T1D Exchange: A Quality Improvement Initiative to Enhance Transition Readiness Education for Adolescents with Type 1 Diabetes

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Background

Young adults with type 1 diabetes are at increased risk for poor health outcomes during the transition from pediatric to adult care.

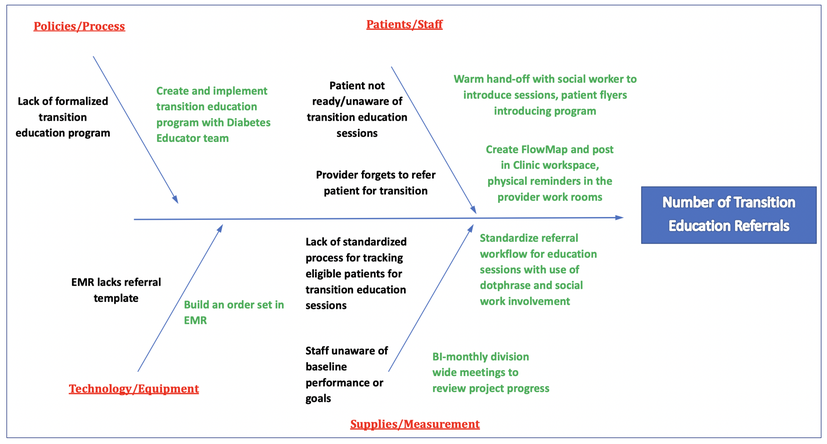
The ADA Standards of Care (2025) recommend that diabetes care teams implement structured transition preparation programs beginning in early adolescence.

Prior to this QI initiative, no structured transition education program existed beyond routine discussions with the clinic provider or diabetes care team.

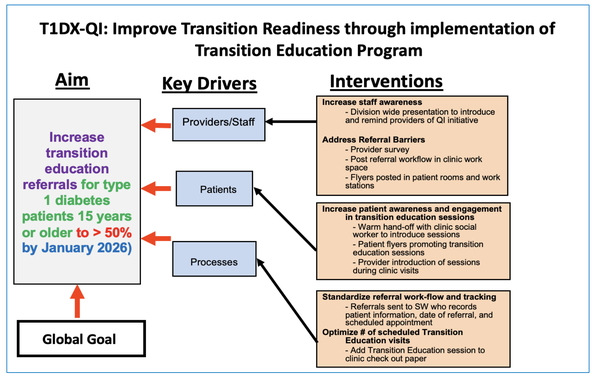
Aim Statement

By January 2026, we will increase the percentage of education referrals for patients with type 1 diabetes aged 15 years or older to greater than 50% from baseline.

Fishbone



Key Driver Diagram



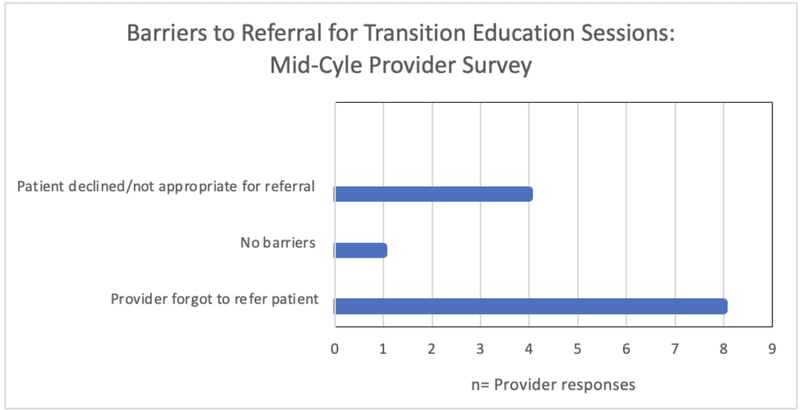
Implementation

Target Population: Patients ≥ 15 years old with T1DM
Team: CDCES team, clinic social worker, & pediatric diabetes providers
Implementation:

- Program and referral process introduced to providers at division-wide meeting (Jan 2025)
- Reminder communications sent in March and June
- Referral rates tracked biweekly by comparing eligible patients v those referred
- Mid-cycle provider survey conducted to identify referral barriers

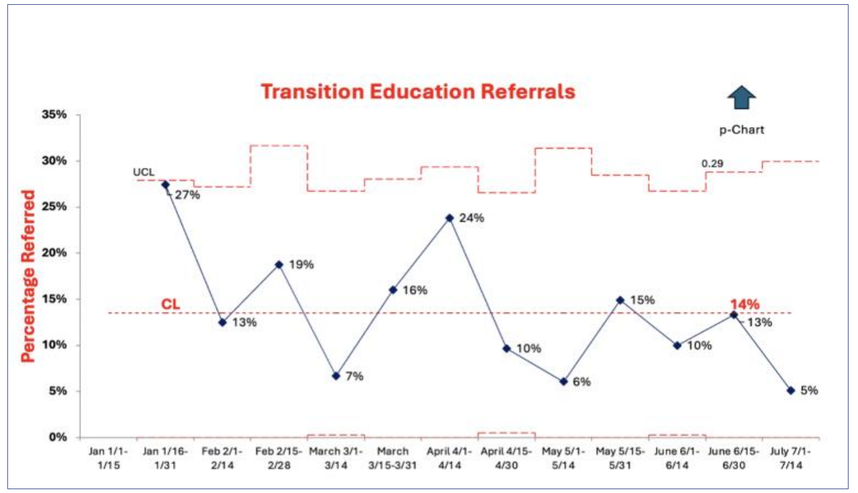
PDSA #1: Introduce project and review referral process
PDSA #2 (March): Re-introduce project and address provider-identified barriers to increase referral rate
PDSA #3 (June/July): Implement patient and provider handouts; add transition education session to checkout sheet to encourage referral and after visit scheduling of education sessions

Provider Identified Barriers to Referral



"Families not ready for transition, social concerns, or I flat out forgot!"
"Forgetting about the project, complex social situation, too much to cover in a visit"
"I forgot about this after the initial few weeks..."

Results



Transition education referral rates increased from a baseline of 0 to an average of 14% over 6 months, demonstrating early progress toward our project goal.

Lessons Learned/Next Steps

Consistent patient identification and regular provider reminders are key to increasing transition education referrals.

Planned next steps include:
•Warm handoffs with the clinic social worker
•Visual reminders on workstation computers
•Addition of transition education sessions to the clinic checkout worksheet

Future iterations will focus on increasing the proportion of patients who complete transition readiness sessions following referral.

Provider and Patient-Facing Materials