care, as well as considering the patient's return home³.

Because it is a chronic condition, people with DM require ongoing care from various points in the healthcare network (HN) to ensure that the transition of care occurs effectively. Care Transition is the foundation for continuity of care and one of the main strategies for linking NHs. The transition of care process can occur between different sectors of the same institution, such as from a hospital to an outpatient clinic, primary care, or even to the patient's home⁵.

The transition from hospital to home care and continuity of care in health services are vulnerable processes, especially for people living with chronic diseases, multiple comorbidities, complicated treatment regimens, or limited caregiver support⁶. A study conducted with people with DM found that the lack of planning and involvement of patients or their families in education and self-management of their disease and medications is associated with increased rates of hospital readmissions⁷.

On the other hand, Care Transition strategies reduce readmissions for preventable causes, pointing out that the better the preparation for self-management, the lower the readmission rates within 30 days. In addition, there is a positive impact by improving the quality of life of patients and their families, as well as minimizing the occurrence of Adverse Events (AE), strengthening Patient Safety⁸. Accordingly, people with DM, due to their complex therapeutic regimen, generally receive care at various points in the NH and frequently move around in care settings. Therefore, they are more vulnerable to discontinuity of care⁹.

According to a conceptual analysis of transitional care, the proper implementation of the Transition of Care should consider several factors, such as the situation of patients and families, the participation of different members of the healthcare team, and environmental and social conditions and facilities. This study examined transitional care for different populations, such as the elderly, people affected by myocardial infarction, stroke, and mental disorders¹⁰.

Some concepts related to the Transition of Care were found in the context of patients with heart failure¹¹ and people with cancer¹². Thus, there is a shortage of production related to diabetes. Therefore, a thorough analysis of the transition of care to the home of people with DM is necessary. This understanding may contribute to improving the hospital discharge process and quality of care, with a consequent reduction in readmission rates and healthcare costs. Furthermore, it is hoped that theoretical discussions will become more consistent.

That said, considering that concepts evolve over time, it is pertinent to conduct a conceptual analysis of the transition of care to the home of people with DM based on Rodgers' evolutionary method¹³, which is characterized by clarifying vague and ambiguous understandings, taking contextual aspects into account. Understanding the concept, considering its historical and contextual use, allows us to grasp the essence of the concept, contributing to a more effective use of the term.

In view of the above, the following guiding question is presented: "What is the definition of the concept of Transition of Care to the home of people with Diabetes *Mellitus* according to scientific health publications?" The study aimed to analyze the concept of Transition of Care to the home of people with Diabetes *Mellitus*, from Rodgers' evolutionary perspective.

METHOD

This is a conceptual analysis based on Rodgers' evolutionary method, which describes six stages for achieving the proposed objective: I) define the concept of interest; II) select the field for data collection; III) highlight the attributes of the concept and contextual bases (antecedents and consequents); IV) analyze the characteristics of the concept (substitute terms and related concepts); V) identify, if necessary, an example of the concept; and VI) determine the implications of the concept¹³.

The antecedents are events/phenomena that contributed to the emergence of the term, while the consequents refer to the consequences after the term was applied. Substitute terms are words or expressions that replace the term, and related concepts refer to assumptions that formulate the meaning of the term analyzed¹³.

In this study, the concept of interest was defined as "Transition of Care to the Home of People with Diabetes *Mellitus*" in order to promote robust and more complex discussions on the topic and clarify the applicability of the concept in the approach.

Data collection was carried out in October 2024 in the following databases, repositories, and directories: *American Literature in Health Sciences* (LILACS), *Medical Literature Analysis and Retrieval System Online* (MEDLINE) via Pubmed, BDENF, SCOPUS, *Web of Science*, COCHRANE, SciELO, EMBASE, in addition to the CAPES Thesis and Dissertation Portal and the Brazilian Thesis and Dissertation Database (BBTD), for allowing more in-depth reflections on the topic.

Data related to the identification of the material were extracted, such as: authorship, year of publication, country of study, type of publication, objective, method, area of knowledge, population; and data related to the concept: attributes, antecedents, consequents, substitute terms, and related concepts.

