Transition Services at a Tertiary Care Setting

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Presentation Overview

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

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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

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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

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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

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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

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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.

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Lessons Learned

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

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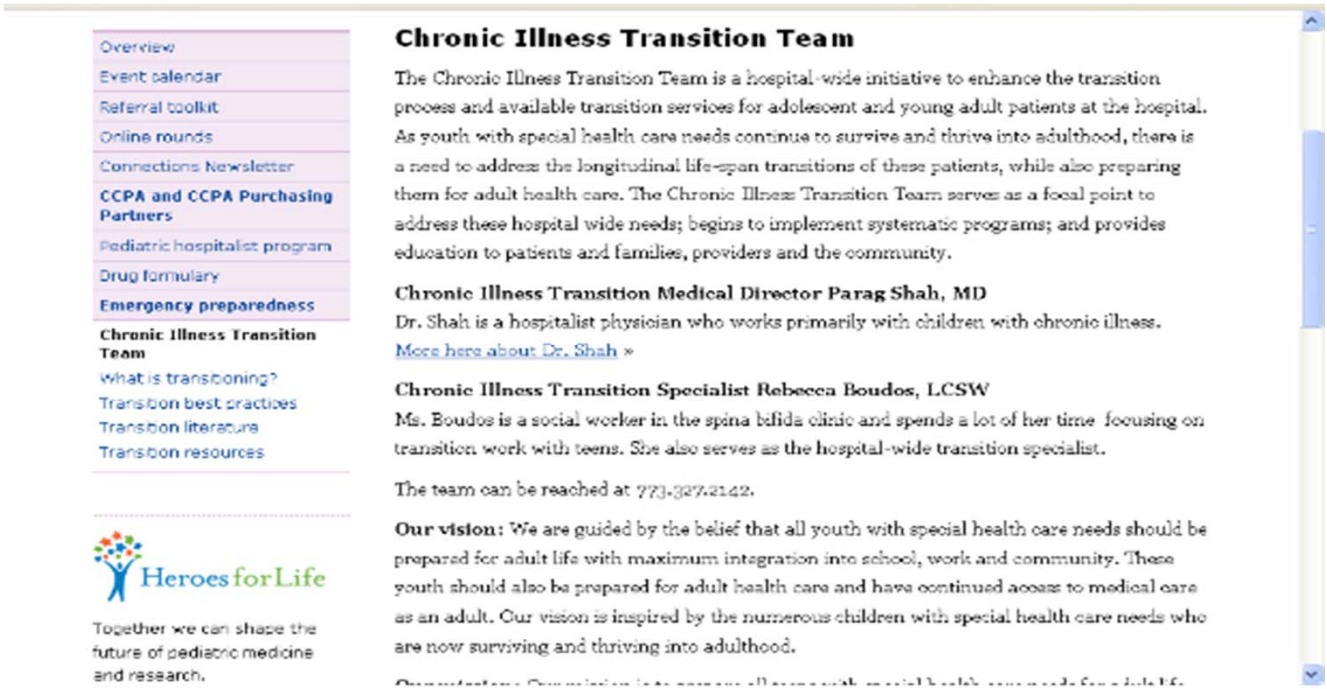
Hospital Website

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



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Building Transition Services

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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

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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

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Additional projects

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

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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!

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Come see us!

- Live transition visits: Spina bifida clinics

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