Welcome to our Transition Programme

Transition Programmes are generally an integrated part of diabetes care provided by healthcare services. Transition programmes aim to support young people to learn more about their condition during adolescence and provide coaching for young people in developing strategies to take more responsibility. Pamphlets about managing specific aspects of diabetes through adolescence should be available through your diabetes service and young people are encouraged to ask any questions about things they want more information about when they meet with diabetes healthcare professionals within their regular clinic consultations. Further youth related diabetes resources can also be found at the Starship Transition website: https://www.starship.org.nz/patients-parents-and-visitors/youth-transition/diabetes-service/

Transition programmes utilises a “Youth Health” approach. This approach values the need for young people to be treated with respect, to be made aware of all health choices and understand that all health information will be kept confidential (unless there are safety concerns for the young person or others). Young people will be reminded of this each time they meet with the diabetes team within the clinic. Part of preparing young people and their families for an adult model of care, is having young people spend some time at clinic appointments talking to the doctor alone without their parents present in order to develop confidence in becoming more independent. Parents/caregivers/support persons will always be encouraged to join young people part-way through each clinic consultation.

Clinical Psychologist support is generally not provided within all clinic environments but should be able to be accessed by discussing psychological needs with the diabetes team at clinic.

The active process of preparing young people for transition to Adult based services (Transition Planning) commences at least one year before the actual anticipated date of transfer, which will vary depending on where care is being provided but is generally around the age of 14-15years. During this preparation phase clinic appointments may take longer than usual. The actual move to adult diabetes care will again vary in relation to where care is being provided but generally happens around the age of 15-18 years.

How will the diabetes team support emerging independence of the young person

- Supporting parents in a changing role from full responsibility towards a gradual transition to cooperative care with the adolescent.
- Identifying and advising on which parental styles are likely to be more successful than others.
- The “HEADSS” (acronym for Home, Education, social Activities, Drugs, Sexual activities and Safety) interview is helpful when screening for concerns which may affect health management. This is generally undertaken by one of the diabetes healthcare team at each clinic appointment once young people are 13-14 years of age
- Encourage the young person to participate with parents and health care team in making decisions about diabetes management.
- Enabling the young person to learn from mistakes without moral judgement.
- Offering a variety of educational opportunities including open-ended discussion and negotiation, discussing health-related quality of life issues, problem solving, target setting, and age appropriate written materials.

Strategies Health Care Teams may use to develop an optimal health care relationship with young people and their families

- Developing a trusting relationship
- Helping the young person to set small achievable targets
- Providing education to help understand the physiological changes of puberty, their effect on insulin doses, issues around weight management and eating for health
- Organising regular screening for complications of diabetes ensuring young people understand and enjoy the benefits of improved metabolic control
- Allowing clinic consultations to be increasingly directed towards the young person but also involving and retaining the trust and support of parents
- Helping the young person and parents to negotiate changing levels of parental involvement in diabetes care

Transition (TN) Checklist

Young Person 13-14 years

- ☐ Introduction to youth health model with YP and family
- ☐ HEADSSS assessment undertaken with relevant supports arranged
- ☐ Full complications screening checked and results discussed with young person and family.
- ☐ Evaluation of self-management knowledge levels and additional education arranged as required
- ☐ TN Starter Pack issued

Ongoing Transition Clinic Visits

- ☐ Ongoing Clinical review with HEADSSS incorporated
- ☐ Ongoing Youth-specific education and support provided
- ☐ Ongoing Screening

Active Transition Phase

Getting Ready (Over 2-3 x formal Transition consultations)

- ☐ Formal discussions regarding differences in service models
- ☐ Collaborative TN Plan created
- ☐ TN Resources discussed/issued
- ☐ YP self-management knowledge review and final education provided
- ☐ TN Independence Survey & Goals completed by YP
- ☐ Date of projected transfer negotiated and documented on TN plan
- ☐ Meeting with Adult healthcare arranged (wherever possible)
- ☐ HCP Liaison with Adult/Young adult service provider

Time of Discharge (Final appointment in Paediatric service)

- ☐ TN Discharge Checklist completed by HCP
- ☐ Emergency plan (for acute support during TN period) discussed
- ☐ Referral letter undertaken
- ☐ Satisfaction Survey completed by YP and family
- ☐ Consent to share health information collected and documented
- ☐ HCP communication with Adult /Young Adult service provider

6 months post referral to adult services

- ☐ Tracked capture within Adult/young adult services within 3 months of transfer
- ☐ Follow up satisfaction survey/phone call/email to YP
- ☐ TN Plan completed and sent to relevant recipients (GP, Diabetes services, YP & Family)

NB: Annual collaborative planning meetings involving Paediatric and Adult/Young adult service providers will ensure cyclic quality improvements in Transition programmes to occur