Transition Services at a Tertiary Care Setting

Parag Shah, MD
Sue Mukherjee, MD
Children's Memorial Hospital (CMH)
May 12th, 2012



Presentation Overview

- Describe the approach and structure of one tertiary care center to incorporate transitioning
 - Precipitating Factors
 - Current structure
 - Examples of activities



Getting Started Office of Child Advocacy

- ■The Office of Child Advocacy at CMH became an initial home for funding and direction
- Provide information from existing transition programs via site visits and interviews
- Partner with hospital administration and finance





Current Structure

- Core Transition Team
 - 1 Medical Director, Physician, 20% time
 - 1 Transition Coordinator, Social Work, 50% time
 - Serve to assist divisions and conduct global transition programs
- Transition Steering Committee
 - Representatives from divisions that received pilo grants
 - Opened to representatives from all divisions (Now up to over 20)
 - Being used to share and generate ideas for hospital-wide implementation





Transition Team Activities Clinical

- Preparing adolescents
 - Established program (SAILS) for life skills in adolescents
 - Incorporated sections into EMR to document transition activities, place checklists etc.
- Preparing for launch of Transition Clinic
- Web based portal for parents, providers
- Full array of reference materials for staff and parents



Transition Team Activities Education

 Created Intro to Transition curriculum for nurses introducing them to transition, use for social work, genetic counselors

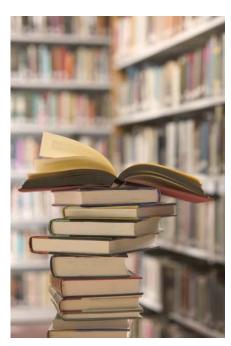
 Provide consultation to 11 different divisions teams around specific needs and starting transition programs

Seminars for medical students and residents



Transition Team Activities Research

- Literature review and reference collection
- Begun analysis of 304 person database of psychosocial factors. 2 manuscripts submitted
- Beginning research project to look at young adults "lost to follow up"
- Various conference presentations and grand rounds etc.







Lessons Learned

- Can generate cultural shifts within the institution
- Providing protected time for a transition consultative team has benefits



Hospital Website

 Website that is publicly accessible created at http://www.childrensmemorial.org/professionals/chronic-illness-transition.aspx



HeroesforLife

Together we can shape the future of pediatric medicine and research.

Chronic Illness Transition Team

The Chronic Illness Transition Team is a hospital-wide initiative to enhance the transition process and available transition services for adolescent and young adult patients at the hospital. As youth with special health care needs continue to survive and thrive into adulthood, there is a need to address the longitudinal life-span transitions of these patients, while also preparing them for adult health care. The Chronic Illness Transition Team serves as a focal point to address these hospital wide needs; begins to implement systematic programs; and provides education to patients and families, providers and the community.

Chronic Illness Transition Medical Director Parag Shah, MD

Dr. Shah is a hospitalist physician who works primarily with children with chronic illness. More here about Dr. Shah st

Chronic Illness Transition Specialist Rebecca Boudos, LCSW

Ms. Boudos is a social worker in the spina bifida clinic and spends a lot of her time focusing on transition work with teens. She also serves as the hospital-wide transition specialist.

The team can be reached at 773,327,2142.

Our vision: We are guided by the belief that all youth with special health care needs should be prepared for adult life with maximum integration into school, work and community. These youth should also be prepared for adult health care and have continued access to medical care as an adult. Our vision is inspired by the numerous children with special health care needs who are now surviving and thriving into adulthood.

Occupation of Communication to Assessment of Communication and Assessment of Communication of Communication and Communic



Contact Information

Rebecca Boudos, LCSW Transition Specialist rboudos@childrensmemorial.org Parag Shah, MD MPH Medical Director pshah@childrensmemorial.org

Chronic Illness Transition Team Children's Memorial Hospital Chicago, IL



Building Transition Services

Sue Mukherjee MD FRCPC Rehab Institute of Chicago and Children's Memorial Hospital



Spina bifida clinic

- Needs assessment:
- Education needs of families/teens
- Separate services for adults
- Preparation of youth for adult services
- Increased physical activity
- Increased community participation



Focus of the clinic

- Independence with self care and medical needs
- Education
- Obesity: concerns in youth and adults
- Transition coordinator: facilitate community participation, sports
- Transfer to adult clinic: preparation, assess satisfaction with transfer

Additional projects

- Across clinic transition database:
- Explored various transition elements and readiness across clinics/conditions
 - Risk behaviors
 - Transition behaviors (responsibility)
 - Community participation
 - Employment



Need for more PCP involvement

- CV risk and diabetes
- Physical activity
- Healthy eating
- Hypertension management
- Preventive care: cancer monitoring
- Care coordination and followup, esp if not in a multidisciplinary clinic
 - Adults need medical homes too!



Come see us!

- Live transition visits: Spina bifida clinics
- smukherjee@childrensmemorial.org

smukherjee@ric.org

