



Twenty-one years and still going strong: A case study of a Type 1 Diabetes transition program in Sydney, Australia

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INTRODUCTION

- Transition from paediatric to adult services occurs ~ 16-18 years.
- In Australia – 73% do not meet recommended glycaemic targets¹.
- For 21 years, a transition program located in a tertiary Western Sydney hospital has consistently achieved positive health outcomes: clinic attendance, HbA1c levels in range, reduced DKA and hospital admissions².
- Program is a good example of a resilient and sustainable model of care.

AIMS

- Identify factors that have enabled long-term sustainability of a young adult T1D clinic, through a resilience in healthcare lens.
- Explore the contribution of patient and stakeholder involvement (PSI) and relations and leadership³ (Fig.1).
- Describe the characteristics of the model.

METHOD

Data collection



- Ethnographic observations of relations in clinics.
- Qualitative interviews with health care providers and teams.
- Qualitative interviews with young people ages 16-25 years, living with T1D.
- Qualitative interviews with children (< 16 years), living with T1D and their families.

1. Map patient characteristics
2. Consider capacity for family involvement
3. Assess the care setting
4. Consider healthcare staff factors
5. Assess degree of contact and collaboration
6. Consider influence of leadership
7. Evaluate applicable policies and guidelines

Figure 1: Resilience principles: Patients and stakeholders (Guise et al. 2021³)

Data analysis

- Data double-coded and thematically analysed with a team
- Deductive and inductive

PRELIMINARY RESULTS

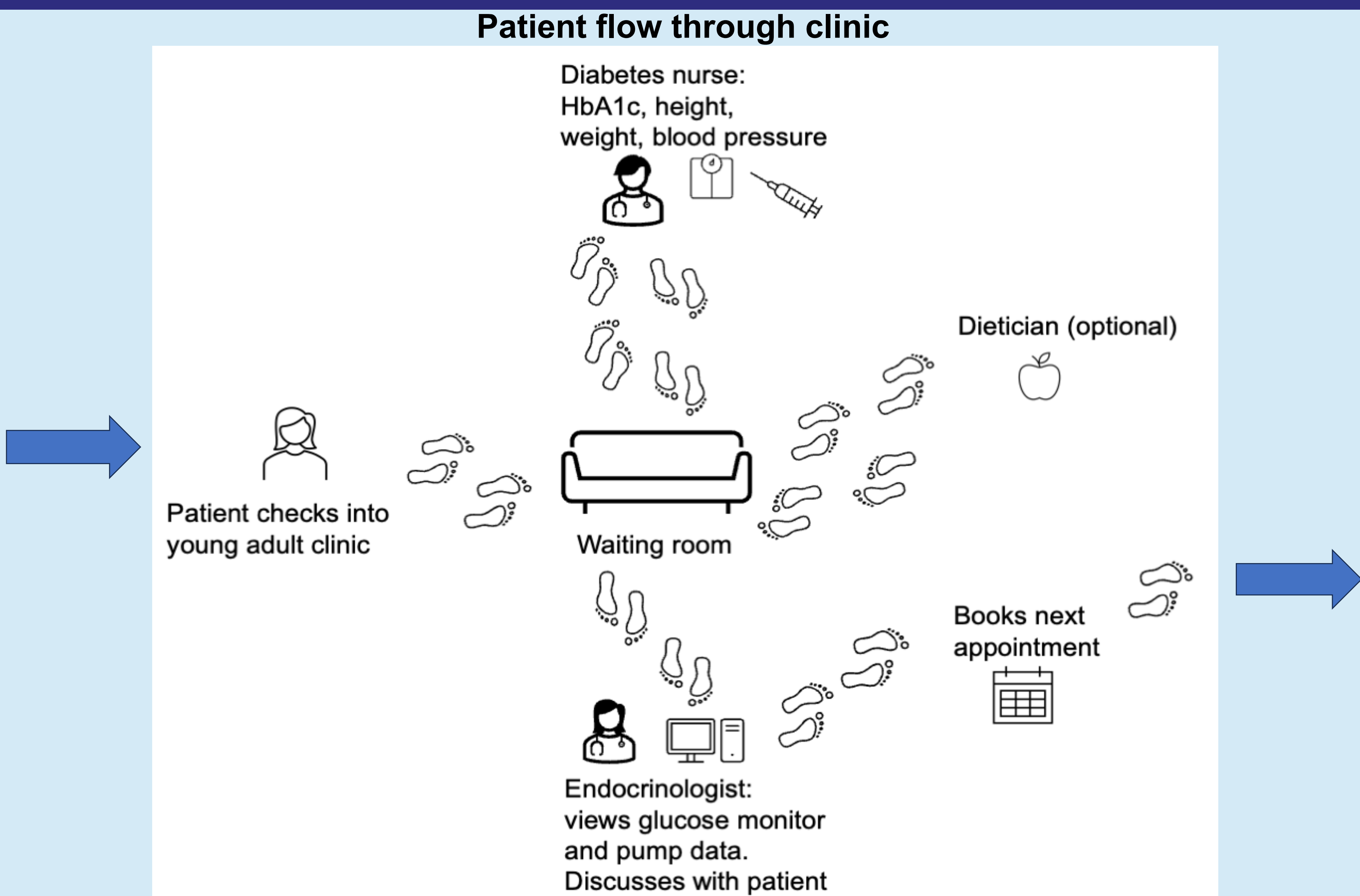


Figure 2: Patient flow through clinic

Capacity	Description	Illustrative Quotes
Communication	Supportive but not controlling; Dr addresses patient clearly and asks open ended questions. High use of technology for communication and apps. Glucose data communicates online for Dr to check.	What do you think we can do to fix that up? Prov 3 Does that sound about right? Prov 4
Structure	Clear roles and responsibilities of a multidisciplinary team; staff understand where/when meant to be. Patient centred care.	The people (staff are) familiar with her and with the young kids, that's the advantage of the clinic. Prov 1.
Coordination	Patient navigator ensures continuity of patient's care and makes adaptations when needed. e.g., missed appointments.	I get to text (the educator) and access to information all the time. And somebody is quick to answer. YA 2
Leadership	Sharing the workload in the clinic with no apparent hierarchy.	Once we are busy, we cover each other well. Prov 1
Risk awareness	Proactive and reactive. Patient involved in care decisions and made aware of risks for not complying with treatment.	Can you (the patient) check these numbers (on insulin pump) and sign this document? Prov 2 Dr makes me aware of like consequences and you know, the benefits of actually looking after myself. YA 1
Involvement	Patient autonomous with parental support; staff allow patient to initiate level of involvement.	I feel like they show a bit of tough love, you know what I mean? At the end of the day, it's (care) is in your hands, right? They provide you with information but really they're putting the onus on you. YA 1
Competence	Staff high level of experience and understanding; patient knowledgeable.	I was forced to take over control myself... because I didn't want my Mum hovering, I guess. YA 3
Facilitators	Patient navigator ensures patient and staff are kept abreast of patient flow.	I've been helping with the out of clinical hours – helping at the front. Prov 3

Table 1: Identified resilience capacities with examples based on Lyng et al. 2022⁴.

CONCLUSIONS

The key factors contributing to the resilience and sustainability of a young adult T1D clinic are:

- A skilled multidisciplinary team that is patient focused
- Accessible communication tools and out of hours care
- A consistent patient navigator that coordinates care
- Staff and parents facilitating the self-management of care

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