In Brief

The transition to adult-centered care occurs at a crucial and vulnerable time for adolescents with type 1 diabetes. Despite the importance of transition care, scant literature exists examining different models of transition care and their impact on health outcomes in adolescents with type 1 diabetes. Loss to follow-up, increased hospitalizations, and deterioration in metabolic control are likely mitigated by structured transition programs.

Moving On: Transition of Teens With Type 1 Diabetes to Adult Care

Denis Daneman, MBBCh, FRCPC, and Meranda Nakhla, MD, FRCPC, MSc

Whereas “transfer of care,” in essence, refers to the act of handing over care from one physician or health care team to another, “transition of care” is far more involved with the before-and-after events surrounding transfer. The transition to adult medical care has long been defined by the Society of Adolescent Medicine as “the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-centered health care systems.”1 The ultimate goal of such a transition is seamless, comprehensive, and developmentally appropriate health care throughout. Yet all too often, the partnership between those saying goodbye to emerging adults and those welcoming them is tenuous at best. E.A. Coleman put it succinctly as follows: “Complex problems like improving care transitions rarely can be solved with simple solutions.”2 In this article, we address the transition of adolescents with type 1 diabetes from child- and family-centered care to adult-centered care.

The 2008 clinical practice guidelines of the Canadian Diabetes Association1 recommend that, “To ensure ongoing and adequate metabolic control, pediatric and adult diabetes services should collaborate to prepare adolescents and young adults for the transition to adult diabetes care.” This recommendation is supported by Grade C evidence, Level 3,3 but it fails to provide advice on the more practical hows and whens of transition. We focus here on three aspects of transition: 1) a model of life transitions first proposed by Hopson and Adams4 that highlights the complex psychological and psychosocial upheavals inherent in such transitions, 2) a brief review of the diabetes literature on the outcomes of transition, and 3) a review of the impact of interventions on these outcomes.

Transition: It’s More Than Just Crossing the Road

More than 30 years ago, Hopson and Adams5 proposed a model of transition in an attempt to understand and manage personal change. An adaptation of this model is depicted in Figure 1. It fits well with many of the experiences witnessed with the transition of adolescents with diabetes and their families from pediatric to adult health centers.

Adolescents are often excited to move on in their lives, leaving the crowded waiting room of the children’s hospital behind (represented by the solid line labeled “a” in Figure 1). Their parents, on the other hand, often are much more loathe to cut the apron strings (represented by broken line “b” in Figure 1). The timeline for what is termed “re-construction and recovery” is, in reality, much more variable than that depicted in Figure 1 and will depend, at least to some extent, on what else is happening in the lives of these adolescents and their families. The move from high school, whether to university, college, another training facility, or into the job market, plus...
the presence of other stressors, makes transition a much greater challenge.

Why, then, if it is potentially so traumatic and personally so disruptive, is transition necessary, and when should it occur? The majority of children and young teens in developed countries receive their diabetes care in the context of pediatrician-driven interdisciplinary health care teams (pediatric endocrinologists in North America and pediatric diabetologists in many other countries). Maintaining indefinite care of these youth is not necessarily in their best interests given the differences between child- and family-centered approaches and adult-centered approaches to care. In addition, the vast majority of pediatricians are not trained in the treatment of complications, but rather in surveillance for early changes. In many places, it is also a capacity issue, and policies about the timing of transition are very prescriptive (e.g., in the Province of Ontario, Canada, individuals > 18 years of age are not admitted to a children’s hospital except under exceptional circumstances).

This highlights an important issue: timing of transition should be situation-dependent. In many countries, especially those in which adolescent medicine is not recognized as a pediatric subspecialty, transition often occurs around the time of puberty (12–16 years of age). In others, it occurs at 16–18 years of age, and in some countries, no rules define the timing of transition.

In our opinion, transition to adult care requires a more common-sense approach that combines two important principles: 1) timing of transition should occur at a maturational stage of demonstrated effective self-care rather than at an arbitrary chronological age and 2) multiple simultaneous transitions (i.e., health care transition plus completion of high school and moving away from home) are likely to significantly enhance the risk of patients dropping out of ongoing care. Should adolescents leave their pediatric unit and home at the same time and follow-up with a new diabetes team in their new city, or should the transition occur closer to home?

Studies of Transition Outcomes
Transition of chronic childhood disease conditions is a relatively new field, and research to guide practice is severely lacking. The available literature tends to have focused most, but not all, of its attention on two conditions: type 1 diabetes and cystic fibrosis (CF). These two disorders account for 60 of 96 articles on transition from pediatric to adult care found in a systematic review of the literature published between 2000 and 2010. A breakdown of the research in diabetes transition care by year and type of publication (original study or review article) is shown in Figure 2. The reasons for the increasing attention in type 1 diabetes and CF are quite different. In type 1 diabetes, transition is important in the need to maintain ongoing excellent control during the difficult stages of late adolescence and early adulthood. In CF, the attention to transition has been necessitated by the enormous increase in longevity brought about by modern therapy.

There are two types of studies reported in the transition literature. First are those in which the outcomes of the transition or transfer process are described, with most addressing loss to follow-up and ongoing metabolic control. Second are studies that are mainly observational, consisting of case series or cross-sectional studies reporting the impact of different transition care models such as anticipatory guidance or transition care coordinators on diabetes-related health outcomes.