In the search fields, a combination of controlled descriptors was used, according to DeCS/MeSH/EMTREE: "Cuidado transicional/*Transitional care/Home transition*", "Diabetes Mellitus" and "Alta do paciente/*Patient Discharge/Discharge Planning*", connected by the Boolean operators **AND** and **OR**, using search strategies according to each data source, as shown in Chart 1.

As this is an evolutionary analysis of the concept, no time frame was established. Full publications available electronically in Portuguese, English, or Spanish on the subject were included. Excluded were editorial productions, summaries, experience

reports, letters to the editor, ongoing studies, and those that did not correspond to the concept of interest.

Chart 1. Search strategies for reviewing data sources. Fortaleza, CE, Brazil, 2024

Data sources	Search strategies
Medline via PubMed	"Diabetes mellitus" AND (Transitional care OR Home transition) AND "Patient discharge"
SCOPUS, Web of Science, COCHRANE	"Transitional care" AND "Diabetes mellitus" AND "Patient discharge"
SciELO, BDEF, LILACS	(Transitional care OR Home transition) AND "Diabetes mellitus" AND (Patient discharge OR Discharge planning)
EMBASE	"Transitional care" AND "Diabetes mellitus" AND (Patient discharge AND Discharge planning)
CAPES	("Cuidado transicional OR Transição para casa") AND ("Diabetes mellitus") AND ("Alta do paciente" OR "Planejamento de alta")
BBTD	("Cuidado transicional OR transição para casa") AND ("Diabetes mellitus") AND ("Alta do paciente")

Source: The authors (2024).

The selection of studies followed three stages: identification of studies; evaluation of titles and abstracts; and full reading of the preselected studies, in pairs. The study did not involve research with human beings and therefore did not require ethical review.

Two reviewers independently assessed the eligibility of the studies using *Rayyan* QCRI online *software*¹⁴ and *Excel* spreadsheets to manage the studies. Initially, reviewers conducted a screening based on the titles and abstracts. Subsequently, each of the selected studies was read in its entirety to confirm its permanence and, if so, extract the data of interest, justifying the exclusion of the others according to the established criteria. Next, the references were analyzed for inclusion of new studies.

The data collection indicators were guided by the definitions and questions of Rodgers' evolutionary method and are summarized in Chart 2.

Chart 2. Items, concepts, and questions from the conceptual analysis of the transition of care to the home of people with diabetes *mellitus* in light of Rodgers' Evolutionary Method. Fortaleza, CE, Brazil, 2024

(continued)

Item analyzed	Concept	Questioning
Background	They represent situations, events, or phenomena that preceded the concept of interest.	What events contributed to the transition of care to the home of people with diabetes mellitus?
Consequential	They correspond to the results of applying the phenomenon analyzed.	What are the consequences of transitioning care to the home of a person with diabetes mellitus?
Substitute terms	Use of various words or expressions throughout the body of the text.	What words or expressions replace the expression "transition of care to the home of the person with diabetes mellitus"?
Related concepts	They correspond to assumptions and the network of other concepts that enable the formulation of a meaning for the phenomenon under study.	What philosophical assumptions shape the meaning of the transition from care to home for people with diabetes mellitus?

Chart 2. Items, concepts, and questions from the conceptual analysis of the transition of care to the home of people with diabetes *mellitus* in light of Rodgers' Evolutionary Method. Fortaleza, CE, Brazil, 2024

(conclusion)

Item analyzed	Concept	Questioning
Attributes or concepts	Actual definition of the term, as well as the expressions or words used to represent the phenomena.	How do the authors conceptualize the transition of care to the home of people with diabetes mellitus?

Source: Adapted from Rodgers¹³ (2024).

A thorough review of all selected material was conducted to analyze the information and assess the knowledge. The authors followed the recommendations of *the Preferred Reporting Items for Systematic Reviews and Metas — Extension for Scoping Reviews* (PRISMA-ScR), as outlined in the JBI Manual¹⁵. The findings were presented using thematic categories based on similarity of content.

RESULTS

The initial search resulted in 5,693 articles, and after filtering, 2,949 were selected for export to the selection *software* by independent reviewers. After screening using the inclusion and exclusion criteria, the final sample consisted of 34 publications (Figure 1).

