# Appointment Lag Time and Tracking Transition in Young Adults

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## Background

- Transfer from pediatric to adult providers is a sensitive time for Type 1 diabetes care
- Transfer is part of a larger transition process that should start early in adolescence
- If transition is not appropriately discussed, transfer of care is often frustrating for both patients and providers. Delay in transfer can lead to gaps in care and sub-optimal outcomes

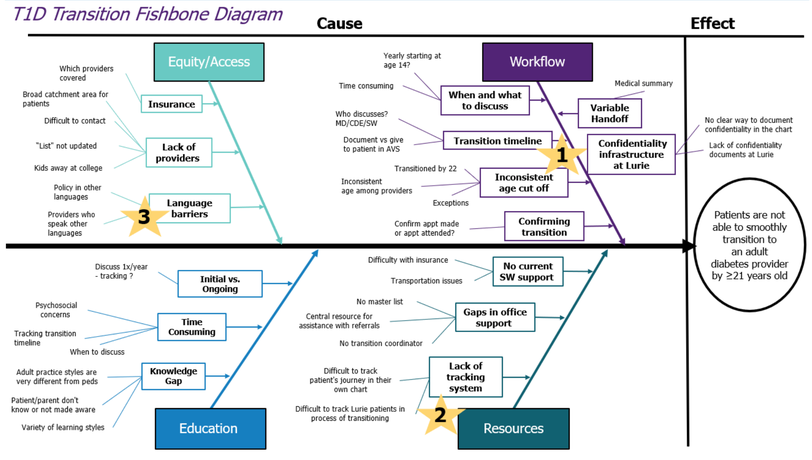
## Aim Statement

1. Decrease the number of Type 1 diabetes patients ≥ 21years old who are seen each month in pediatric endocrinology by 10% by 12/31/2023
2. Decrease the time between the last pediatric visit and the first adult visit (new intervention; no baseline data) and increase the number of patients with a completed adult appointment each month by 10% by 12/31/2023
3. Increase the discussion of transition during clinic appointment for patients ≥ 14 years old (new intervention; no baseline data) by 12/31/2023

## Current State Analysis

- The current state analysis information was gathered in a variety of ways including rounding with front line staff
- Additionally, providers spent time speaking with patients about their barriers to transitioning to adult care
- The core transition team analyzed the barriers and prioritized three areas to begin improvement work

## Fishbone Diagram

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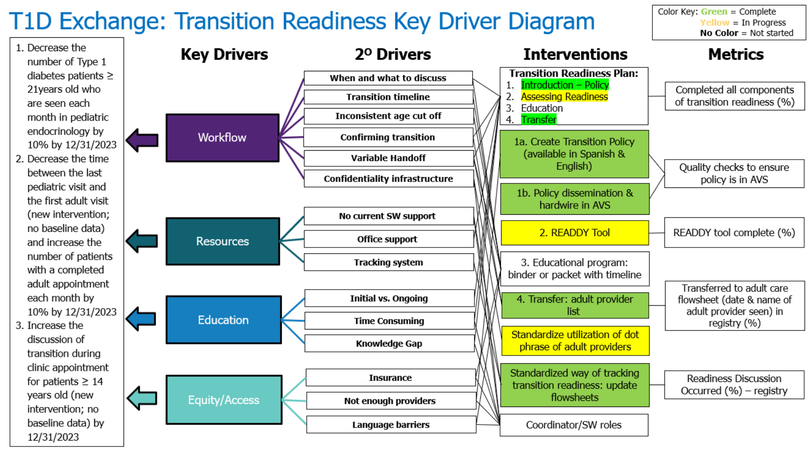
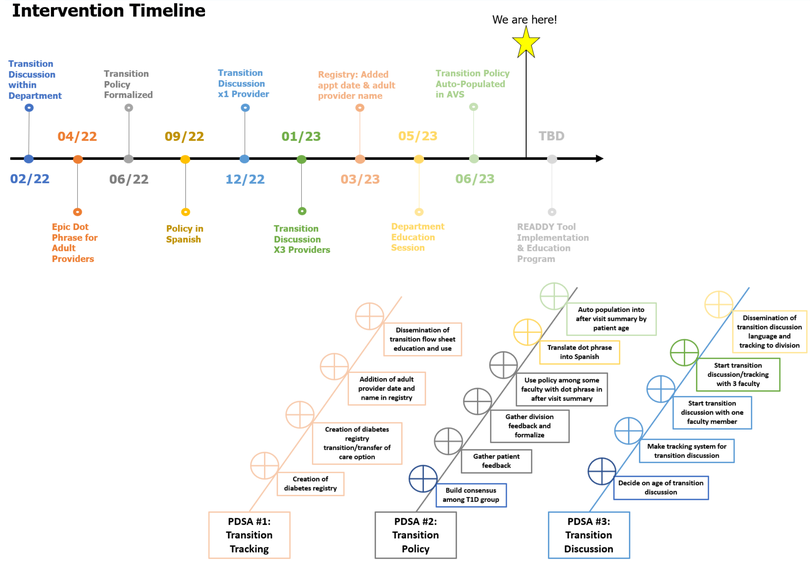
## Key Driver Diagram




