

# Type 1 Diabetes Consolidated Model of Care

## Phase One: Planning (12–14 years)

Tasks	Resources/Tools	Designate*	Organisational considerations
<ul style="list-style-type: none"> <li>• <b>Invitation to transition</b></li> <li>• <b>Skills assessment</b></li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Transition Progress Sheet (part one)</li> <li>• Patient Information sheet 'What is Transition?'</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Educator</li> </ul>	<ul style="list-style-type: none"> <li>• Are we equipped to begin this journey?</li> <li>• For Rural and Remote clinicians – do we need to consider linking in with a Multidisciplinary team in a Diabetes Centre?</li> <li>• Do we need training in Young Adult Health?</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Clinical Interview and psychosocial assessment</b></li> </ul>	<ul style="list-style-type: none"> <li>• DPAT (Paediatric version) including PAID-C, PAID-C-Parent</li> </ul>	<ul style="list-style-type: none"> <li>• Psychologist</li> </ul>	<ul style="list-style-type: none"> <li>• A strengths-based approach to transition</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Knowledge Assessment</b></li> </ul>	<ul style="list-style-type: none"> <li>• M-WIKAD</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Educator</li> </ul>	<ul style="list-style-type: none"> <li>• Other recognised Diabetes Knowledge Assessments</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Ensuring primary care involvement e.g. GP</b></li> </ul>	<ul style="list-style-type: none"> <li>• Letter to GP</li> </ul>	<ul style="list-style-type: none"> <li>• Paediatric Medical Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Does the patient have a GP? Is it possible to arrange shared medical appointments with this GP?</li> <li>• Have you advised the GP of the transition process?</li> <li>• Have you involved the school or school nurses?</li> <li>• Map the resources accessible to the person – the 'social capital'.</li> </ul>

*\*Recommended where staff are accessible. Where recommended staff are not accessible, the tools can be administered by the medical officer or nominee from the clinical team.*

## Phase Two: Preparation (14–16 years)

Tasks (what's involved)	Resources/Tools (to be administered)	Designate*	Organisational considerations
<ul style="list-style-type: none"> <li>• <b>Independent or part-independent visits encourage and discussed.</b></li> <li>• <b>Skills assessment</b></li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Transition Progress Sheet (part two)</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Educator</li> </ul>	<ul style="list-style-type: none"> <li>• Encouraging the young person to become more independent</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Knowledge Assessment</b></li> </ul>	<ul style="list-style-type: none"> <li>• M-WIKAD</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Educator</li> </ul>	<ul style="list-style-type: none"> <li>• Other recognised Diabetes Knowledge Assessments</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Psychosocial Assessment including goal setting and identify any risk factors for poor control.</b></li> </ul>	<ul style="list-style-type: none"> <li>• DPAT (Paediatric version 2)</li> <li>• Readiness to Transfer Checklist</li> </ul>	<ul style="list-style-type: none"> <li>• Psychologist</li> </ul>	<ul style="list-style-type: none"> <li>• A strengths-based approach to transition</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Assessment of eating patterns impacting diabetes control e.g. Eating disorders.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional checklist</li> <li>• Screening for eating disorders or problematic eating patterns – DEPS-R</li> </ul>	<ul style="list-style-type: none"> <li>• Dietitian</li> </ul>	<ul style="list-style-type: none"> <li>• Are there suitable professionals with relevant training/expertise to deal with this</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Correspondence addressed to young person as well as parent/carer</b></li> </ul>	<ul style="list-style-type: none"> <li>• Any standard communication</li> </ul>	<ul style="list-style-type: none"> <li>• Paediatric Medical Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Have you ensured all correspondence/communication is addressed to the person as well as the parent/</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Ensuring primary care involvement</b></li> </ul>	<ul style="list-style-type: none"> <li>• Any standard communication</li> </ul>	<ul style="list-style-type: none"> <li>• Paediatric Medical Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Has the GP been advised the young person is now part of a transition clinic?</li> <li>• Has the young person been provided with additional details of new clinic including: clinic times, contact details, maps and transport options.</li> <li>• Provide or arrange resources which will support the young person's needs and support the transition of chronic condition management from the carers to the young person.</li> </ul>

