
Developing transition processes for young people with Diabetes Mellitus across Queensland

Initiative Type

Model of Care

Service Improvement

Status

Deliver

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Summary

Diabetes affects approximately one in 700 young people in Australia. Adolescents with diabetes struggle with glycaemic control which is exacerbated during the transition from paediatric to adult centred care.

The Australian National Diabetes Strategy 2016 – 2020 identified strengthening and expanding programmes which assist young people with diabetes to adult care services as an area for action. Successful transition to adult diabetes services and care is crucial in terms of both immediate outcomes (such as better glycaemic control) but also longer term concerns such as diabetes related complications and mortality, reduced economic burden on the health system and increase productivity. Clinicians, consumers and other relevant stakeholders will be consulted to co-design processes, tools and materials when developing a transition model of care.

Key dates

Feb 2020

Oct 2020

Implementation sites

Townsville Hospital,

Partnerships

Townsville HHS, Children's Health Queensland, Mater Health

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Aim

The development of web-based resources for Queensland clinicians to assist young people with Type 1 Diabetes to transition to adult services. Statewide tools will be developed to guide clinicians through the transition process for use by all clinicians across Queensland. This might be a Diabetic Centre, a community-based clinic or a sole-practitioner GP.

Benefits

This project will focus on the development of a transition model of care and subsequent processes and tools to assist people affected by diabetes. Clinicians, consumers and other relevant stakeholders will be consulted to co-design these tools and materials.

Background

The 2012 Diabetes Australia Youth Transition Survey revealed that almost half (49%) of the 17 to 24 year olds and 71% of the 14 to 17 year olds had never discussed transition to an adult service with their healthcare professional. Thus in the absence of a formal transition process, losses to patient follow-up are common. The survey reported clinic attendance falling by 30% (71% clinic attendance in 14-17 year olds versus 42% of 18-24 year olds). Lack of satisfaction in the transition process has been highlighted by feedback from young adults. Developing a core model of care and subsequent processes and tools that address key elements, including early preparation for transition, provision of specific transition information and materials and active preparation in decision making processes are well described. There are several models of support for transition between paediatric and adult care. M.Clement et al (2018) in their study into 'Organization of Diabetes care' state that: 'The most important member of the diabetes health-care team is the person living with diabetes. Current evidence continues to support the importance of a multidisciplinary and inter-professional team with specific training in diabetes within the primary care setting;' Pihoker et al (2018) fortify this belief; 'The Team should consist of: Paediatrician specialising in Diabetes or Endocrinology, Diabetes Nurse specialist or Diabetes nurse educator. Dietitian trained in paediatrics with knowledge of childhood diabetes and normal growth, psychologist trained in paediatrics and knowledge of childhood diabetes and a paediatric social worker trained in childhood diabetes and chronic illness.'

Evaluation and Results

The project will produce measurable outcomes:

- Assessment of existing transition processes, materials and capabilities
- Development of materials and tools to support the transition of young people with Diabetes in Queensland.

Lessons Learnt

This project will utilise lessons learnt from previous transition campaigns to develop consistent and developmentally appropriate processes that can be utilised in both rural/remote and metropolitan settings across Queensland.

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