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The Transition from Pediatric to Adult Care for Type 1 Diabetes

Type 1 diabetes mellitus (T1DM) is a chronic disease that requires continuous medical care and self-management by the patient to prevent long-term complications. One of the most critical moments in managing this disease occurs when patients transition from pediatric care to adult care. This period can be complex for both patients and their families, making proper planning and the involvement of a multidisciplinary team essential.

Transition should be a planned, gradual, and structured process that prepares the adolescent to assume a more active role in managing their diabetes. This process should not only focus on education about the disease but also on the development of skills necessary for independence and self-care.

THE MAIN OBJECTIVES INCLUDE

- **Promoting autonomy:** helping the adolescent develop skills to manage their diabetes independently, including insulin administration, glucose monitoring, and decision-making about diet and physical activity.

- **Maintaining continuity of care:** ensuring that there are no interruptions in treatment and follow-up once they move to the adult unit. This involves coordination between pediatric and adult medical teams.

- **Reducing complications:** preventing metabolic decompensation and long-term complications through education, adequate monitoring, and adherence to treatment.

- **Addressing psychosocial needs:** managing the emotional and social challenges associated with the change, such as fears and false beliefs about abandoning medical care if they move to the adult unit. Many adolescents fear that their medical care will become less personalized, which can affect their commitment to treatment.

DIFFICULTIES THAT CAN ARISE WITHOUT ADEQUATE TRANSITION

- **Differences in care models:** in pediatrics, the approach focuses on caregivers, gradually transferring autonomy to the patient, while in adults, greater patient independence is expected. Despite this, this change can cause stress in some adolescents who do not yet feel prepared to assume this responsibility.

- **Treatment adherence:** adolescents have a higher risk of treatment abandonment and poorer glycemic control. Factors such as lack of parental supervision, social pressure, and denial of the disease can influence adherence.

- **Emotional and psychological aspects:** anxiety, stress, and depression can increase during the transition. Additionally, the feeling of isolation and lack of support can make the patient feel overwhelmed.

- **Lack of preparation:** many adolescents demand adequate information or training before the change. Insufficient education about the new healthcare system and changes in the structure of medical appointments can be significant barriers.

STRATEGIES TO IMPROVE TRANSITION

- **Start the process early:** between 14 and 16 years old, depending on the patient's maturity. It is recommended to establish progressive goals to ensure that the adolescent gains confidence in their self-care.

- **Personalize the plan:** not all adolescents are prepared at the same age; their autonomy and level of knowledge about diabetes should be evaluated.

- **Agree on the timing of the transition:** it should be discussed with the adolescent and their parents in advance to identify the most appropriate time. Prepare the transition 2-3 years in advance, promoting the progressive transfer of responsibility for diabetes management from the family to the patient.

- **Create an action plan with the medical team:** define the steps to follow, including self-care education sessions and joint consultations with pediatric and adult specialists.

- **Provide continuous education:** adapt the information to the patient's age about diabetes management and emergencies. Provide a transfer summary to the adult team, including a detailed medical history and personalized recommendations.

- **Close follow-up:** schedule frequent consultations within the first year after the

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THIS PROCESS SHOULD NOT ONLY FOCUS ON EDUCATION ABOUT THE DISEASE BUT ALSO ON THE DEVELOPMENT OF SKILLS NECESSARY FOR INDEPENDENCE AND SELF-CARE

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transition to prevent treatment abandonment and assess the patient's adjustment to the new environment. Some programs recommend monthly visits within the first 3-6 months to avoid loss to follow-up.

- **Use technology applied to diabetes** as a tool to improve disease control and treatment adherence at this stage. Remote monitoring and telemedicine can also facilitate access to periodic check-ups, without missing school days or exams.
- **Inform about the new care system:** explain the follow-up process in adults and review times.
- **Facilitate spaces to resolve doubts:** encourage the adolescent to ask about their fears and concerns to increase their confidence and reduce anxiety.

THE ROLE OF FAMILIES:

Although the ultimate goal is to promote adolescent independence, family support remains fundamental. Families can play an active role in helping to organize appointments, discreetly monitoring treatment adherence, and providing emotional support. It is recommended that they continue to accompany the adolescent to adult check-ups, at least in an initial phase. Transition is a process that involves the whole family, and it is key that parents provide support without being too intrusive. D

CONCLUSIONS

Transition from pediatric to adult care in patients with type 1 diabetes is a complex process that requires planning, collaboration, and a patient-centered approach. With adequate preparation and continuous support, it is possible to minimize the challenges and maximize the benefits of this change.

Coordination between the pediatric and adult teams, through a well-structured action program, is key to maintaining treatment adherence and the success of this phase. Tansition should never be abrupt, but progressive, planned, and agreed upon with the patient and their family.

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