The Role of the Transition Navigator in Health Care Transition

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Hematology Transition Program

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Objectives

1) The role of a Transition Navigator in health care transition
2) How a Transition Navigator differs from a care coordinator or case manager
3) How successful transition is measured in this program

Outline

- Case
- Context
- Overview of transition program
- Overview of Transition Navigator role
- Program evaluation

Case

Maya is 14 years old and has sickle cell disease (HbSS). She comes for outpatient appointments in the hematology clinic at SickKids four times a year. Maya is prescribed two daily medications for the management of her sickle cell (hydroxyurea and folic acid). She has been admitted to the hospital five times over the past year for pain episodes. Maya is in her first year of high school. She is a highly motivated student but has been struggling to keep up with the workload due to frequent hospitalizations.

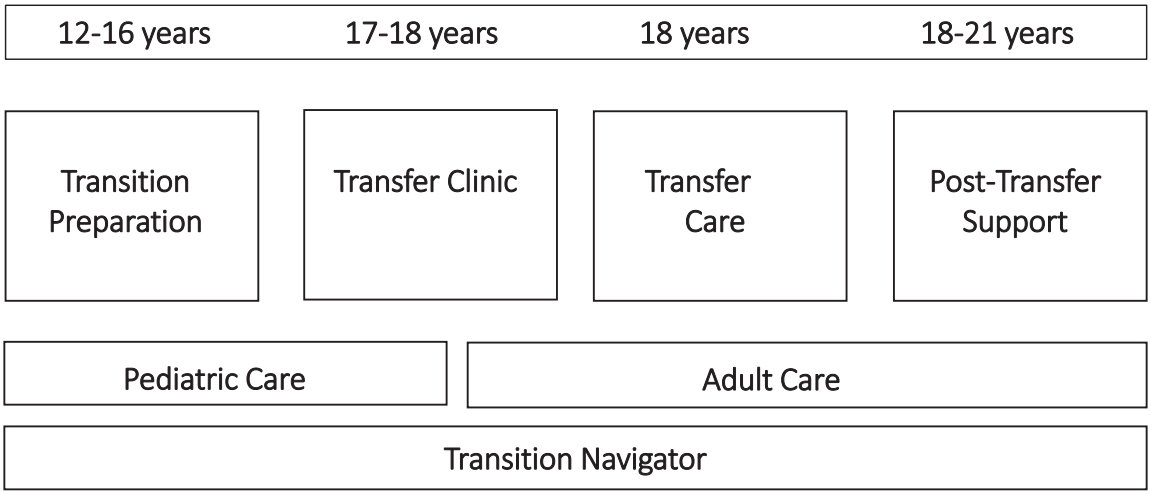
Context

Context: Why Sickle Cell?

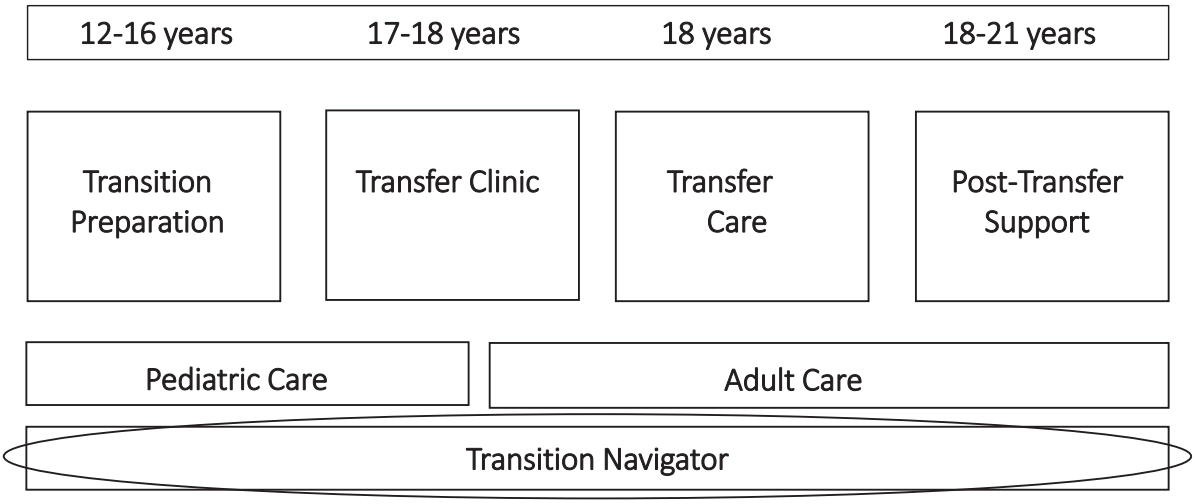
- At-risk population
- High volume
- Loss to follow up
- Lack of experience with self-management

