

Young Adults' Transition Service

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What is Transition?

The purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from a child-centred to adult-oriented health care system.

Health Care Transition :Destination unknown
Pediatrics No 6. Dec 2002

Setting the scene

- 90% of children with a disability survive to adulthood.
- Increasing numbers of young people with complex disabilities transferring from child and family centred care to adult systems.
- Often still receiving inappropriate paediatric health services as no appropriate alternatives available.

Setting the scene in Victoria

2002 Review of Victorian Paediatric Services:

- Transfer of young adults with chronic conditions to adult services identified as a major issue
- Recommended review of transition process
- **Issues**
 - Many adolescents fail to engage into the adult health system
 - Funding systems not in place to support transition
 - No evidence based models to base a transition service .

Issues for young adults and his/her family

- Resistance to change – stay at RCH forever?
- Complex time of life – educational, vocational, social, medical etc
- Parents/carers
 - Change of focus
 - Change in their role from primary carer to support provider
- Complex health and social services required.

Goal of Transition for Young Adults with Disabilities

Maximise lifelong functioning and potential through provision of high quality, developmentally appropriate health care services that continue un-interrupted as an individual moves from adolescence to adulthood.

MMC Young Adults' Transition Service Model



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Model for Transition at MMC

Model developed out of paediatric services

Patient centred care with cornerstones of:

- Continuity
- Collaboration and participation
- Comprehensiveness
- Co-ordination
- Flexibility and responsiveness
- Clinically competent and developmentally appropriate

Model for Transition at MMC

- Model based on WHO International Classification of functioning, disability and health (ICF).
- Transfer of medical care only one component of transition process. Also vocational, psycho-social, educational, cultural, equipment and general health status etc.

2005/2006 YATS established at MMC

- Appointment of Clinic Coordinator.
- Develop Transition Clinic Protocols & Procedures.
- Establish team, EFT allocation & location of clinics.
- Develop clinic assessment documents.
- Establish coordination and administration roles and responsibilities.
- YATS Resource Directory

Young Adults' Transition Team 2005/06

- Neurologist
- Rehabilitation Consultant
- Urologist
- Occupational Therapist/Clinic Coordinator
- Physiotherapist
- Social Worker
- Secretarial support

Changes to Young Adults' Transition Team 2007/08

- Neurologist
- Occupational Therapist/Clinic Coordinator
- No change to Physiotherapist, Social Worker or Secretarial support
- Allied Health Assistant – proposed
- Speech Pathology – proposed
- Referral to: Rehabilitation Consultant and Urologist or Continence Clinic as required

Eligibility Criteria

- Complex medical needs and/or developmental disabilities.
- Aged 16 to 25 years of age
- Victorian resident

YATS process

1. Telephone screen - to obtain relevant background information to assist in the prioritisation of referrals.

This includes:

- Professionals involved
- Social
- Health
- Vocation/leisure
- Functional issues



YATS process

2. Allied Health Assessment Clinic - 1 per month

- Full screen of all issues by SW, OT,PT of new referrals
- Young adult's or carer concerns and priorities discussed
- Issues assigned to team members



YATS process

3. Multi-disciplinary Clinic - 2 per month

- Allied Health team + Neurologist
- Review A.H assessment with Neurologist
- Individual care plan – collaborate with young adult and his/her family or carers
- Referrals to medical and community
- Medical/health referrals
- Neurologist writes comprehensive report

YATS process

- Young adults transition to **ADULT** services – not stay within YATS
- Transition proceeds at different rates for different individuals and families.
- Timing of discharge/transfer depends on:
 - Complexity of issues in individual's care plan
 - GP care plan
 - Family/carer and young adult readiness
 - Appropriate community and medical referrals in place

Case Study: Matthew

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Case Study

Matthew - 20 years

Background

- Transitioning from RCH
- Cerebral palsy (quadriplegia)
- Lives at home with his mother in MOH property.
- Has current case manager. Currently on FYA program and Support and Choice package.
- Attends day placement 5 days/week – mother not happy with placement.
- Private therapists ad hoc as required – lack of co-ordination and follow-up.

Matthew: YATS Identified Issues

- Medication management, hip and spine x-rays and bone scan required
- Equipment: shower/toilet commode, electric wheelchair
- Weight and fitness issues
- Manual handling issues
- Poor access to computer at home/day placement
- Mother stressed, and health issues

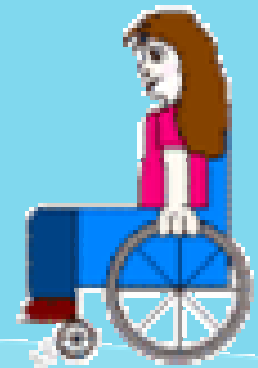
Matthew: YATS Care plan

- **Medical:**
 - Nutritionist
 - Bone scan
 - Medication reviewed
 - Hip and spinal x-rays
 - Adult spasticity clinic – ongoing care
- **Equipment:**
 - Commode - Follow-up funding and prescription
 - EWC: Follow-up re-issue EWC and prescribe new EWC
- **Fitness/strengthening program** - implemented at home/day placement
- **CRU:** Letter of support for CRU placement
- **Manual handling:** Review at home/day centre
- **GP care plan**
- **Commtech referral**

Southern Health YATS Challenges

1. Wheelchairs

- No state-wide wheelchair service in Victoria.
- ++ O.T. time in prescription and follow-up
- Prescription is driven by manufacturer
- Recent wheelchair clinic at MMC established and YATS clients seen here.



Southern Health YATS Challenges

2. Admissions to A & E

- YATS clients not being identified in A & E
- Improving profile of YATS service in busy A & E dept
- Alert systems
- Client held files?

3. Difference in provision and resources from RCH

- Pharmacy
- Equipment

Future steps: 2007/2008

- Refine clinical protocols
- Further develop links with community service providers such as FFYA, day centres, community therapy services, case management services etc.
- Continue to develop profile of YATS within Southern Health and within community.
- Evaluation

Evaluation of YATS?

DHS aim to:

- Assess effectiveness and quality of process, ongoing care and follow-up.
- Collect data and information to compare across diagnostic groups
- Identify elements of model of care and processes that are effective or not
- Evaluate mechanisms for knowledge sharing and collaboration

Evaluation of YATS - DHS

How?:

- Review of best practice service delivery models
- Mapping of current Transition clinic models in Victoria
- Key stakeholder and clinic staff consultation
- Client consultation - survey/phone interview
- Qualitative and Quantitative data analysis

How to contact YATS?

Contact:

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