### 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 follow the steps provided by Got Transition to provide developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood

### Project Aims

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

**Specific Aim:** By January 2025, the social documentation tab will be documented for 50% of the young adults between ages 12 and 14 and the clinic staff checklist will continue to get updated as new interns come in

### Project Design/Strategy

**Design:**
- A pre-experimental design using pre- and post-implementation data evaluation

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

**Sample:**
- Children and youth 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)

- **PLAN**
  - 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 checklist
  - Email all staff, including new interns, with proper documentation of health care transition needs in EPIC
  - Many residents that were present at noon conferences signed checklist
  - Front desk staff still unaware
  - Social documentation tab is getting updated but still less than 50% of patients
  - New interns in July and now to flow of clinic

- **DO**
  - Posting transition guide/policy in waiting rooms and patient exam rooms
  - Develop ECU med-peds clinic staff checklist to document their awareness of transition guide
  - Emailing staff about regularly updating social documentation in EPIC
  - Work alongside clinic transition care coordinator

- **ACT**
  - Transition Care Monitoring Database Documentation Rates

- **STUDY**
  - Review of Process Measures and Balancing Measures

### Documentation Tracking

- Transition Care Monitoring Database Documentation Rates

### Results

**PDSA 1:** Posting transition guide around the clinic

**PDSA 2:** Developing a clinic checklist

**PDSA 3:** Emailing clinic staff about updating social documentation in EPIC

### Measures

**Outcomes Measures:**
- Percent of patients that have social documentation updated
- Number of staff that signed the checklist

**Process Measures:**
- Tracking 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


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