Research Days

May 4th, 11:30 AM - 1:30 PM

Improving Transition to Adult Care Discussion in a Diabetes Clinic

Erica Wee

Erica Zarse

Lindsay Baldridge

Improving Transition to Adult Care Discussion in a Diabetes Clinic

Submitting/Presenting Author (must be a trainee): Erica Wee MD, Erica Zarse MD, Lindsay Baldridge DO
Primary Email Address: ewee@cmh.edu
X Fellow

Primary Mentor (one name only): Sonalee Ravi MD

IRB Number (if applicable): NA

Describe role of Submitting/Presenting Trainee in this project (limit 150 words):
The presenting trainee/s developed and implemented the different countermeasures with the guidance of our mentor and as we go through our Problem-Solving for Fellows Curriculum with GME.

Problem Statement:
Diabetes mellitus is a chronic condition requiring complex care. Adolescents with diabetes face challenges when transitioning to an adult care setting which can lead to suboptimal glycemic control and emergence of complications. It is important for a pediatric diabetes clinic to provide support and prepare adolescents for success when they transfer to adult care.

Aim Statement:
In our diabetes clinic, patients are eligible for transition assessment if they are over age 17 years without a documented discussion in the past 1 year. A review of clinic data between October 2021 and November 2021 revealed that an average of 24.6% of eligible patients received a transition discussion. Our aim was to improve documentation of transition discussions in eligible diabetes patients to 50% by April 30, 2022.

PDSA cycles:
The transition assessment involves patients completing a readiness survey, providers reviewing the survey to lead a discussion with the family, and documentation of this discussion. Cycle 1: The biggest barrier to having a discussion was the provider not recognizing eligible patients. For countermeasure, we placed a reminder note in the ambulatory organizer for all eligible patients. Providers appreciated this reminder but would still forget to document their discussion in the EMR. Cycle 2: We added transition planning as part of the smart-text diabetes plan as a reminder to document discussion. Documentation remained below goal. Cycle 3: We implemented a small test of change to encourage 2 providers to have a pre-clinic huddle with their diabetes educator before clinic to discuss transition eligible patients and improve documentation rate. This is the active cycle. All providers and diabetes educators were informed of this project and countermeasures through emails and provider meetings.

Results:
After cycle 1, 25.8% of eligible diabetes patients received a transition discussion. Most providers and diabetes educators felt that the reminders were helpful, however noted the ambulatory organizer notes are used for multiple purposes. Other barriers reported include lack of time, more critical issues with diabetes care and providers perception that this project is to transfer to adult care.

Conclusions:

We are continually reassessing small tests of change to attain the ultimate goal of establishing a system where transition readiness assessment is a routine part of adolescent diabetes care.