Development of the Lifespan Transition Clinic (LTC): A collaboration between inter-professional specialty clinic and community partners in Oregon

Kim Solondz, MS, OTR/L

Clinical Need:
• 79% of Oregon families with special health care needs (SHCN) do not receive adequate health care transition services
• The Child Development & Rehabilitation Center (CDRC) at Oregon Health & Science University (OHSU) provides inter-professional services for families from Oregon and SW Washington who experience SHCN
• Provider surveys show lack of time during specialty clinic visits to address transition
• Limited adult providers, variation in family readiness to start the transition process, delayed start to transition planning, and inadequate information of community resources exist
• Support to achieve goals is often fractured across agencies

LTC Clinic goals
Providers: Occupational Therapy and Social Work
1. Provide health care transition support for families age 12+ who visit our inter-disciplinary clinics and have chronic health, developmental, or behavioral conditions
2. Help families identify transition readiness, prioritize transition goals, and facilitate the steps to successfully transition to an adult system of care
3. Connect the individual and their family with community partners (i.e. health providers, education system, developmental disabilities service coordinator) to coordinate care and transition goals
4. Support development of current care plan, emergency care plan and provide support and resources needed for identification of adult primary care provider, including contact information for consultation from pediatric provider

Barriers
Travel Time: It takes family to come up to clinic visit in Portland, OR
Insurance: Coverage for follow-up appointments with OT and SW
Community supports: Knowing what supports are available in client’s area

CARE COORDINATION: Who manages all the family’s services? Who helps implement transition plan?

Evaluation:
Mental Health Assessment
Canadian Occupational Performance Measure (COPM)
Step 1: Identification of Occupational Performance Issues
Step 2: Rating importance on a scale of 1 (low) - 10 (high) for each activity
Step 3: & 4: Identify performance (P) ratings on a scale of 1 (low) - 10 (high) and satisfaction with performance (S) 1 (low) - 10 (high)

Connection to community:
Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHN):
• Contracts with 34 counties with community health teams to develop Shared Plans of Care (SPoC)
• Contract requires 20% SPoC include transition goals
• Community teams request input from LTC for health care transition goals

Feedback:
From parent (1-month post clinic call): “right now she feels that T’s transition needs are being met and is excited about T’s new opportunities. Mother reports that Care COordinatinON (CaCoon) nurse checks in with her on a monthly basis and is available for support”

From CaCoon nurse: “putting together the SPoC takes a great deal of time and this process helped reduce the overall workload in identifying stakeholders and transition goals for the SPoC. She likes the ‘warm hand-off’ from our team to hers. She shared ‘this may be the most exciting thing I do in my career’.”

Future plans:
➢ Outcome measures
➢ Expanding model to partner with Coordinated Care Organizations (CCOs) and brokerages
➢ Clinic-Community Advisory Board
➢ Self-advocate in clinic
➢ LEND Training in community outreach

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