Increasing Scheduling of Adult Diabetes Care Prior to Graduation from Pediatric Diabetes Care for Emerging Adults with Type 1 Diabetes

Intermountain Health

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Background

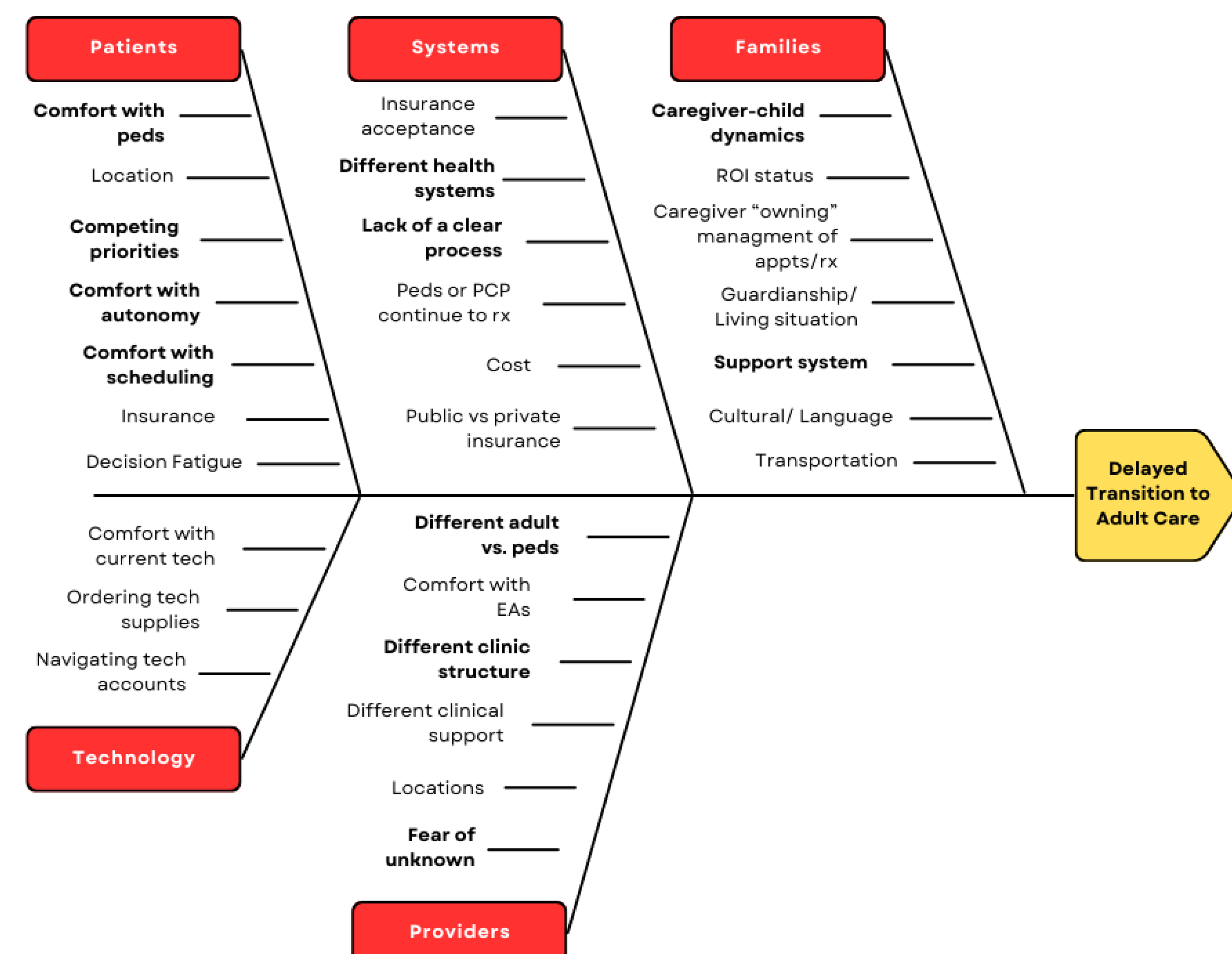
- Delay in establishing adult diabetes care is common among emerging adults (EAs) with type 1 diabetes (T1D)
- Prolonged transition gap is associated with higher HgbA1c, increased emergency visits, and higher rates of hospitalization
- Our pediatric diabetes center did not have a formalized transition process to adult care

