Aim Statement

Through an APRN CNP led Transition Clinic, Gillette patients and families are assisted in their transition from a pediatric care model to an adult care model. Help is provided to assist in identifying skills and knowledge needed to navigate the adult specialty healthcare environment.

Team Progress

Transition Screening Tool used prior to meeting provider to assess patient needs and readiness prior to transition process

Key Changes Being Tested and Implemented

- Age 16+ Gillette patients who would fit Lifetime Clinic entrance criteria
- Anyone can refer to Transition Clinic
- Transition resource nurse plays an integral role in the Transition Clinic. Responsibilities include extensive chart review, establish rapport and trust during lengthy intake, collect and organize data, follow to assure coordination of care and appointment adherence
- Tour of Lifetime Clinic by nursing assistants
- Specific Transition Clinic intake form used by nurse and provider
- Appointments take place in conference room with round table and no computer which helps establish foundation of trust and caring
- Readiness self-assessment screening tool
- Parent/caregiver asked to leave the room if comfortable in doing so; often the first time for separation of patient and family/caregiver
- Individualized discharge plan for referrals and identified goals
- Introduction to Lifetime Clinic social work for counseling and resource support
- Outpatient clinic note dictated to provide snapshot of patient – includes past surgical/procedural history, previous providers, medical profile and psychosocial history. A holistic assessment
- Care coordination and follow-up
- Annual return to update medical care plan and review goals

Measurement

- Tracking appointment adherence for:
  - Transition Clinic
  - Other services at Lifetime Clinic

Lessons Learned

- Patients and families are unprepared for transition. Discussion needs to start early
- Trust and rapport is essential for smooth transition. Not all staff can easily engage adolescents and young adults
- Creation and distribution of educational tools to providers, staff, and families is essential
- Patient/family attachments to pediatric providers and staff is very strong (and vice versa)
- Pediatric primary care providers often recommend their older patients find an adult primary care provider; this is difficult for many patients and families
- Parent needs for transition support are often as great as those of patient
- Difficult and often emotional when parent is asked to leave the patient alone with provider
- Assistance with transportation is the leading request for social work support
- Most transition patients do not carry any personal identification
- Care coordination is essential for successful transition

Activities

- Identify appropriate means for all patients to carry or wear some form of identification
- Investigate opportunities for virtual Transition Clinic appointments
- Creation of patient education appropriate for transitioning adolescents and young adults
- Continue to monitor patient and family satisfaction and input surveys to improve transition clinic
- Continued education for Gillette providers and staff regarding the Transition Clinic
- Formalize evidence and research based care pathways

Team Members

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Most identified needs:

- Finding a new primary care provider
- Future vocation
- Future living situation, e.g., group home, remain with family, independent living

Number of transition patients seen:

- Cerebral Palsy – 40
- Spina Bifida – 8
- Neuromuscular – 13
- Miscellaneous diagnosis e.g., arthrogryposis, Accutane embryopathy, Dyggve-Melchior-Clausen, Dandy Walker
- Total transition patients: 83
- 216 referrals for other services within Gillette
  - 176 scheduled