Disclosure to Participants

- Notice of Requirements For Successful Completion
  - Please refer to learning goals and objectives
  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours

- Conflict of Interest (COI) and Financial Relationship Disclosures:
  - Presenter: Andréa Houchen, MSW, LISW-S - No COI/Financial Relationship to disclose
  - Presenter: Allison Deisinger, RD, LD, CDE - No COI/Financial Relationship to disclose

- Non-Endorsement of Products:
  - Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products discussed in conjunction with this educational activity

- Off-Label Use:
  - Participants will be notified by speakers if any product used for a purpose other than for which it was approved by the FDA and CMS Administrator.

Program Objectives:

- Define the difference between transfer and transition of care
- Describe the importance of transition readiness assessment and self-management education prior to transfer to adult health care
- Identify developmentally appropriate educational interventions and curriculum necessary for self-management in adult health care
What is Transition?
• A purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centered to adult-oriented health care systems

It’s a process, not a single point in time.

What is Transfer?
Single point in time when patient moves from pediatric to adult healthcare

Goals of Transition:
• Uninterrupted health care that is patient centered, age and developmentally appropriate, high quality, coordinated, culturally competent, flexible and comprehensive
• Smooth transfer without becoming lost to follow-up
• Commitment to educating patients about their medical conditions
• Promoting skills in communication, decision-making, self-care and self-advocacy
• Patients capable of personal and medical independence

Risks of Poor Preparation:
• Gaps in care from pediatric to adult care
• Poor glycemic control, inadequate prevention/screening, increased morbidity
• Knowledge deficit of diabetes
• Inadequate self-management skills

“Key” Elements for Success:
• Set expectations for transition
• Flexible guideline on timing
• Dedicated Transition Coordinator for program oversight
• Joint meeting(s) with both pediatric and adult care providers when possible
• Transition plan created with the patient and family, with regular review and updates
• Skills training in communication, decision-making, creative problem-solving, self care, self-determination and self-advocacy

Transition Task Force:
• Leadership members from Cincinnati Children’s Hospital Medical Center (CCHMC), University of Cincinnati Medical Center (UCMC) and patients & families
• Examined existing practices at CCHMC and UCMC
• Conducted literature review to create plan
• Identified barriers and perceptions
• Addressed barriers

Initial Pilot Groups:
- Cystic Fibrosis
- Diabetes
- Inflammatory Bowel Disease
- Kidney Transplant & Dialysis
- Lupus
- Sickle-Cell Disease
Disease-Specific Plan
- Definition of success
- Plan to address identified barrier
- Step-by-step transition process
- Timeline for transfer of care
- Team members, roles and responsibilities
- Preparing the patient for transfer
- Assessing readiness
- Transfer of information
- Accepting the patient at UC
- Program evaluation
- Defining research opportunities

Supportive Tools & Assessments:
- Planning for the Future brochure outlining guidelines
- “Knowing My Diabetes” Passport
- Diabetes-specific readiness assessment (vs. Transition Readiness Assessment Questionnaire)
- Adult provider list
- Psychosocial assessment & depression screening
- Program evaluation

Transition Program Personnel:
- Transition Coordinator (funded)
  - Organization and supervision
  - Program development
  - Program implementation
  - Troubleshooting & measuring success
- Transition Program Director (funded)
  - Med/Peds trained physician board certified in pediatric & adult endocrinology
  - Program development
- Multidisciplinary Team from Diabetes Center

Program Timeline:
- Planning phase: Evaluation, Review, Planning, Resource Development
- Exploration of Financial Resources
- Implementation phase: Pilot Trial of Tools
- Definition of Metrics & Tracking Outcomes

Strategic Improvement Priority:
- Multidisciplinary Team: Transition Program Director (physician), Transition Coordinator, Quality Improvement Manager, Quality Improvement Consultant, Data Analyst, Nurse practitioners, Social workers, Dietitians (CDE), Nurse Educators (CDE), Psychologist (CDE)
Strategic Improvement Priority:

**FY14**
- Increase number of patients 16-18 years old who have a transition plan in place from 3.9% to 23.9% by June 30, 2014

**FY15**
- Increase number of patients 16-18 years old who have a transition plan in place from 28% to 48% by June 30, 2015

**FY16**
- Increase number of patients 16-18 years old who have a transition plan in place from 53% to 75% by June 30, 2016

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Staff Engagement:

- **Why this is important:**
  - Large multidisciplinary team, including: 10 MDs, 9 CNPs, 8 RDs, 9 RN Educators, 7 Social Workers and Clinic RNs
  - Leadership support
  - Change in process for introducing future planning

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Transition of Care Guidelines:

**CCHMC Diabetes Center model:** a transition pathway and care flows provided to the American Academy of Family Physicians, the American Academy of Emergency Medicine, the American Diabetes Association, and the National Diabetes Council for Children. A successful transition includes a young adult with diabetes and their caregivers including transition into adult diabetes care. Transition should ensure the right provider at the right time in the right place.

