



Transition to Adult Health Care

Keys to Independence

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Why a "New" Transition Program?





Old Transition Plan

- Disorganized
- Un-defined process without benchmarks and evaluation
- No formal communication between pediatric and adult diabetes providers





Getting Started

- Adult and Pediatric Diabetes Providers - Physicians, Nurse Practitioners, Nurses, Dieticians, Social Workers
- Members of the Cystic Fibrosis team - Social Worker and Dietician
- Patient/Family
- Identified Needs





What will we do to help youth
prepare for the transition to
adult diabetes care?





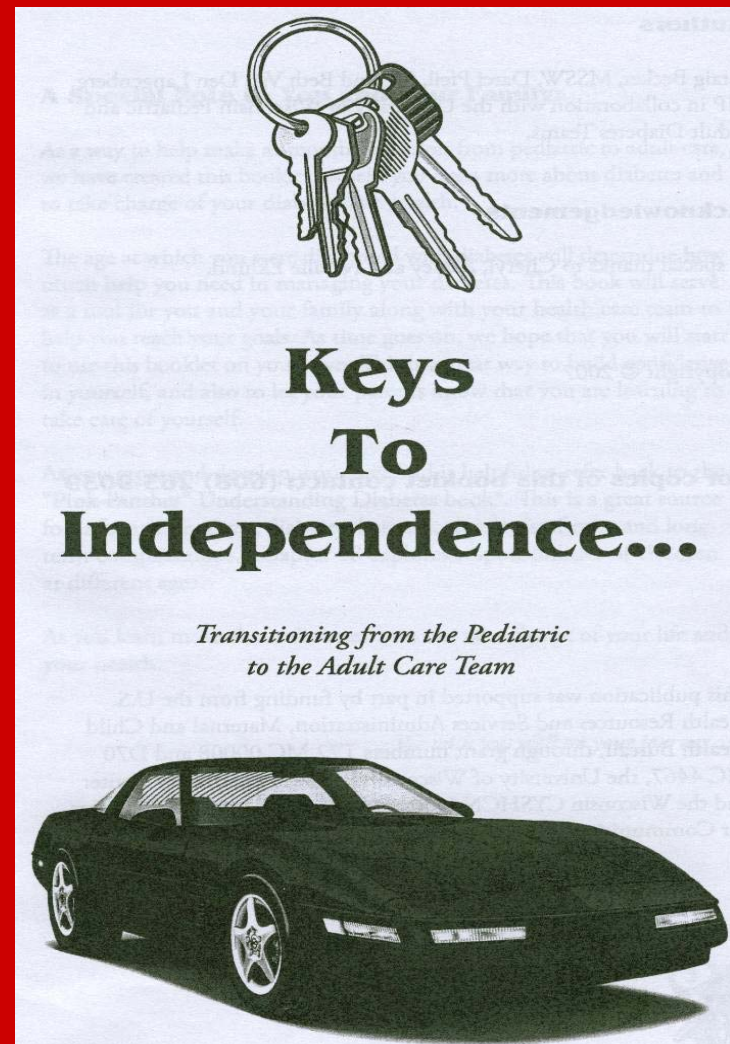
Increase Knowledge

- Disease
- Medications
- General health maintenance
- Emergency care
- How/when to contact diabetes team
- Insurance coverage



Keys to Independence...

- Informs children/families of a formal transition process
- Reviewed and discussed at each clinic visit



Divided by age/stages of development with age-appropriate tasks

- Stage 1 (8-10 years)
Begin to learn to give yourself insulin
- Stage 2 (10-12 years)
Continue to give yourself insulin
- Stage 3 (13-15 years)
Give all insulin with minimal reminders
- Stage 4 (16-17 years)
Independent with all insulin doses without
parental reminders



How Do You Know When It Is Time to Transition?

1. Do you take responsibility for your diabetes most of the time? Are you independent with your blood sugar testing and medication administration? Do you choose and make your own meals? Do you know how these choices affect your diabetes?
2. When you give the diabetes team your health history, does it sound the same as what your parents tell the team? Does your health history match with the diabetes team's view of your health and diabetes control?
3. Do you speak directly with the diabetes team?
4. Do you know when you need refills for your medication and supplies? Do you call the pharmacy?
5. Do you have a plan for your future, such as college or work?
6. Have you met the goals in each checklist?

If the answer to all the questions is "YES" then you are ready for transition.

If the answer to any of the questions is "NO," more help will be made to help you be more independent with that part of your diabetes management. However, answering no to any of the above does not stop you from transitioning to adult care. The adult care team is experienced in helping young adults become independent.





Written Communication to Adult Diabetes Team

- Medical Summary Transfer Form
- Release of Information Form
- Medical Records
- Youth and family notes to the adult diabetes team





Supplemented with additional resources as needed

- Advanced Directives
- Insurance Information
- Nutrition Information/Resources
- Sexual activity/reproductive choices
- Driving
- Exercise/Sports
- Sick Day Management
- List of Adult Diabetes Providers
- Differences between the pediatric and adult diabetes teams/services





What's Next?

- Restructuring our practice to include our new transition process
- Develop the resource binder
- Potential for a Teen/"Transition" clinic staffed by pediatric and adult diabetes team members
- Research studies to assess effectiveness of transition program





- Challenges - Restructuring

- Enhance communication between adult and pediatric providers
- “buy-in” by all stakeholders
- formal introduction to existing patients
- need “catch-up” time for existing patients (big challenge)
- Documentation of Progress





- Challenges - Issues of Age

- Access to adult providers
- Young adult workers vs young adult students
- Parent health insurance - insured patient vs uninsured patient
- Encourage struggling patient to transfer/hold on to "compliant" patient





Future

- Can we introduce kids to both adult and pediatric providers at an earlier age?
- Transition/teenage clinic
- Possible research studies





Research

- Currently developing a survey for 16 year olds regarding current knowledge and skills
- Will pre/post test of age group





Financing

- Booklet funded by the US Health Resources and Services Administration Maternal and Child Health Bureau through Grant numbers T72MC 00008 and D70 MC4467
- UW Pediatric Pulmonary Center
- Wisconsin CYSHNCCN Program's Wisconsin Integrated Systems and Communities Initiative





Potential Additional Funding

- Educational grants through pharmaceutical and medical equipment companies
- Friends of UW





Replication

- Use booklet as template
- Utilize colleagues as resources
(Learning Collaborative)
- Current Literature





Questions?