Aims

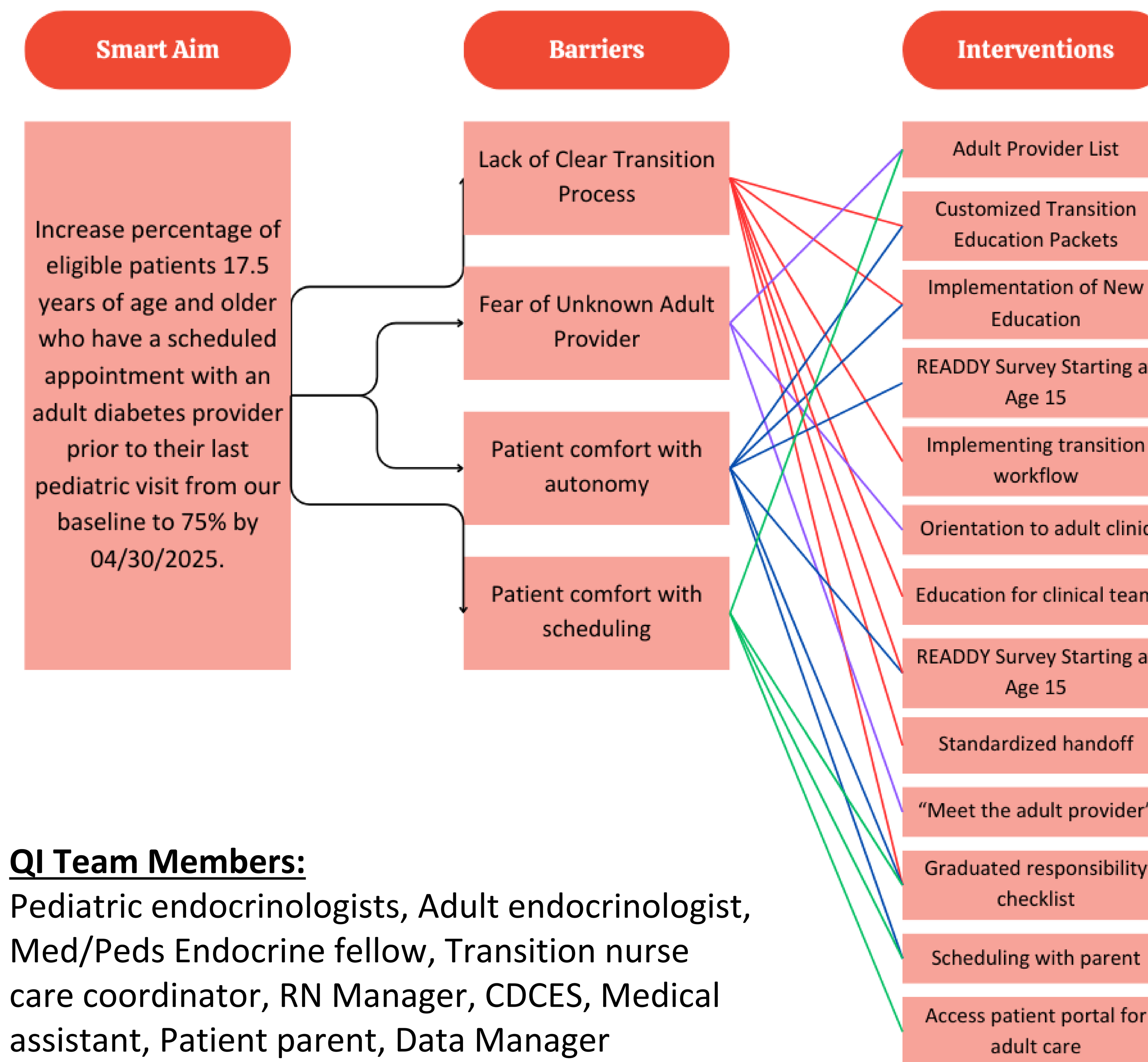
- Global Aim: Improve the healthcare transition from pediatric to adult diabetes care.

- SMART Aim: We will increase the percentage of eligible patients 17.5 years of age and older who have a scheduled appointment with an adult diabetes provider prior to their last pediatric visit to 75% by 04/30/2025.

