Transition Confirmation of T1D Pediatric to Adult Care

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Introduction

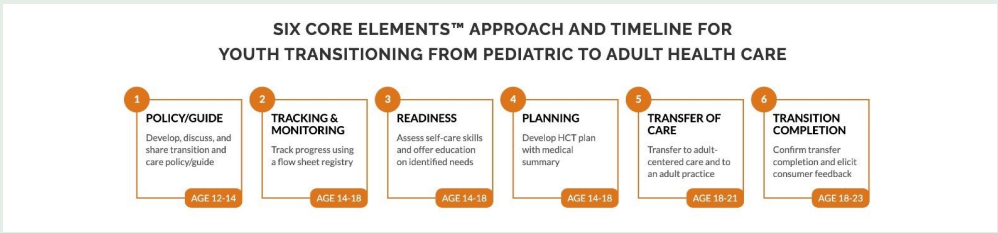
- The transition from pediatric to adult care is a high-risk period for adolescents with type 1 diabetes, often leading to gaps in care.
- As a response, in 2018, Le Bonheur Children's Hospital launched a T1D transition clinic but soon identified the lack of a system to track referrals and confirm follow-up.
- Our team aimed to improve referral and appointment confirmation in adult endocrinology clinics, specifically increasing the percentage of referrals resulting in a scheduled appointment within two months.

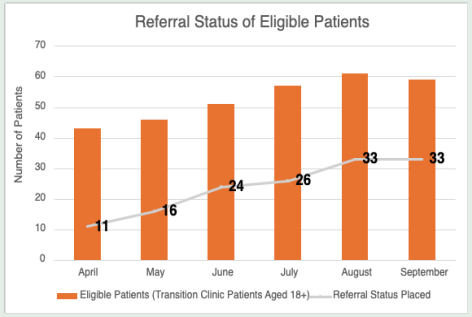
Results

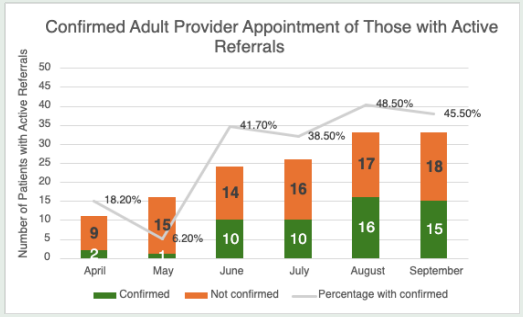
- In April 2025, 25.6% of 43 active patients aged 18+ had an adult endocrinology referral, with an average scheduling wait time of 3.7 months.
- By August 2025, 54.1% of 61 patients had referrals (13 with appointments scheduled), and the average wait time decreased to 3.1 months.
- For the adult endocrinology referrals tracked during this time, 8 patients were confirmed to have attended their first visit.
- Notably, while both confirmed and attended appointments continue to be measured, confirmed appointments were prioritized in the analysis due to the influence of adult provider scheduling wait times on actual attendance.

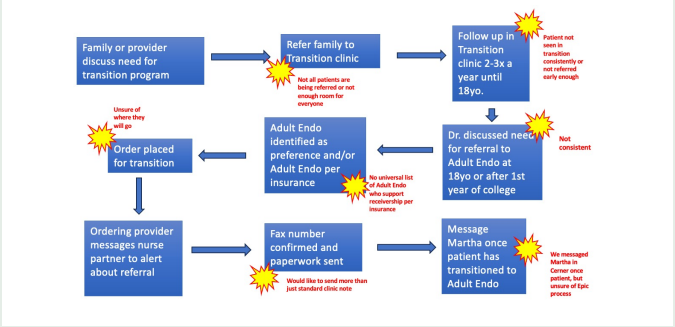
Methods

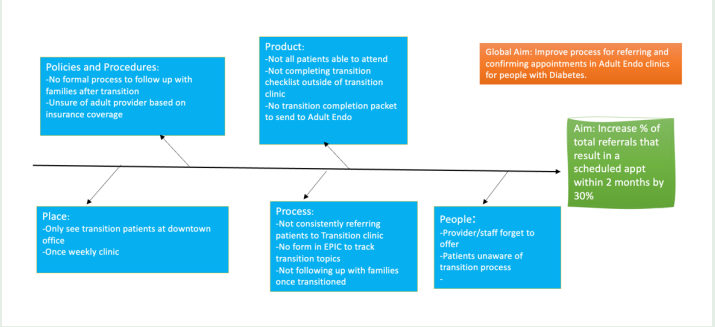
- Beginning in April 2025, referral status for all transition clinic patients with diabetes aged 18 and older was manually tracked by a transition focus team.
- For active referrals, adult providers were contacted iteratively to confirm appointment status and whether the scheduled appointment was kept.
- Referral orders and scheduled appointments were time-stamped to calculate the monthly wait time.
- All data, including transition clinic visit dates, were recorded in an ongoing IRB-approved Excel spreadsheet.











Conclusion

- Successful transition-focused diabetes care improves outcomes and depends on confirmed handoffs between pediatric and adult providers within a complex system. This approach provides a clear framework for tracking transition success while minimizing gaps in care.
- A key goal is to streamline workflows by itemizing transition "tasks" using Epic functionalities, including a patient registry and physician flowsheet.
- Ongoing use of the transition checklist in the transition clinic supports tracking transition readiness, aligned with Core Element 2 of the Six Core Elements framework.
- Efforts continue to sustain and increase the upward trend in referral placements for patients aged 18 and older, while also focusing on reducing wait times for those with confirmed adult endocrinology referrals to ensure timely access to care.
- Another future goal is to implement a chart alert indicating transition completion, aligned with Core Element 6 (Transfer Completion) with potential for department-specific customization.