Transition Program for Young Adults with Type 1 Diabetes: The Role of the Clinical Nurse Leader

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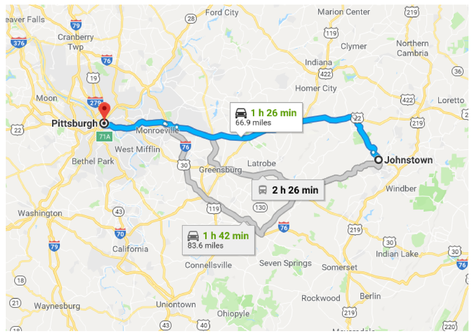
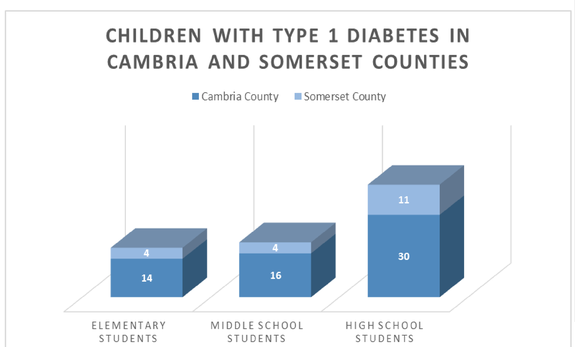
Abstract

The need for a transition program for young adults with type 1 diabetes is crucial in rural areas where there is a lack of pediatric endocrinologists. These young adults must travel 70 miles to a larger, urban hospital to receive their care.

No current transition of care programs exist for young adults with type 1 diabetes in Johnstown, Pennsylvania.

The clinical nurse leader is a master's prepared nurse who helps to transform healthcare through quality improvement, care coordination, patient advocacy and interdisciplinary team leadership.





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Introduction

Healthcare Transition:
"the purposeful, planned process that addressed the medical, psychosocial, educational and vocational needs of adolescents and young adults as they grow up learning to live with their lifelong health condition (Sheehan, While & Coyne, 2015)"

Lack of healthcare transition for young adults with type 1 diabetes may result in:

- Poor glycemic control
- Disengagement with healthcare providers
- Increased risk of complications
- Decrease in adherence to treatment
- Gaps in care
- Early mortality
- Decrease in self-efficacy
- Increase in hospitalizations
- Increase in unsafe behaviors
- Feeling of isolation
- Lack of care coordination
- Inability to maintain work
- Decrease in quality of life

Goals for Transitioning from pediatric to adult care provider:

- Pediatric diabetes providers should begin to prepare youth for transition in early adolescence, but no later than 1 year before the transition to adult care
- Pediatric and adult diabetes care providers should both provide support and resources for transitioning young adults

(Chiang et al., 2018)

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Methods & Materials

Got Transition Program

- Evidence– Based program that aims to improve transition of care through the use of new and innovative strategies
- Six Core Elements for Successful Healthcare Transition
  - ⇒ Transition Policy
  - ⇒ Transition Tracking and Monitoring
  - ⇒ Transition Readiness
  - ⇒ Transition Planning
  - ⇒ Transfer of Care
  - ⇒ Transfer Completion
- Resources available that are specific to type 1 diabetes developed by the Endocrine Society
- Program is currently being utilized at the facility in a telemedicine program for young adults with epilepsy

Multiple methods were utilized to gain more information:

Structured Interviews:

- March 2018
- Young adults at different points on their transition journey

Children's Hospital of Pittsburgh (CHP):

- Conference Calls to discuss the potential of a partnership or telemedicine options to improve transition of care for those in rural areas
- CHP has a transition program, similar to a support group

School Nurse Outreach:

- Data collected from the school nurses regarding number of students with type 1 diabetes
- Development of education for school nurses and resources for them to provide their students who are transitioning

Young Adult Outreach:

- Development of an event for young adults with type 1 diabetes to help spread the word about the importance of transition of care
- Resources provided that are helpful during the transition of care period
- Outreach to young adults to attend current support group and/or develop a support group just for this age group

Results & Conclusions

Results of Structured Interviews:

- Only 2 participants felt that their provider discussed the process of transition of care with them "Somewhat"
- Differences were noted in environment—pediatric setting was described as more "nurturing"
- Challenges included: college, scheduling appointments, "embarrassed" about their health condition, lack of healthy food choices, self-efficacy

Conclusions:

The need for a transition program for young adults with type 1 diabetes is crucial in rural areas. There are many barriers that exist for this high-risk population including scarcity of resources, lack of access to care, and financial concerns. The Got Transition program is an evidence based program that can be utilized to improve this process. The organization has demonstrated readiness to change and current initiatives are being developed to improve transition of care for this population.

To Summarize:

- The clinical nurse leader has a great impact on quality of care while functioning as a patient advocate
- A transition of care process must exist to improve patient care outcomes
- The Got Transition program is an evidence based program that can be incorporated to assist with the transition of care process