**PROJECT BACKGROUND**

- Children and youth with special health care needs (CYSHCN): Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally

- 99% of children diagnosed with special health care needs survive into adulthood

- Only 44% of CYSHCN (ages 12-17) receive services necessary to make appropriate transitions to adult health care

- Our project is intended to improve transition services at APHC following the Six Core Elements provided by Got Transition to provide developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood

- According to Got Transition, having a structured Health Care Transition (HCT) process has been shown to significantly improve population health, patient experience, and health care utilization

**PROJECT AIMs**

- **Global Aim:** Improve health care transition activities at APHC using Got Transition best practices

- **Specific Aim:** By January 2025, the social documentation tab will be populated with transition specific information for 50% of youth and young adults 12 to 24 years of age with special health care needs at APHC

**PROJECT DESIGN/STRATEGY**

- **Design:**
  - A Quality Improvement project with a multidisciplinary team that carried out multiple Plan-Do-Study-Act (PDSA) Cycles

- **Setting:**
  - ECU Physicians Adult & Pediatric Clinic

- **Sample:**
  - Youth and young adults with special health care needs – 127 patients

- **Data Collection:**
  - Pre-implementation data was collected in November 2022
  - Made sure transition guide was publicly displayed in the clinic and created a checklist of all the staff to track that every clinic staff was aware of this document
  - Post-implementation data was collected in March 2023 and September 2023
- collected information to see whether there was an increase in social documentation

**CHANGES MADE (PDSA CYCLES)**

- Lack of awareness of transition guide among clinic staff and families
- Limited documentation of health care transition needs in social documentation tab
- Continue to circulate transition policy and awareness checklist
- Awareness of transition policy
- Emailing physicians about regularly updating
- Work alongside clinics transition care coordinator
- Front desk staff still unaware
- Social documentation tab is getting updated but still less than 50% of patients
- New interns in July and new to flow of clinic

**DOCUMENTATION TRACKING**

- Monthly data collection
- Service capture during patient follow up

**RESULTS (RUN CHART)**

- Transition Care Monitoring Database Documentation Rates

**MEASURES**

- **Outcomes Measures:**
  - Percent of patients that have social documentation updated

- **Process Measures:**
  - Tracking Got Transition’s Health Care Transition score in each domain

- **Balancing Measures:**
  - Additional time required for clinic visits
  - Accuracy of documentation

**LESSONS LEARNED/ NEXT STEPS**

- This project highlights the importance of multidisciplinary collaboration for transition care
- Periodic discussions regarding transition care during resident conferences can help remind providers to document consistently

**LIMITATIONS:**

- Time for completion of extra documentation for complex patients
- Trying to adjust practice and documentation for 23 resident physicians who are intermittently in clinic
- Resident physician turn over every year
- Different interval frequency of patient follow up to capture the documentation

**Next Steps:**

- Emailing the entire clinic staff including new interns an example of social documentation and reminder to keep documenting
- Create patient checklist to document patient’s progress in transition
- Monthly data collection

**REFERENCES/ACKNOWLEDGEMENTS**

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