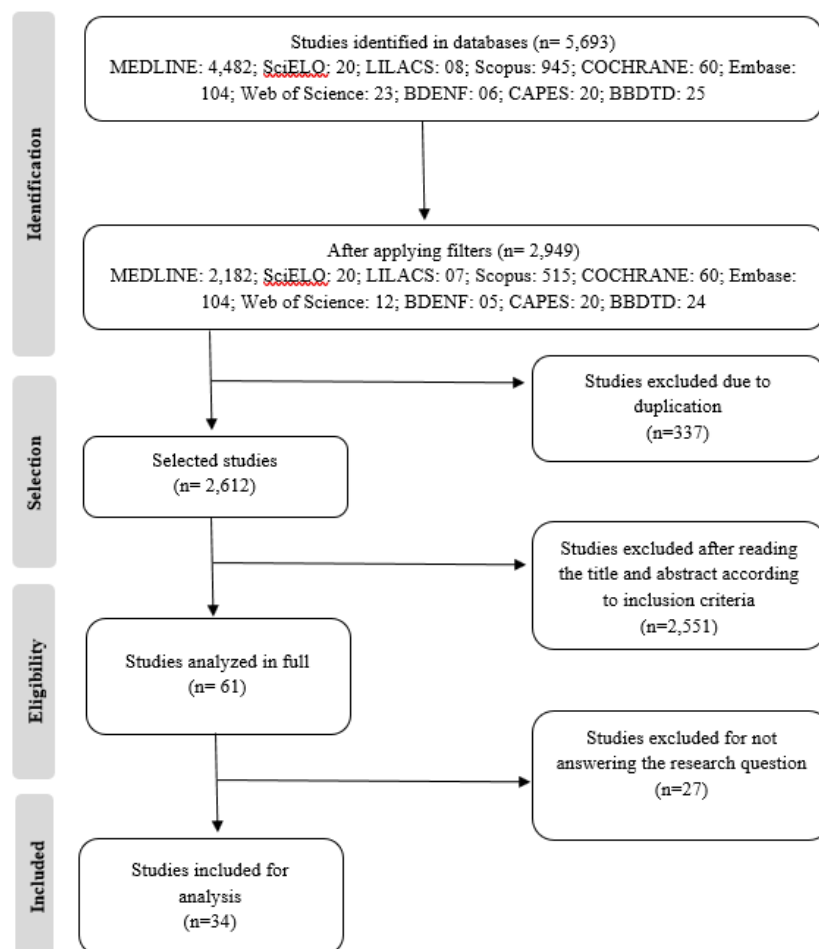


Figure 1. Flowchart of the search and selection of studies based on Prisma-ScR. Fortaleza, CE, Brazil, 2024

Source: The authors (2024).

All 34 materials analyzed were articles. The year with the most publications was 2024 (5-14.7%), followed by 2023, 2022, and 2021 with four (11.7%) in each year. The country that stood out in terms of production was the United States of America (USA) (18-52.9%), followed by China (5-14.7%).

In terms of knowledge areas, nursing stood out (32-94.1%), followed by medicine and public health, with one publication (2.9%) each. As for the study population, patients were more frequent (28-82.35%), followed by professionals (6-17.6%).

The relevant data extracted were presented separately as attributes, antecedents, and consequents. The attributes were categorized into three main classes: 'patient-related attributes', 'nurse-related attributes', and 'organization-related attributes'. The background information included two main categories: "patient-related background" and "care process-related background." The consequences were categorized into two main classes: "patient-related consequences" and "care process-related consequences" (Figure 2).

With regard to the description of conceptual aspects according to each categorization, the main attributes, antecedents, and consequences of the concept of transition of care for people with diabetes at hospital discharge, as identified by the studies investigated, are presented in Chart 3.

