

## **Moving on...with Diabetes**

### **DIABETES TRANSITION PROJECT CONSULTANT ROLE**

#### **The Transition Project Consultant will...**

- Accept referral from specialty diabetes teams/physicians for consented young adults
- Accept referral from family physicians/nurse practitioners for consented young adults
- Accept referral from the Emergency Department, or other Mental Health Services, MOSH, etc., for consented young adults
- Accept self-referral from young adults
- Respond to/create response to (FAQ) general queries through a Facebook Page and direct contact (e-mail/phone/text)

#### **The Transition Project Consultant will...**

- Review and ensure consent is understood and acceptable, where applicable.
- Share resources aimed at preparing for and improving the transition experience.
- Explain/describe adult-focused care—what to expect, differences (if applicable), navigation tips.
- Provide guidance in preparing for adult-focused visits—general guidelines that provide limited introductory information about the specialty adult teams, as required.
- Provide limited introductory information about the specialty adult physicians (i.e., practitioners affiliated with, but not hosted within, the specialty teams), based on their approach to care and expectations as it relates to young adult referrals. (Information to be developed with/approved by specialist physician.)
- Attend/facilitate an “open house”/introductory group meeting(s) with young adults and the specialty adult teams.
- Connect the individual to programmatic areas of interest/need—Mental Health and Addictions Services, Laing House, etc.
- Provide information on Community Services, Family Pharmacare, and the Nova Scotia Insulin Pump Program, as needed.
- Connect the individual to other young adults living with type 1 DM—D-Tour, JDRF, or other forums (i.e., Community Health Teams) and individuals willing to share their transition to adult care experiences.
- Provide feedback to referring/accepting team/specialist/family physician on support provided and related outcome.
- Continue to provide contact following transition to adult services (time may be variable but should include two adult visits) to assess, learn from, and improve upon the young adult’s experience.
- Provide general information about the transition processes and available resources.

#### **The Transition Consultant cannot...**

- Provide direct medical/diabetes advice.
- Attend/support young adults during individual appointments.
- Share information provided in confidence without the expressed permission of the individual, with the exception of the expressing desire to intentionally harm self or others.