

Improving Transition to Adult Care in Children & Youth with Special Health Care Needs



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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
- **90%** 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

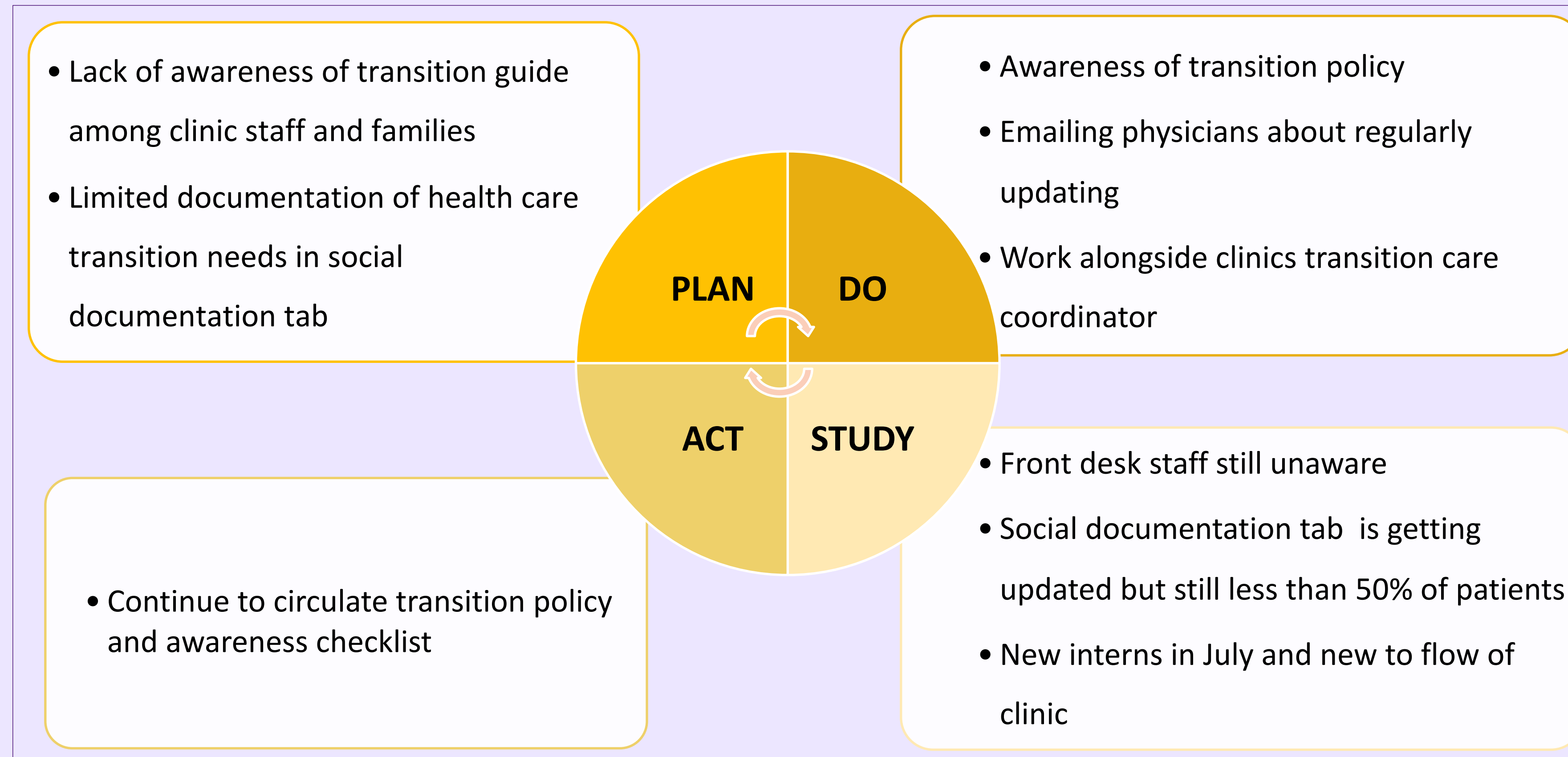
Sample:

- 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

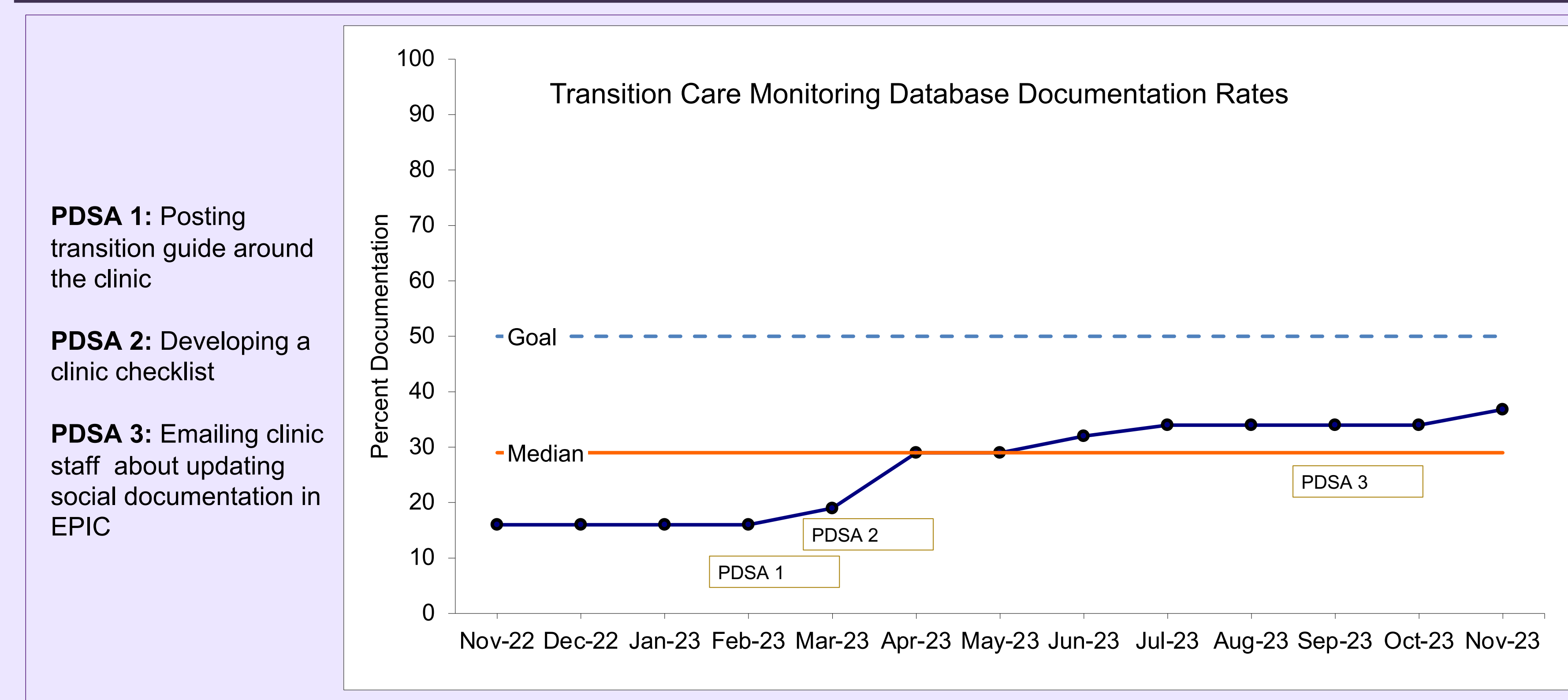
CHANGES MADE (PDSA CYCLES)



DOCUMENTATION TRACKING

The image shows two screenshots from the Epic EHR system. The left screenshot displays a patient's 'Transition Readiness' assessment with various checkboxes and questions related to medical history, medications, and social support. The right screenshot shows a 'SmartPhrase' for 'TRANSITIONCARECOORDINATION' with fields for developmental status, living situation, educational status, and community resources.

RESULTS (RUN CHART)



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

- Thank you to all ECU Adult & Pediatric Healthcare Clinic providers and support staff that have helped launch and integrate this project.
- Mazzucato M, Visonà Dalla Pozza L, Minichiello C, Manea S, Barbieri S, Toto E, Vianello A, Facchin P. The Epidemiology of Transition into Adulthood of Rare Diseases Patients: Results from a Population-Based Registry. Int J Environ Res Public Health. 2018 Oct 10;15(10):2212. doi: 10.3390/ijerph15102212. PMID: 30309015; PMCID: PMC6210512.

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