Table 1 summarizes the main studies of outcome. In general, when there is no formal transition program in place, a “loss to follow-up” rate of > 20–25% can be expected in the 2–4 years after discharge from the pediatric center. One study from Finland showed a significant improvement in metabolic control after transition to adult care, although other studies have failed to confirm this. Of note, in a recent health services study of 1,507 adolescents with diabetes undergoing a transition of care at 18 years of age in the Province of Ontario, Canada, we reported two important findings: there was a small but significant increased risk of hospitalization for
diabetic ketoacidosis (DKA) in the 2 years after transition. Also, female sex, lower socioeconomic status, poorer local medical resources, and previous hospitalizations for DKA were significant predictors of post-transition hospitalizations.

Adolescents leaving their pediatric team and starting afresh with a new physician and new team were more likely to be hospitalized for DKA than those whose adult team included some of the members of their pediatric team. This suggests that some continuity of care should be a consideration during transition.

Table 2 summarizes the major intervention studies. In essence, interventions aimed at decreasing loss to follow-up achieve this aim. However, no studies show a better outcome in terms of metabolic control, psychosocial adjustment, complication rates, or other metabolic or medical indicators. The major approaches have included anticipatory guidance, transition care coordination, and young adult clinics. Virtually all interventions include a strong education or psychoeducation component with the opportunity to meet with members of the adult diabetes team.

**Summary and Conclusions**

Although often hotly debated, the issue of transition to adult diabetes care has received scant attention in the medical literature. Findings from observational studies indicate that, unless specific programs are in place, there is a significant loss to follow-up; that there tends to be more DKA episodes after transition, although metabolic control outcomes are quite variable; and that...
little is known about factors that may support or hinder the transition process. The intervention studies suggest that, with careful support and attention, these negative outcomes can be mitigated. Successful interventions include anticipatory guidance starting early in the course of diabetes, care ambassadors, and young adult diabetes clinics incorporating pediatric and adolescent health care professionals.

The gaps in our knowledge of the transition care process remain considerable; for example, quantitative data about when and where to transition are essential, as is the impact of different transition models on metabolic control, diabetes-related hospitalization rates, and long-term complications. More qualitative outcome measures ought to assess quality-of-life issues (e.g., anxiety/depression, fear of hypoglycemia, and the impact of fear on compliance). The different approaches to transition ought to be studied in terms of their impacts on education level, job performance, interpersonal relationships, and driving. There can be no doubt that carefully performed studies have the opportunity to shed important light on the issues at hand and to replace the uniform protocols currently used in transition programs to more individualized approaches.

Table 2. Intervention Studies of Transition to Adult Care in Type 1 Diabetes

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Design</th>
<th>n; duration</th>
<th>Method of transition</th>
<th>Outcome measure</th>
<th>Results and comments</th>
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</thead>
<tbody>
<tr>
<td>Frank, 2002, Canada13</td>
<td>Case series</td>
<td>76; 2–4 years</td>
<td>Anticipatory guidance; formal and informal workshops</td>
<td>Loss to follow-up</td>
<td>7% loss; significant improvement compared to 1989 cohort</td>
</tr>
<tr>
<td>Kipps et al., 2002, United Kingdom14</td>
<td>Retrospective cohort study</td>
<td>229; 2 years</td>
<td>Four groups of post-transition care</td>
<td>Follow-up and A1C</td>
<td>Significant decrease in attendance (98 vs. 61%, $P &lt; 0.001$); greatest declines in those directly transferred to adult clinic or young adult clinic; no change in A1C; not randomized</td>
</tr>
<tr>
<td>Johnston et al., 2006, United Kingdom14</td>
<td>Case series</td>
<td>33; 15–18 months</td>
<td>Young adult clinics</td>
<td>Attendance</td>
<td>18% loss to follow-up; twice attendance to Saturday young adult clinic (NS)</td>
</tr>
<tr>
<td>Vidal et al., 2001, Spain15</td>
<td>Case series</td>
<td>72; 1 year</td>
<td>Anticipatory guidance and meeting with adult staff</td>
<td>A1C; knowledge and self-adjustment</td>
<td>All improved; A1C results not given ($P &lt; 0.001$); improved diabetes knowledge on self-management ($P &lt; 0.001$); no comparison group</td>
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<tr>
<td>Holmes-Walker et al., 2007, United Kingdom16</td>
<td>Retrospective</td>
<td>181; 5 years</td>
<td>Transition coordinator; after-hours phone</td>
<td>A1C and DKA</td>
<td>A1C lower by 0.13% ($P &lt; 0.001$); no comparison group</td>
</tr>
<tr>
<td>Van Walleghem et al., 2006, Canada17</td>
<td>Retrospective cohort study</td>
<td>101; 1 year</td>
<td>Transition coordinator; education groups</td>
<td>Number of physician and nurse visits</td>
<td>Increased number of visits in those directly referred to program at 18 years of age and in those enrolled in program after the age of 18 years (significance not provided)</td>
</tr>
</tbody>
</table>

References
19Pacaud D, Yale JF: Exploring a black hole: transition from paediatric to adult care services for youth with diabetes. *Paediatr Child Health* 10:31–34, 2005


Denis Daneman, MBBCh, FRCPC, is a professor in and chair of the Department of Pediatrics at the University of Toronto and pediatrician-in-chief at the Hospital for Sick Children in Toronto, Ontario, Canada. Meranda Nakhla, MD, FRCPC, MSc, is an assistant professor in the Department of Pediatrics at McGill University and Montreal Children’s Hospital in Montreal, Quebec, Canada.