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Transition of Care from Pediatrics to Adult Health Care

Heather Mahsman and Holly Henderson

Executive Summary

Introduction of Problem

Healthcare transition (HCT) is the process during which adolescents and young adults move from pediatric-focused to adult-focused health care delivery system. It involves purposeful, planned movement of adolescent and young adult health care into the adult delivery system (Sawicki et al., 2015). In 2002, a joint statement coauthored by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American College of Physicians (ACP)-American Society of Internal Medicine, stated the importance of developing, facilitating and supporting the transition of care for special needs patients from the pediatric setting into adult health care setting (American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, 2011). A recent nationwide survey indicated that over half of pediatric practices surveyed neither initiate transition planning in early adolescence, nor offer transition support services. These services have been found to be critical for ensuring a smooth transition into adult health care settings (American Academy of Pediatrics, Department of Research, 2009). The pediatric clinic chosen for this project did not have a specific protocol for when and how to begin transition of care, which supported the need for implementing the project at this site.

Literature Review

Data from the 2001 National Survey of Children with Special Health Care Needs showed that less than 50% of parents of children with special needs reported discussing transition of care with their adolescent's provider. Only 30% of providers surveyed had a plan for addressing

transition needs. A following survey in 2007 showed that just over half the youths ages 19 to 23 years reported receiving counseling around transition (Sharma, O'Hare, Antonelli, & Sawicki, 2014). Failures in transition of care can lead to serious long-term health consequences, including increased emergency care utilization, increase hospital use, and lack of preventative care. Mental health issues, unintentional injury, substance abuse, and sexually transmitted diseases also need to be addressed. Furthermore, this is a pivotal time to address health issues such as obesity, smoking, drug use, sedentary lifestyles, and onset of adult chronic conditions. It is estimated that 30% of young adults have no consistent source of healthcare (Greenlee et al., 2017).

The American Academy of Pediatrics recommends a well-timed transition from child to adult health ideally being completed between the ages of 18-21 (American Academy of Pediatrics, 2011). Both Healthy People 2020 and the Maternal and Child Health Bureau have established transitional planning as one of their outcome measurements. Specifically, this objective calls for states to increase the percentage of adolescents with and without special health care needs to make transition to adult health care (Fortuna et al., 2012). A 2015 study found that most youths are transferring care later than recommended, with gaps of more than a year without care (Wisk et al., 2015). Limited staff support and resources, a lack of an identified staff member responsible for ensuring transition, and lack of resources to provide staff with developmentally-appropriate training and transition planning all contribute to a lack of transition to adult health care (Maddux, Ricks, & Bass, 2015). A 2012 study showed that forty percent of youths are not receiving adequate resources for a successful transition to adult care. In addition, young adults with public health insurance or no health insurance were more likely to have delayed transition. Limited availability of qualified adult health care providers to accept

transitioning patients also contributes to the problem (Fortuna, et al., 2012). Gabriel, McManus, Rogers, and White (2017) found that those who did not have an initiation of transition plans had lower than expected health care literacy, discontinuity of care, delays in securing an adult provider and specialty care, problems with medical adherence, dissatisfaction with care, and excess morbidity and mortality. Lastly, higher incidences of smoking and marijuana use have been associated with lack of transition of care to adult health, which has overall negative health consequences (Yu et al., 2016).

Project Methods

The purpose of this project was to assess and increase awareness of transition planning and assess the feasibility of instituting a transition program in a rural health pediatric clinic in west central Illinois. Staff and providers were educated about transition of care planning and the current recommendations from the American Academy of Pediatrics. Education consisted of information about existing tools to encourage the adoption of the transition of care protocol developed by gottranstion.org. The intent was to improve transition from pediatric to adult healthcare thus reducing healthcare costs and furthering health promotion in this age group.

The project was initially presented to one provider and her staff in the rural pediatric health clinic. From their feedback, the project was then presented to all the pediatric staff at a unit meeting. Participants answered a pre-presentation survey to gauge their understanding of currents recommendations in transition planning. After a PowerPoint presentation that included educational materials as well as tools that can be utilized to assist with transition, a post-presentation survey was conducted testing their knowledge of the current recommendations for transitioning and feasibility of implementing the program into their current practices. The project was approved by the Institutional Review Board at Southern Illinois University

Edwardsville prior to implementation. The clinic selected for the project also provided approval prior to beginning the project.

