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Cathy Cartwright
*Children's Mercy Hospital*, cccartwright@cmh.edu

Teresa Hickam
*Children's Mercy Hospital*, thickam@cmh.edu

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SCOPE OF ADVANCE PRACTICE PROVIDERS ROLE IN TRANSITION TO ADULTHOOD CARE

Cathy Cartwright MSN, RN-BC, PCNS, FAAN; Terri Hickam MSW, ACSW, LCSW, LSCSW, CCM

Children’s Mercy Kansas City, Kansas City, Mo.

Background
Effective pediatric transition programs are often based upon multidisciplinary teams who divide many responsibilities in teaching patients/caregivers to learn self-health management and successfully transfer to the care of an adult provider when aging out of pediatric care.

Using members of their Transition Committee, Children’s Mercy Kansas City developed a list of topics and responsibilities that could present as part of the education and services needed. As teams begin adopting transition planning practices, they are encouraged to jointly review the list and identify which team member would be responsible for addressing the item.

Methods
- The list of Transition Program responsibilities was developed into a REDCap survey. The survey encouraged additional comments.
- The survey was sent out electronically to 354 advance practice nurses (APN) and 6 physician assistants employed by the hospital.
- Advance Practice Providers (APP) were asked to identify transition responsibilities they assume for their teams and whether other team members assume those duties in their absence.
- The proposal was submitted as a QI project with the hospital IRB program.

Results
60 out of 360 APPs completed the Transition Responsibilities survey. Approximately 31% of respondents were actively using the hospital’s standardized transition planning process. The primary responsibilities generally provided only by the APP are related to medical education, follow up on test results, medication, and when to seek treatment. Duties often delegated to the physician, staff nurse or social worker include use of patient portal, obtaining health insurance and release of information, and creating a list of providers and phone numbers.

Conclusion
APPs are responsible for a majority of medical oversight. Further work is needed to confirm how a greater understanding of the transition planning process expands the role of the APP to include enhanced engagement with the multidisciplinary team, patient/caregiver, and transfer to adult providers.

Next Steps
Participate in a Care Coordination Project to identify a minimal set of transition-related responsibilities. When patients are seen in multiple clinics, the APP’s would determine for which patients they would provide overall care coordination.

Use of Patient Portal
Creating List of Adult Providers
Obtaining or changing health insurance
Obtaining Release of Information to Transfer Records

Shared with other team members