# EXPANDING OUR TRANSITION PROCESS

C.S. MOTT CHILDREN'S HOSPITAL
MICHIGAN MEDICINE

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## Background

- Our Cystic Fibrosis (CF) Center has had an established transition process, since 1980; however, the process was lacking an objective measure in assessing patients' readiness for transition.
- Our center had a support personnel increase, moving from having the same social worker (SW) and dietitian (RD) covering pediatric and adult clinics to having separate teams.
- After this separation in May 2015, it became evident that improved communication was needed to reduce any misunderstandings between the pediatric and adult teams.
- Through the monthly coordinators meeting and with each patient's transition visit, the pediatric team updated the adult team members including:
  - Adult CF Program Director
  - Assigned physician
  - SW
  - RN
- However, the rest of the adult team had questions about some patients' readiness for transition.
- To address these issues, we implemented the CF RISE program (CF Responsibility. Independence. Self- Care. Education.), funded through Gilead, as part of our standard practice (patients 16-21y/o). CF RISE provided a summary of each patient's knowledge base; however, the adult team reported additional concerns about some patients' readiness for transition.

## Objective

To supplement the CF RISE program without losing individualized focus, and communicate each transition in a more meaningful and comprehensive manner.

## Methods

To strengthen our transition process, once the CF RISE program was incorporated, the following steps were taken:

1. SW coordinated with the adult team during monthly meetings regarding additional information needed for a smooth transition.
2. CF Center RN Coordinator developed a template for the pediatric RNs to document patient education and their CF knowledge.
3. SW developed a transition summary incorporating the RN template, social history, and the patient's report on their individual goals to highlight previously missed areas (medication knowledge, clinic interactions, level of responsibility, patient specific goals, and CF RISE program involvement). SW also coordinated with the RD and physician to gain further input on areas of concern.
4. SW presents each patient's transition summary at the monthly adult caregiver team meeting, prior to the patient being seen in the adult clinic. These meetings include both outpatient and inpatient team members.
5. SW then documents the transition summary in the patient's electronic medical record.

## Transition Summary Example

Genetics: R117H/N1303K PFT's – maintained in the 100's BMI: 22 kg/m$^2$
Hospitalizations: zero

**Evidence of Transition Readiness:**

- **Pt is able to name / understand meds and treatments:** Yes
- **Pt can answer questions independently:** Yes
- **Pt has been seen alone in clinic visits:** Yes
- **Pt can problem solve how to get to appointments:** Yes
- **Pt calls clinic:** Yes (and is on patient portal)
- **Additional information:** MP is very responsible, career-focused, and has prioritized her CF needs.
- **Additional diagnoses (i.e. CFRD):** N/A

**Pt. Stated Goals:**

- MP is in her 4$^{th}$ year of college, majoring in Business.
- MP is hopeful that her current internship will lead to a career opportunity.

**Areas of Concern / Continued Improvement:**

- MP's mom manages some of her insurance / medication issues; however, this seems age-appropriate as Mom is able to help and enjoys having an "excuse" to deliver MP's Pulmozyme to take her out to lunch throughout the school year.
- MP's busy school/internship schedule sometimes wears on her health. So far she has avoided needing any admissions.

**CF RISE Summary / Update:**

MP has completed all of the CF RISE program (both Knowledge and Responsibility sections). She appears to have a good understanding of her CF, as well as making age-appropriate steps in increasing her responsibility.

## Results / Discussion

- Adult team members stated having a better sense of the individual patient and their current knowledge of their CF Care.
- The adult team continues to provide feedback on additional information that should be included in the summary
  - (i.e. CFRD information, if adult endocrinology appointment has been scheduled)
- The pediatric team incorporates these changes, leading to increased confidence in the process.
- This team format allows SW to communicate with the whole team; better preparing the team for any anticipated challenges or concerns.
- Patients have also responded well to the process, gaining more confidence in their readiness to transition and continuity of care.
- 21 patients have successfully transitioned since this change in process.