Diabetes Care for Teens- A Successful Transition to Independence

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What are we going to learn?

* Define health care transition
* Discuss role of health care transition
* Review steps to prepare for transition
* Outline when transition should occur

What is health care transition?

* Transition is a move from pediatric-based care into the adult-based healthcare system.
* During this time, you are preparing to not only move to a new diabetes healthcare team but also to take over more responsibility for your healthcare.

What is health care transition?

* **Transition care** is the process of preparing to move to adult care services which occurs over time
* **Transfer of care** is the actual move to the new provider and diabetes team

Why is transition care important?

* Transition care and the transfer of care typically occur in late adolescence (18-20 years old)
* This is a turbulent time for youth and their families both physically and emotionally
* Transition needs to be addressed to prevent unwanted health concerns such as hypoglycemia and diabetic ketoacidosis with hospitalization

Why is transition care important?

* Patients and families need to be prepared
* Patient responsibility will increase overtime
* Better long term health for patients if there is a plan for transition

* We all need to work together….

The steps for successful transition

* Planned, structured method to prepare patient for healthcare responsibilities
* Continued co-management with parent/caregiver
* Guidance form pediatric healthcare team about transition needs
* Follow-up with patient after transfer of care to ensure success

How to prepare for transition

Things patients and caregivers can do to prepare for the transition of care include:

- Talk about your current healthcare responsibilities and how comfortable patient is with taking care of themselves
- Share your concerns about moving to a new healthcare team with caregivers and current provider
- Work on preparing for transition over time

How to prepare for transition

The National Diabetes Education Program (NDEP) has resources for patients/families and healthcare providers on transition preparation.

http://ndep.nih.gov/transitions/

Tools

* Transition planning checklist
* Summary of information for the new healthcare team
* Links to resources such as videos, message boards, social networks, workbooks, checklists and guides

How to prepare for transition

* Start process of preparation at least 1-2 years before considering transfer of care (NDEP checklist provides a time line)
* This will make changes in diabetes care responsibilities easier to take over for patient
* Everyone is unique so do what works for you
* As time goes start to think about who you will be living with and where you will be living in relation to diabetes team

How to prepare for transition

* Work towards making own appointments
* Re-ordering and pick up prescriptions
* Understand health insurance (carry a card)
* Attend appointments without caregiver
* Discuss alcohol, tobacco, and sexual activity with provider
* Contact diabetes team with blood sugars on own
* Learn about blood work related to diabetes

When to make the move…

* Each health system is different so talk with your diabetes team about when you need to move to another provider
* Pediatricians can see people through age 24 years
* Many patients move to adult services in early 20's or when they move for college/jobs
* There is no right age, it is up to the patient (16/17-24 y)

When to make the move…

* When you have decided you want to move:
  * Pick a provider (your current team may be able to help)
  * Pick a date
  * Make a plan, including:
    * Transferring records (if necessary)
    * Make an appointment with new MD, CDE, and dietitian
    * Follow-up with peds team to ensure move went well

Transition Project Overview

* The practice improvement project was a pilot project to implement a new process for transition preparation with providers at Sanford Health children's diabetes center

* The project was designed to adapt and implement a transition-planning checklist with youth ages 16-22 years

Project Objectives

* Objective 1: To generate provider buy in to support transition care services for youth with diabetes at Sanford Health.

* Objective 2: Design a transition-planning checklist to improve the preparation for transition from pediatric to adult health services among youth with Type 1 diabetes at Sanford Health diabetes center.

* Objective 3: Implement the transition-planning checklist into practice at Sanford Health children's diabetes center and evaluate provider feedback regarding the efficacy and utility of the transition-planning checklist.

Project Results-Quantitative

Month	Number of patient visits	# given checklist	% given checklist
August	22	8	36.40%
September	31	9	29.00%
October	34	11	32.40%
November	32	4	12.50%
December	27	5	18.50%
Total	165	41	24.90%

Project Recommendations

- Utilizing a structured transition-planning checklist assisted providers during transition preparation care.
- Implementing a new process into practice is challenging.
- Standardized age for introduction of transition checklist maybe helpful to improve implementation rate.
- Reminders in medical record may enhance a change in practice.
- Further work is needed to make transition care successful at Sanford Health diabetes department.

Summary

* Transition preparation is a individualized but important process for all young adults, especially those with chronic disease
* Process is a team effort from healthcare team, patient and caregivers
* Preparing for transfer of care will make connection with the new healthcare team more successful

Questions or Comments

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