Evaluation

The pre-presentation survey demonstrated that a majority of the staff and providers (72.73%) were not aware of the current recommendations for transitioning and were also unaware of the tools available to aide in transitioning. Despite not knowing current recommendations, over half the staff (63.64%) reported participating in transition planning at least sometimes. Only nine percent correctly identified the correct age the current guidelines suggest on when you should start transition of care.

After the educational presentations, post presentation surveys were completed by all those who participated in the educational session, resulting in two more post- surveys than pre-surveys since two of the participants were not present at the beginning at the very beginning of the presentation. The majority of the participants were able to identify the correct age to start transitioning, indicating successful education to staff and providers. Two participants incorrectly identified 16-18 being the age for transition, which coincidentally was covered in the beginning of the presentation, and a couple of the participants had arrived after the presentation had begun. After the presentation, there was an improvement in an understanding of the national recommendations, with the majority (76.9%) being somewhat aware, aware, or very aware. All of the participants agreed that transition planning was important, with 76.9% saying it was very or extremely important. The majority (76.9%) stated they rarely or sometimes participated in transition planning. All participants agreed that after the presentation they understood the process and steps for transition planning, with 61.54% agreeing and 38.46% strongly agreeing. Of the participants, 84.62% agreed that they have adequate resources to implement the proposed

transition program, 76.9% stated they agreed or strongly agree they have time to implement the program, and 84.62% expressed they have the support to implement a transition program. All participants agreed the patients would benefit from implementation of the program.

Qualitative data collected was broken into categories. For the question regarding benefits of transition planning, three categories or answers were identified. These categories included self-advocacy, adequate to prepare patients for owning their own health, and process improvement in the clinic. Not all participants answered the questions. Of the participants who answered the question, 46.15% agreed implementing this transition plan would promote self-advocacy. About 8% agreed that it would be a process improvement for the clinic and it would give the patient adequate time to prepare for transition to the adult healthcare model. Concerns for implementation were broken down into two categories. Concern of patient/family reluctance to participate concerned 23.1% of participants, while having the time to implement in the office concerned 7.7% of participants.

Limitations in the project included sampling bias and small sampling sizes. Because of the nature of the project, a convenience sample was chosen. Thirteen staff members/providers completed the post-presentation survey, and due to the small sample size, results may not be generalizable.

Impact on Practice

The immediate impact noted from this project was that awareness of transition planning was increased, and staff understood the benefits of transition planning to the patients and the clinic; however, implementation of transition planning has yet to be implemented in the clinic. After the presentations, evaluation of implementation of the program in the setting was

conducted through conversation and observation in the clinical setting. Though the program was not initiated, verbal feedback indicated that time and volume of patients prevented discussion of transition with current patients. Also, there is a small number of patients who fall within the age ranges for implementing transition because many teenagers who visit are in for sick visits and school physicals, not regular well visits. Another issue is there is no champion to help implement the project. Without administration understanding the project is beneficial financially to the clinic, they may not see the necessity of implementing such a program, which might also lead to a lack of support in having time throughout the day to devote to transition planning. Having an administrator at the presentations may have benefitted the program because if they could have seen the financial benefit, they might have been more inclined to help implement the project in the clinic. Future projects focusing on long-term impact could focus on involving clinic administrators in education and implementation planning.

Through post surveys, staff stated they understood the importance of transition planning, and there are several interventions that can aide the staff in achieving this goal. One intervention would be collaborating with Information Technology to build reminders to address transition planning in the electronic medical record when a child reaches the age for transition planning. Also, when these patients are scheduled, incorporating additional time into acute visits to address transition would be helpful. Quarterly team meetings could be held to identify pediatric patients in need of transition planning, those who are nearing the age to start addressing transition, and especially those with complex medical conditions. Then, assigning a staff member to contact patients identified and schedule transition appointments to address and plan for transition of care could improve the compliance with health care. In patients with medical conditions, having meetings with family and specialists to address their unique transition needs would prevent delay

in care for these patients. These strategies would assist in transition planning and reduce anxiety regarding transition to adult healthcare.

Conclusion

Transition planning has been found to benefit pediatric populations on the journey from child to adult health. There are current recommendations and tools available to assist clinics in developing transition programs for this vulnerable population. Despite an increasing understanding of the benefits of implementing such a program, various factors such as time, lack of a staff champion, administrative support, and limited access to applicable patients limited implementation of the program in the rural health pediatric clinic selected for this project. Further efforts are needed to address these barriers so that implementation of transition of care programs can be implemented at the site and other locations, which could potentially benefit the health of pediatric patients as they move into adult care.

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