Fishbone Diagram



Driver Diagram

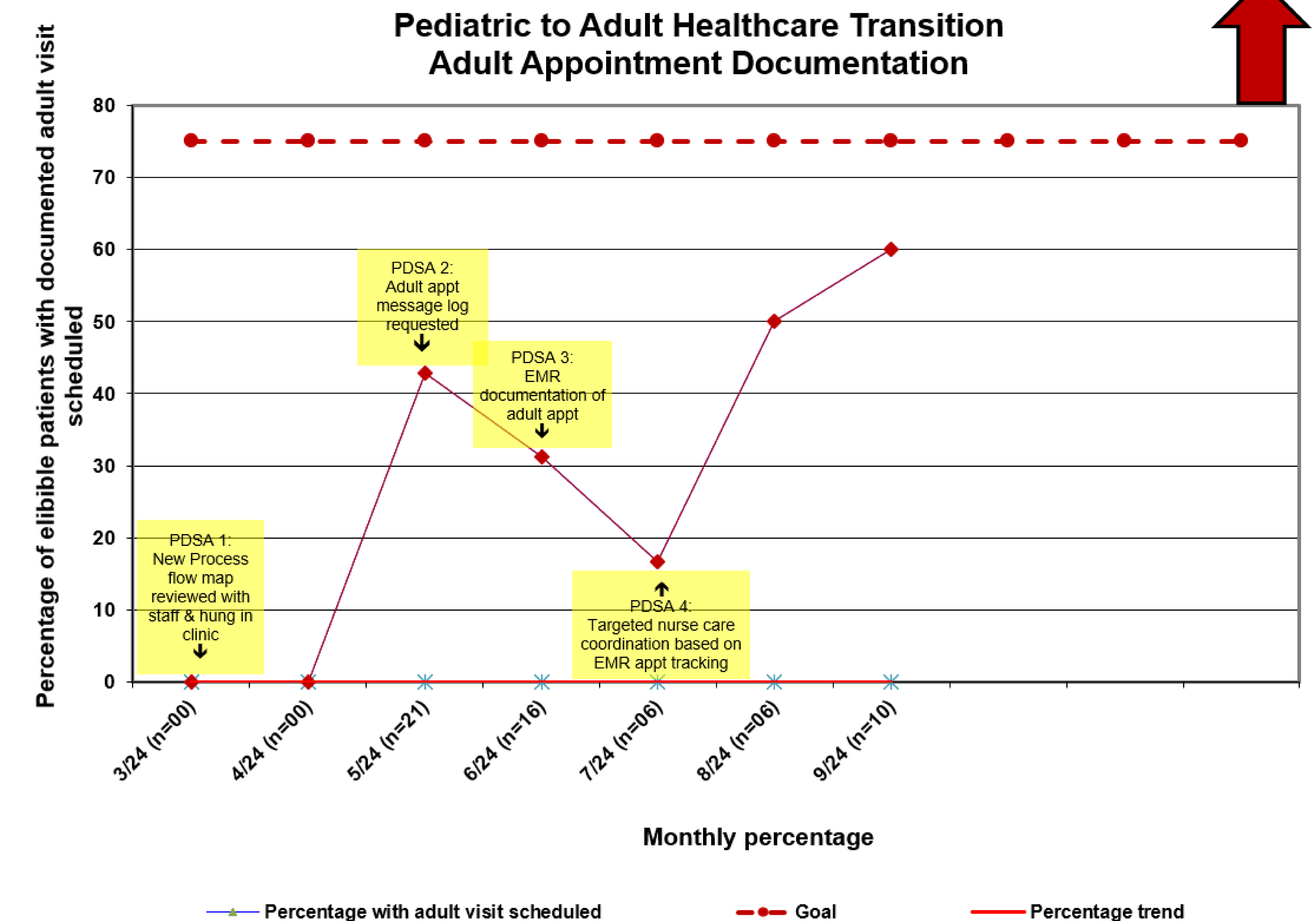


QI Team Members:
Pediatric endocrinologists, Adult endocrinologist, Med/Peds Endocrine fellow, Transition nurse care coordinator, RN Manager, CDCES, Medical assistant, Patient parent, Data Manager

PDSA Cycles

1. Create a transition process flow, including rescheduling in pediatric clinic if no adult appointment is scheduled
2. Adult appointment message log
3. Tracking adult appointments in the electronic medical record using standardized documentation
4. Targeted nurse care coordination based on EMR tracking
5. Transition skills checklist and standardized transition education

Results



- After implementation of a new tracking system, it became apparent that many patients were leaving our pediatric diabetes center without scheduled adult care
- Through targeted transition nurse care coordination, the percentage of patients with scheduled adult visits prior to graduation has increased from 17% to 60%

Insights/Future Directions

- Standardizing the tracking of adult diabetes care appointments helps identify EAs who are at risk of interrupted diabetes care
- Standardizing our transition process, utilizing transition nurse care coordination, and rescheduling in pediatric clinic are promising to reduce the gap in care between pediatric and adult care for EAs with T1D
- Future plans include expanding to satellite clinics, tracking completed transfers to adult care, and soliciting patient feedback

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