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Appendix 1 of Type 1 Diabetes Transition Model of Care Guideline | Version 1.00 | Effective: Dec 2020 | Review Dec 2023

## Phase Three: Transfer (16 years or older)

Tasks	Tools	Designate*	Organisational considerations
<ul style="list-style-type: none"> <li>• <b>Assessment of readiness to transfer</b></li> </ul>	<ul style="list-style-type: none"> <li>• DPAT (Paediatric version 3) including PAID T and Transition care plan goals</li> <li>• Readiness to Transfer checklist</li> </ul>	<ul style="list-style-type: none"> <li>• Psychologist</li> </ul>	<ul style="list-style-type: none"> <li>• A strengths-based approach to transition</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Reviewed knowledge and skills assessment</b></li> </ul>	<ul style="list-style-type: none"> <li>• M-WIKAD</li> <li>• Diabetes Transition Progress Sheet (part three)</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Educator</li> </ul>	<ul style="list-style-type: none"> <li>• Other recognised Diabetes Knowledge Assessments</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Comprehensive information transfer</b></li> </ul>	<ul style="list-style-type: none"> <li>• Letter to GP</li> <li>• Letter to Adult team 'Transition letter template'</li> </ul>	<ul style="list-style-type: none"> <li>• Paediatric Medical Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Has the GP been advised of the discharge to the adult service?</li> <li>• What do we need to provide to the young person's GP and Adult team to ensure they are well supported when they transition?</li> <li>• Has the process of transfer been explained in detail? When their referral will be sent, how soon they will likely be seen, who they can call if they are concerned, what the first important appointment will look like and what they should bring with them to it.</li> <li>• Has the young person been provided with additional details of their new service including; contact details, maps and transport options?</li> <li>• Provide an opportunity for the young person to ask questions about the transfer and the new service.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Assessment of eating patterns impacting diabetes control e.g. Eating disorders.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional checklist</li> <li>• if indicated based on previous screening in Phase 1 or 2, screen for eating disorders or problematic eating patterns using DEPS-R</li> </ul>	<ul style="list-style-type: none"> <li>• Dietitian</li> </ul>	<ul style="list-style-type: none"> <li>• Are there suitable professionals with relevant training/expertise to deal with this?</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Final appointment with Paediatric Medical Officer if required</b></li> </ul>	<ul style="list-style-type: none"> <li>• Appointment</li> </ul>	<ul style="list-style-type: none"> <li>• Paediatric Medical Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Has the GP been advised of the discharge to the adult service?</li> <li>• Provide or arrange for services, facilities or resources which will prevent, delay or reduce the young person's need for care and support or the need for the support of carers</li> </ul>

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## Phase Four: Evaluation (16 years or older)

Tasks (what's involved)	Resources/Tools (to be administered)	Designate*	Organisational considerations
• <b>First appointment with adult and paediatric MO</b>	• Standard Appointment	• Paediatric Medical Officer	• Encouraging the young person to become more independent
• <b>Six month Follow-up</b>	<ul style="list-style-type: none"> <li>• Diabetes Transition Progress Sheet (part four)</li> <li>• M-WIKAD</li> <li>• DPAT (adult version) including PAID Adult</li> <li>• Screening for eating disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetes Educator</li> <li>• Diabetes Educator</li> <li>• Psychologist</li> <li>• Dietitian</li> </ul>	• Are there any outstanding psychosocial needs or treatment consideration that need to be addressed to ensure the young person continues to management their chronic condition independently?
• <b>Evaluation</b>	• Transition survey	• Psychologist	• Evaluation feedback will inform future organisation consideration for the ongoing quality improvement of services provided

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