medication reconciliation (med rec), admission/discharge orders, and insulin orders (types/delivery). The EDW list was compared to the list of patients who received insulin teaching from the Certified Diabetes Care and Education Specialist (CDCES), during the same period. Providers (N=8, 3 endocrine attending MDs, 2 fellow MDs, 3 resident MDs) were interviewed in key informant interviews (N=3) and focus groups (N=2); transcripts were independently coded by 2 coders, utilizing a constant comparative method to generate key themes. The EDW list (N=554) was audited by EHR review (n = 42, 8%); 83% (35/42) were correctly identified as newly discharged on insulin. Of the 7 incorrectly identified, 4 likely had incomplete med rec. The EDW algorithm was unable to correctly identify patients with inaccurate/incomplete med rec, patients transferring from outside hospitals or those without e-Rx at discharge (vouchers, call-in). The CDCES list (N=257) was audited (n=25, 10%), and of patients not meeting criteria (n=15), some had prior insulin prescribed (n=5), and most ended up not discharged on insulin after CDCES insulin teaching (n=9). Comparison of the EDW and CDCES lists had 177 patients (32% of EDW list) in common, with 377 on the EDW list with no CDCES consultation. An audit (n=21/377, 5%) of these EDW patients, who did not have CDCES or endocrinology consultation, revealed patients across service lines, with minimal formal documentation of insulin training/education. Key identified themes from interviews identified barriers including lack of availability of a CDCES after-hours and on weekends, low health literacy/numeracy, and lack of time during stay. In training MDs noted variability in discharge prescribing by supervising MDs and the need to assess "chart lore," given cut and paste documentation in EHR. This study suggests that an EDW algorithm can be used to identify patients newly being discharged on insulin, for whom teaching by a CDCES is recommended. The data suggest the need for more targeted and increased CDCES capacity as only a portion of those eligible for insulin teaching were seen while others were seen but then not discharged on insulin. Additional resources for insulin teaching are needed and standardized training and documentation need to be developed.

Diabetes Mellitus and Glucose Metabolism

DIABETES IN WOMEN AND DURING PREGNANCY

Breastfeeding Is Associated With Lower Prevalence of Metabolic Syndrome in Women With Recent Gestational Diabetes in the Early Postpartum Period

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Introduction: Women with gestational diabetes (GD) are at increased risk of future cardiovascular disease. The identification of factors that reduce metabolic syndrome (MetS) is important to improve cardiovascular outcomes. MetS has been shown to be associated with breastfeeding in women remote from pregnancy. We examined the association of breastfeeding with MetS in women with recent GD in the very early postpartum (pp) period. **Methods:** We performed a secondary analysis of the Balance After Baby (BAB) program which enrolled women with recent GD. GD was defined by Carpenter-Coustan criteria, a 50 gram glucose load test >200 mg/dL or by clinician diagnosis. Data collected during an early (~6 weeks) pp visit was used in this analysis. At this visit, weight, height, waist circumference (WC), blood pressure (BP), fasting plasma glucose (FPG) and lipid panel were obtained. MetS was classified per NCEP III. We defined breastfeeding as currently breastfeeding or not currently breastfeeding. We performed Student's t-tests and Wilcoxon rank-sum tests as appropriate, and fit logistic and linear regression models. Models were adjusted for age, race/ethnicity, low household income, pre-pregnancy BMI, and weeks since delivery. An exploratory model further adjusted for postpartum weight retention. **Results:** Of 181 women enrolled in BAB, 178 were included in this analysis (3 excluded for missing lipid panels). The mean (± SD) age of participants was 33 ± 5 years and were 8.0 ± 1.8 weeks since delivery. Thirty-four % were Hispanic. Of non-Hispanics, 31.5% were White, 18.5% Asian and 12.9% Black/African American. The prevalence of MetS was 42.9% in women not breastfeeding versus 17.1% in women breastfeeding ($P < 0.001$; adjusted odds ratio [aOR] 0.16 [95% CI 0.06–0.41]). Breastfeeding women had significantly lower odds of FPG ≥100 mg/dL (aOR 0.36 [95% CI 0.14–0.95], p=0.039), HDL <50 mg/dL (aOR 0.19 [95% CI 0.08–0.46], p<0.001), and triglycerides (TG) ≥150 mg/dL (aOR 0.26 [95% CI 0.10–0.66], p=0.005). There was no significant difference in WC or BP between groups. All ORs remained significant after adjusting for weight retention. When evaluated as continuous variables, WC, FPG, and TG were significantly lower and HDL significantly higher in women breastfeeding in the early pp period (vs not breastfeeding). **Conclusion:** In a diverse population of women with recent GD, there was a lower prevalence of MetS in women breastfeeding compared to those not breastfeeding in the early postpartum period. This study extends the findings of an association of breastfeeding with MetS previously reported at times remote from pregnancy. Further studies are needed to determine if there is a protective role of breastfeeding on the risk of MetS.

Diabetes Mellitus and Glucose Metabolism

DIABETES IN WOMEN AND DURING PREGNANCY

Cardiometabolic Outcomes of Women Exposed to Hyperglycaemia First Detected in Pregnancy at 3–6 Years Post-Partum in an Urban South African Setting

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