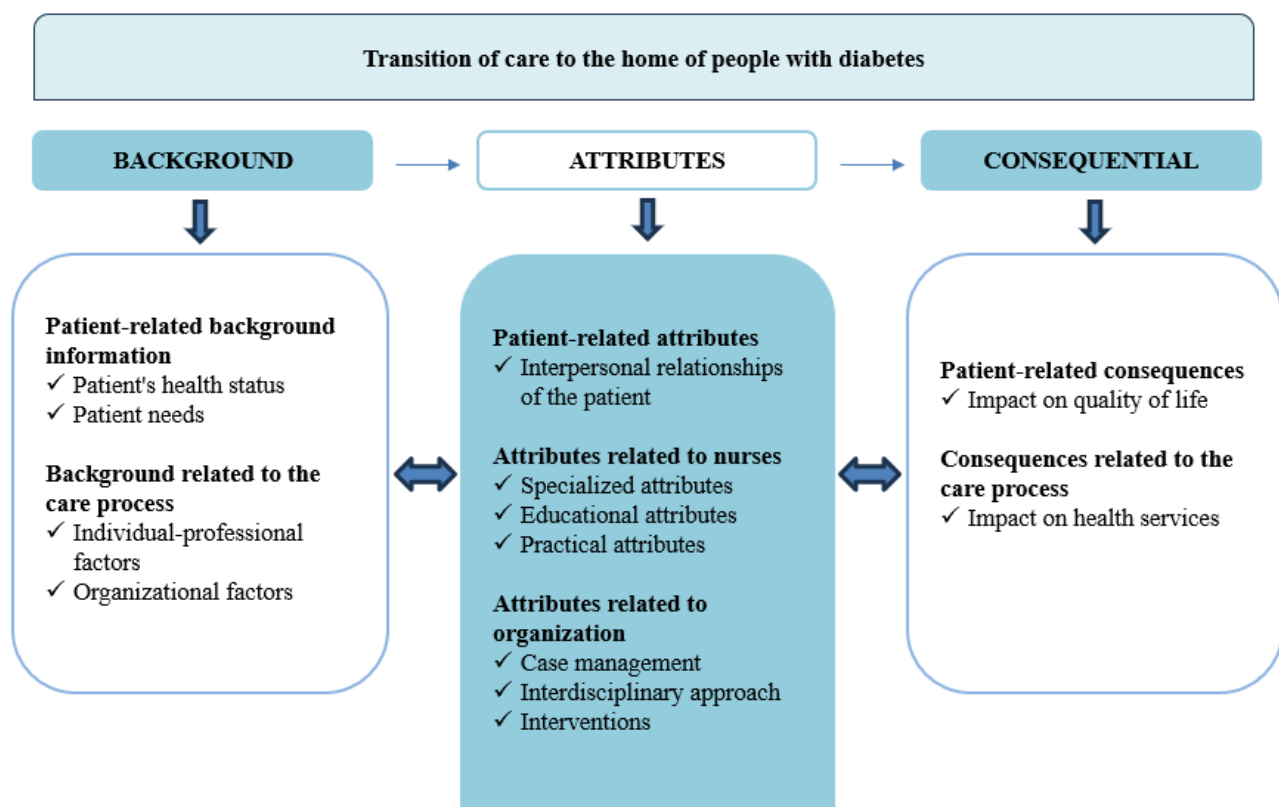


Figure 2. Background, attributes, and consequences of the conceptual analysis of the transition of care to the home of people with diabetes. Fortaleza, CE, Brazil, 2024

Source: The authors (2024).

Chart 3. Description of conceptual aspects according to each categorization of attributes, antecedents, and consequences of the concept of transition of care for people with diabetes at hospital discharge. Fortaleza, CE, Brazil, 2024

Conceptual aspects		Description
Background	Patient-related	Patient's health status: hospital discharge process; clinical improvement; implementation or adjustment of insulin therapy
		Patient needs: specialized diabetes care; information; social support; diabetes education; coping skills; medication management
	Related to the care process	Individual-professional factors: communication skills; professional relationship between healthcare provider and patient; establishment of trust
		Organizational factors: time management; appropriate facilities; communication between staff; interdisciplinary approach
Consequential	Patient-related	Impact on quality of life: improved clinical outcomes; glycemic control; reduction in glycosylated hemoglobin (HbA1c); reduction in hypoglycemia; engagement in treatment; adherence to treatment; post-discharge follow-up; greater patient satisfaction
	Related to the care process	Impact on health services: reduction in readmissions; reduction in adverse events; reduction in demand for urgent/emergency services; coordination of health services; longitudinal care; safe care; reduction in health costs.
Attributes	Patient-related	Patient interpersonal relationships: involvement in the transition process; bond with healthcare professionals and family/friends; social support; interdisciplinary approach; effective communication
	Related to nurses	Specialized attributes: visits/follow-up by a nurse specializing in diabetes; communication between specialist nurses and general nurses; appointment scheduling; individualized care plan
		Educational attributes: verbal and written information/guidance; demonstration of insulin management; encouragement of self-care; adherence to therapeutic regimen; training on symptom identification and management; training of family members/caregivers.
		Practical attributes: interventions, telephone follow-up after discharge; written planning; summary of treatment plan
	Related to the organization	Case management: transitional care plans; discharge planning, care coordination; transitional care meetings
		Multidisciplinary approach: high multidisciplinary guidance; involvement of specialist diabetes nurses and endocrinologists
		Interventions: diabetes management tools; self-care/self-management programs; strategic technologies for transition