- At diagnosis, patients and families learn that diabetes is a lifelong condition.
- At age 21 or upon transition to adult care, patients should be educated about their condition, follow-up visit intervals, and referrals for adult care. They should be prepared for changes in insulin and other medications.
- At age 21 or upon transition to adult care, patients should be educated about the importance of self-management, including blood glucose monitoring, diet, exercise, and medication. They should be provided with the necessary tools to manage their condition and be referred to resources for support.
- At age 25 or upon transition to adult care, patients should be educated about the importance of maintaining healthy lifestyle choices, including smoking cessation, weight loss, and regular exercise.
- At age 30 or upon transition to adult care, patients should be educated about the importance of developing close relationships with their healthcare provider, including regular follow-up visits and prompt communication.
- At age 35 or upon transition to adult care, patients should be educated about the importance of regularly monitoring their health status and adjusting their treatment plan as needed.
- At age 40 or upon transition to adult care, patients should be educated about the importance of developing a family or care plan, including identifying a primary care provider and ensuring that their healthcare team is aware of their condition.

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Key Driver Diagram FY14

**Introduction:**
- **Aims:** Increase the percentage of patients who have a transition plan in place to 25% by June 30, 2014
- **Key Drivers:**
  - Staff Engagement
  - Transition of Care Guidelines

**Key Driver Diagram FY15**

**Aims:** Increase the percentage of patients who have a transition plan in place to 48% by June 30, 2015

**Key Drivers:**
- Staff Engagement
- Transition of Care Guidelines
Percent of Patients with Plan by Age:

![Graph showing percent of patients with plan by age.]

Transition Self-Readiness Assessment:
- Reviewed available readiness assessments (i.e. TRAQ)
- No standardized assessment for diabetes
- Worked with Seattle Children’s Hospital to develop current assessment
- Conducted psychometric analysis and validation of assessment tool

Transition Self-Readiness Assessment (cont.)
- Necessary to determine areas of competency and need for further education prior to transfer
- Helps guide annual education visits (RD, RN, SW)

Readiness Assessment Categories:
- Diabetes knowledge
- Healthcare navigation
- Health behaviors
- Self-management (insulin management and pump skills)
Module: Finding a Primary Care Provider

- Curriculum Objective:
  - Upon completion of this teaching module, the participant will be able to:
    - Identify a primary care provider (one main health care provider I see for all my medical needs other than diabetes).

Module: Diabetes & Sexual Health

- Curriculum Objectives:
  - Upon completion of this teaching module, the participant will be able to:
    - Explain the impact of diabetes on sexual health and function (for both males and females)
    - Describe safe sex practices

CONCEPT | CONTENT | INSTRUCTOR NOTES AND METHOD
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Module: Finding a Primary Care Provider
- Curriculum Objective:
  - Upon completion of this teaching module, the participant will be able to:
    - Identify a primary care provider (one main health care provider I see for all my medical needs other than diabetes).

CONCEPT | CONTENT | INSTRUCTOR NOTES AND METHOD
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Module: Diabetes & Sexual Health
- Curriculum Objectives:
  - Upon completion of this teaching module, the participant will be able to:
    - Explain the impact of diabetes on sexual health and function (for both males and females)
    - Describe safe sex practices
Staff Training on Curriculum:

- Education Team members paired with diabetes providers to create continuing education sessions
- Sessions will be recorded via digital classroom
- Curriculum grouped by readiness assessment topics

Future Considerations:

- Consistently assessing patient & family satisfaction with transition process
- Ongoing transition readiness assessment & tablet utilization
- Establishing consistent follow-up to determine success of transfer

Future Considerations Continued:

- Develop more interactive teaching methods
- Develop better knowledge assessment strategies and application
- Adapt transition planning for atypical/high-risk patient population
- Explore group education options

Questions?

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