

The Transition Clinic in CHD: an educational project in a Referral National Centre

Flocco S.F., Orlando A., Campioni G., Dellafiore F., Baldrighi S., Micheletti A., Negura D.G., Carminati M., Chessa M.

IRCCS Policlinico San Donato, San Donato Milanese, Milan, Italy

Children with a Congenital Heart Disease (CHD), nowadays, may be treated promptly. An increasing number of children born with cardiac anomaly reach adolescence and adulthood as the result of progress that has been made in recent years by cardiac surgery and interventional cardiology. At the same time, also different problems related to this condition are highlighted.

The transition from adolescence to adulthood is a peculiar developmental phase and becomes more extended and less defined. This period is more difficult for adolescents with CHD, because the transition of care does not avoid the complexities associated with this developmental stage. These people need specialized treatment and follow-up, often lifelong. Therefore, a transitional care program should be guaranteed in order to ensure an integrated care. The aim of this program is to let adolescents with CHD responsible for themselves and their health.

In our hospital Physicians, nurses, psychologists and peer counselors have developed an educational path in order to facilitate the transition. These professionals have designed: informative and training material in order to help young patients and their families in transition; psychological support during all the stages of hospitalization; a communication channel with "former" patients in order to share their experience.

Psychological tests are also used to assess personality and to better understand the impact of the disease on this population. The goal is to optimize the transition's process.

Studies have proved that there is a high risk of discontinuity of care and lost to follow-up of the adolescents with CHD and that families want to be followed and supported during this step of their life. Our project is a model that tries to ensure a suitable and high-quality healthcare for the patient provided by a multidisciplinary team.

The continuity of the follow-up is an important goal of the transition and should be completed even with the transfer, that is, the chance to move adolescents and young adults with CHD from Pediatric Cardiology to an Adult Specialized setting. It is important that transition's project become national, standardized and, therefore, transferable to all national and international Centers who deal with this kind of assistance.