Source: The authors (2024).

The replacement terms included: transitional care in diabetes, transitional care in the hospital discharge process, and transitional nursing care. The related concepts identified were continuity of care, coordination of care, discharge planning, liaison nurse, follow-up plan, and survival care plan.

Based on the conceptual analysis, Transition of Care to the Home for People with Diabetes Mellitus is defined as a complex, multidisciplinary, and individualized strategy during the hospital discharge process for people with diabetes mellitus that requires planning and effective communication to improve self-management, treatment engagement, clinical outcomes, and caregivers' ability to provide care. In addition to optimizing coordination between hospital resources, other levels of health care, and social support systems in order to ensure post-discharge follow-up and continuous, safe, and quality care for people with diabetes.

DISCUSSION

The data analysis showed that no Brazilian studies were found, with most publications developed in the US, confirming the scarcity of research in Brazil related to the transition of care for people with diabetes, especially in the context of hospital discharge¹⁶.

There has been an increase in the number of publications over the years, with a notable increase in 2024. This demonstrates greater interest in more effective and safer transition-of-care methods for people with DM. In addition to the use of tools that support this process, such as soft, hard, and hard technologies, to promote longitudinal care, ensure patient safety, and prevent harm resulting from poorly structured/executed transitions¹⁷⁻¹⁸.

The prominence of the field of nursing can be attributed to the fact that nurses are more involved in care transition processes. In addition, they demonstrate greater skill and ability in developing transition strategies/tools during patient care¹⁹⁻²⁰. Furthermore, nursing care stands out for its proximity to patients in the pursuit of effective care, considering patients and family members as key players in safe care^{19,21}.

Several studies^{18,22-24} have shown that nurses have developed and/or tested strategies for the transition of care for people with diabetes, reinforcing the importance of tools for a safe and high-quality transition for this population. When poorly executed, the transition of care can cause serious harm to patients and health services. Therefore, the implementation of techniques and the development of valid instruments that support this process are essential, assisting in the care provided.

Most of the studies analyzed predominantly included patients as core participants. This is because this population is entitled to the essential care that permeates this transition process, which has an impact on their monitoring, treatment, and, consequently, their quality of life. This finding is supported by studies²⁵⁻²⁶ that emphasize that the patient and their family member/caregiver are the most affected in this stage, regardless of the outcome, since in cases of inadequate transitions, they may be more susceptible to discontinuity of care, inadequate follow-up or its absence, uncertainties, and insecurity regarding treatment management. On the other hand, well-designed and coordinated Care Transition actions provide continuous patient monitoring, greater safety in disease care, encouragement of self-care, better adherence to treatment, and, consequently, lower risks of complications.

Regarding the aspects of concept analysis, according to Rodgers' evolutionary model,¹³ the patient's demands in this vulnerable process stand out, since this profile of individuals requires more targeted and individualized guidance, especially regarding drug therapy, such as the use of oral antidiabetic drugs (ADDs) and/or insulin. Researchers^{19,27} emphasize the need for closer attention to people with DM, since the disease is a complex condition. Glycemic control is constantly sought, and diabetes education is a fundamental pillar because it promotes self-care and greater involvement of the person and/or family member/caregiver in their treatment.

Furthermore, communication between professionals and patients/caregivers and among healthcare team members themselves, in addition to an interdisciplinary approach, were highlighted as antecedents that directly influenced the outcomes of the Transition of Care and were considered essential aspects of this process. These findings are consistent with the literature,²⁸⁻²⁹ which points out that communication skills have the potential to establish links and build bridges between services, ensuring better care and coordination among health professionals. The interdisciplinary team's work is essential, as each professional has their own particular skills and contributes to providing comprehensive care for patients with DM.

