Diabetes Care for Teens-
A Successful Transition to Independence

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Diabetes Summit
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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
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
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
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 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 pediatrics team to ensure the 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.
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

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<thead>
<tr>
<th>Month</th>
<th>Number of patient visits</th>
<th># given checklist</th>
<th>% given checklist</th>
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<tbody>
<tr>
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<td>22</td>
<td>8</td>
<td>36.40%</td>
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<tr>
<td>September</td>
<td>31</td>
<td>9</td>
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<tr>
<td>October</td>
<td>34</td>
<td>11</td>
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<tr>
<td>Total</td>
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<td>41</td>
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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.
Transition preparation is an 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 the connection with the new healthcare team more successful.
Questions or Comments

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