Current Process of Care for High Risk Adolescent with T1D

Patient identified by Clinician as having HbA1c "out of target"

* Clinician adjusts insulin dose

* Clinician has conversation with patient and parents about management

Insulin Administration

BG and insulin dose data discussed in phone call logged by parent

Periodic phone call/email by parent to DNE to review BG data and insulin doses (sometimes initiated by DNE)

Patient goes home

Optional

2-12 weeks**

Follow-up visit with Clinician

Based on criteria assessed management of symptoms provided

Yes

Patient’s HbA1c improved?

Can be each of these or all

Clinician adjusts dose

Clinician adjusts schedule of insulin delivery

Clinician advises Nutrition consult (not always)

Clinician accesses Social Worker (not always)

Letter sent to PCP

"Increase in parental participation in management" requested

SBGM (Self Blood Glucose Monitoring) logging recommended

Quarterly visits with Clinician

Patient goes home

* Existing variability in practice, even though ADA Age Specific Clinical Practice Recommendations exist

** Existing variability in practice with no set standard

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