As for the consequences, terms such as "longitudinal care," "post-discharge follow-up," and "safe care" emerged, demonstrating aspects intrinsic to this process, as well as the associated benefits, by ensuring that patients receive support during the hospital discharge process in a safe manner. Research^{25,30} confirms that the adoption of transitional care promotes more qualified assistance, as it provides continuity of care and follow-up of patients at other levels of care and/or at home, through managerial, educational, and communication processes.

Continuity of patient care after hospital discharge is essential to prevent patients from falling through the cracks in the healthcare system and receiving fragmented care due to a lack of knowledge about the services available to them when needed. The weaknesses of the counter-referral mechanisms lead to helplessness and insecurity among patients/family members, often resulting in the search for inadequate services, such as Emergency Care Units (UPAs), which are intended for urgent and emergency care^{21,31}.

In this perspective, Transition of Care actions influence care practices, encouraging frequent preventive activities, better integration with health services, harm reduction, and, consequently, control of risk factors related to care³². As a result of the transition in care for people with DM, improvements have been seen in therapeutic outcomes, patients' quality of life, and reduced costs to the healthcare system. Other consequences found include: better glycemic control, with reduced levels of Glycosylated Hemoglobin (HbA1c), reduction of acute complications (hypoglycemia, hyperglycemia, Diabetic Ketoacidosis/DKA), as well as greater patient engagement and adherence to treatment^{18,30,33}.

Regarding the attributes of the concept studied, Care Transition is associated with patient involvement in the transition process, the importance of the nurse's role, the implementation of individualized care plans, diabetes education practices, as well as case management, an interdisciplinary approach, communication, and coordination of care. These aspects are highlighted in studies^{18,33-34} that point to the need for an individualized approach to patients in order to meet their demands and implement systematic and organized transition measures to optimize the care provided. To this end, care transition measures for patients with DM must be implemented with quality and safety, in a standardized manner, through the development of management tools supported by scientific evidence.

In addition, communication and coordination of care were strongly identified as other characteristics of transitional care in patients with DM. This care is complex and must be personalized and multidisciplinary, involving various healthcare providers, such as doctors, nurses, pharmacists, physical therapists, and nutritionists. Communication and coordination between hospital resources, other levels of health care, and the social support system are essential for managing transitional care. Common goals, responsibilities, and shared values drive team-based transitional care for people with DM²⁸.

The transition of patients with complex conditions from hospital to primary and/or secondary care services, as well as to their homes, depends on effective communication and requires greater attention to the entire context involved in the care and discharge of each individual³¹. Thus, among other aspects, it is understood that there is a complex dynamic involved in the context of hospital discharge of people with chronic diseases, especially DM, and the responsibility assigned to professionals, services, as well as the entire Health System⁶.

As for the limitations of the study, it should be noted that all materials retrieved were related to research articles published in journals, and no gray literature was included. This could potentially undermine a richer understanding of the dimensions of this concept. Furthermore, the decision to only consider works in English, Portuguese, and Spanish may have limited the selection of publications. On the other hand, most of the included studies used qualitative research designs or were systematic reviews, which enriched our findings.

CONCLUSION

The concept presented contributes to better identification of the challenges for its implementation in clinical practice and post-discharge follow-up, aiming to collaborate in improving the coordination of health care levels and safe longitudinal care in order to meet the needs of people with DM and avoid hospital readmissions and adverse events.

The study identified the essential characteristics of the transition to home care for people with diabetes *mellitus*, clarifying its meaning and broadening understanding of the elements that define this care, the conditions that enable it, and the results associated with it. This conceptual analysis presents evidence-based information and quality improvement strategies to ensure that transition processes produce the desired results.

Thus, we seek to contribute to the explanation of the concept evaluated, with the aim of establishing a relationship between the concept of "Transition of Care" and "Diabetes *Mellitus*," based on scientific literature, to clarify this process and the aspects that permeate it. With this, it is hoped that this study will serve as a basis for future research, such as studies evaluating transitional care and the development of tools to facilitate this process.

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