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

Rishita Yeduri[1], Mary Catherine Turner, MD[2],
LINC Scholar, ECU Brody SOM[1]; ECU Department of Internal Medicine & Pediatrics[2]

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 (ages12-17) 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 APHC 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 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

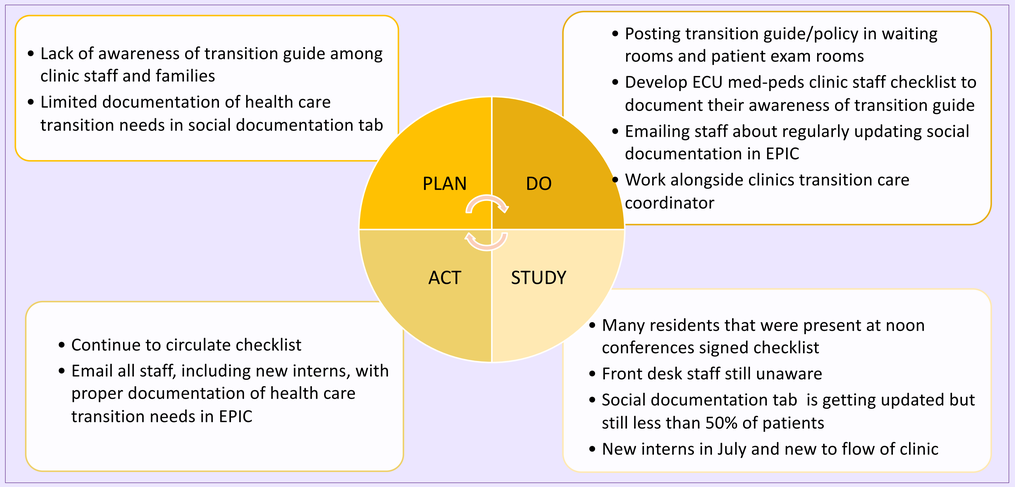
Sample:

- Children and youth with special health care needs – 127 patients

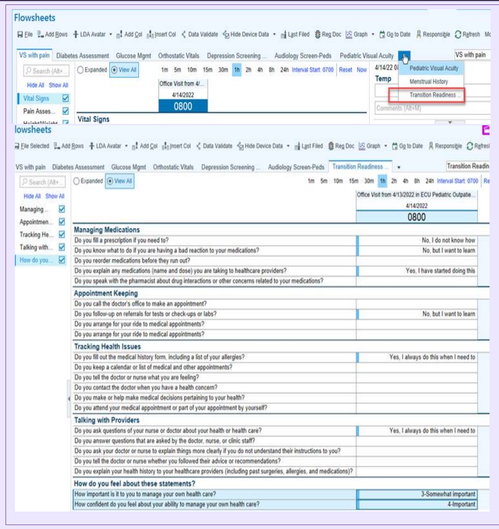
Data Collection:

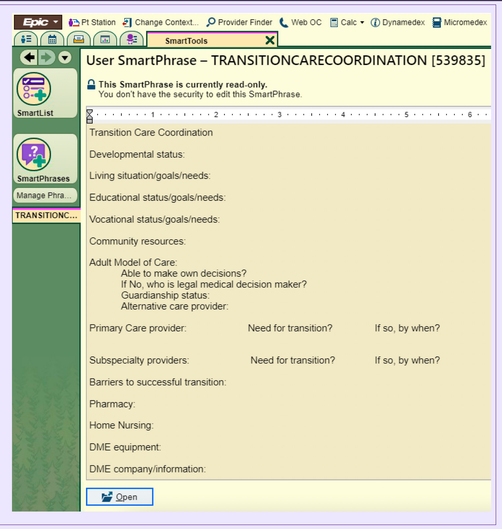
- Pre-implementation data was collected in November 2022
- Made sure transition guide was publicly displayed in the clinic and created a checklist of all the staff to track that every clinic staff was aware of this document
- Post-implementation data was collected in March 2023 and September 2023
  -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

CHANGES MADE (PDSA CYCLES)



DOCUMENTATION TRACKING



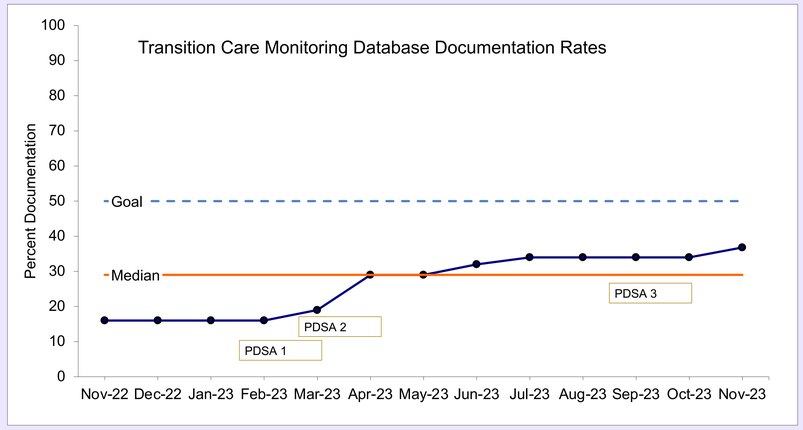


RESULTS

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 has 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

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.

ACKNOWLEDGEMENTS

Thank you to all ECU Adult & Pediatric Healthcare Clinic providers and support staff that have helped launch and integrate this project.