A Program Was Born

Transition Pathway



Transition Pathway



Keep in mind…

- Canadian context
- Patients transfer at age 18
- **One** adult sickle cell clinic
- **First** Transition Navigator
- **Jointly funded** role
- Good 2 Go Transition Program

Transition Navigator

- Cross-appointed
- Patient education
- Resource development & navigation
- Coordination
- Evaluation

Maya's Journey

- Maya's transition preparation begins in routine hematology clinic appointments. Transition Navigator gets involved starting at age 12 when Maya's comes to outpatient clinic visits.

Transition Preparation

- **Understand her health condition** and implications for future
- Begin to take **more responsibility** for her care
- Understand the **expectations of adult care** and the transition process

Transition Preparation

- Transition policy
- Readiness assessment
- Tailored education
- Self-management counselling
- Resource navigation

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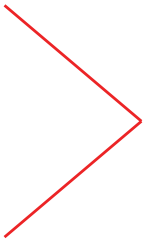

Rapport building

Transition Preparation for Maya

- Knowledge of condition
- Medications
- Self-advocacy
- Academics
- Scholarships

Maya's Journey

- A month before her 18th birthday, Maya is invited to a transfer clinic appointment to prepare her for adult care.

Transfer Clinic

- Pediatric and adult providers
- Detailed rounds discussion
- MyHealth Passport
- Transition resources
  - Transition video
- Tour of adult clinic

Transition Video

http://www.sickkids.ca/Good2Go/For-Youth-and-Families/Transition-Tools/take-it-from-me/index.html

Transfer Clinic for Maya

- Post-secondary accommodations
- Contact information for adult providers
- Drug coverage
- Navigating adult hospital

Maya's Journey

- Now that Maya is 18 years old, her first adult hematology clinic appointment is approaching. She will receive continued post-transfer support from the Transition Navigator.

Post-Transfer Support

- Appointment reminders
- Service navigation
- Self-management counselling
- Coping with life transitions

Post-Transfer Support for Maya

- Medications
- Post-secondary supports
- Who to contact in adult care

One Example of a TN in action

Time for a Comparison…

Transition Coordinator

- Logistics of transfer
- Appointment reminders
- Organizing transfer events/clinics
- Minimal follow-up post-transfer

Transition Coordinator

- Logistics of transfer
- Appointment reminders
- Organizing transfer events/clinics
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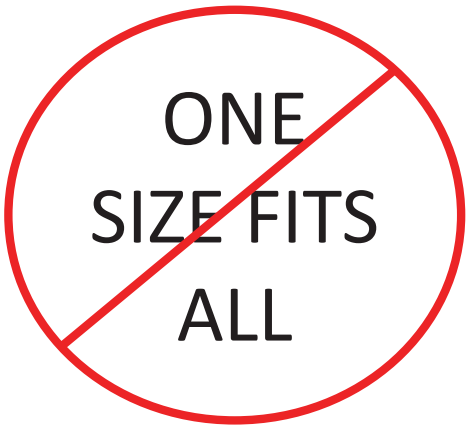
Lack of consistent definitions in the literature

Case Manager

- Overseeing all aspects of a patient's case
- High needs patients
- Cross-sectoral involvement
  - Health care
  - Developmental
  - Employment
  - Education
  - Housing

Take Home Message



My Experience as a Transition Navigator

- Elements of **Transition Coordinator** and **Case Manager** roles
- Unique to patient population
- Understand scope
- Collaboration
- Program evaluation

Program Evaluation

What does “success” like?

Program Evaluation

Initial Deliverables:

- Monthly transfer clinics
- Readiness survey administration
- Transition plans implemented
- Patients seen in adult care within 3 months of referral.
- Decreased number of no shows in first year post-transfer

Program Evaluation

Subsequent Indicators of Success:

- Clinical outcomes
  - Medication adherence
  - Lost to follow up
  - Appointment attendance
- Quality improvement initiatives
  - Patient & caregiver satisfaction
  - Staff satisfaction
  - Post-secondary accommodations
- Sustainability

Program Evaluation

Next steps:

- Longitudinal study
  - Quality of life
  - Patient-reported outcomes
  - Economic analysis
  - Clinical outcomes
- Ongoing quality improvement initiatives
  - Post-secondary accommodations
  - Interviews/focus groups

Patient Quote

Final Thoughts

- One size does not fit all!
- Small interventions → large impact
- Transition success measured in various ways
- Evaluation metrics evolve over time

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