## Hypothesis/Future State Design

- Building in structure to talking about transition and transfer during visits will increase transfer to adult provider
- Creating a policy for the division that standardizes timing of transition discussions and transfer will increase timely and successful transfer
- Tracking transfer systematically will allow for improved follow up and completion of transfer to adult provider

## Implementation

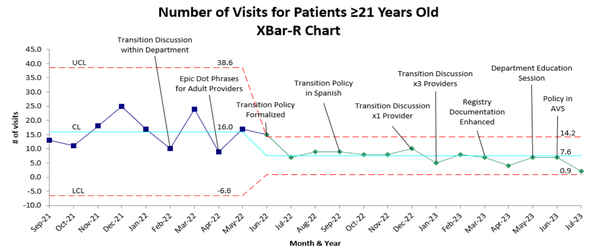



## Patient Characteristics

**Summary of patient characteristics by transition status,** population includes all patients ≥ 20 years old in the diabetes registry as of 7/31/23

| | Transitioned (n=83) | Not Transitioned (n=109) |
|---|---|---|
| Age (median, IQR) | 21 years (20-21) | 20 years (20-21) |
| Females (n, %) | 41 (49.3%) | 54 (49.5%) |
| Last HgbA1C (median, IQR) | 7.7% (6.9-9.7) | 7.8% (7.0-9.1) |
| Lag Time to Adult Appt in months (mean and standard deviation) | 4 (2-8) | NA |

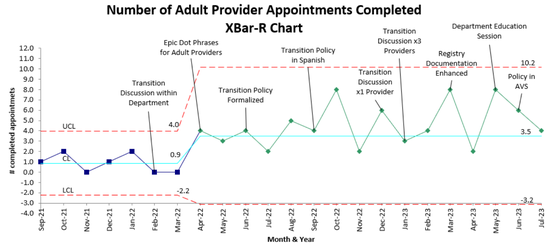
## Results

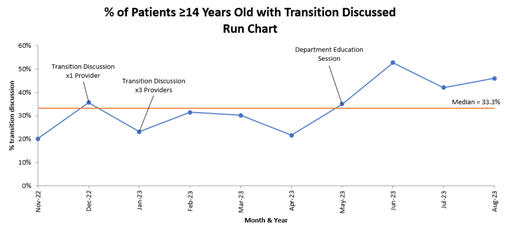



Aim #1: The number of patients ≥21 years old seen each month decreased from 16 to 7.6 visits per month (47.5% decrease)

Aim #2: Those who transitioned to adult providers did so at an average of 4 months after their last pediatric visit

The number of patients with a completed adult appointment increased from 0.9 to 3.5 completed appointments per month (25.7% increase)




Aim #3: The number of times that transition discussion occurred in clinic increased over time, though there is no baseline data available

## Lessons Learned/Next Steps

- Relatively simple interventions of consensus building, creation of formalized policy and tracking/documentation led to substantive change in rates of transfer of care.
- Next steps will include integration of transition readiness assessment and curriculum building around transition.
- No data on race/ethnic group and equity, attempting add into registry so able to better track.