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Multidisciplinary Support for Healthcare Transitioning Across an Urban Healthcare Network

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Background A successful transition from pediatric to adult oriented health care is a vital process in maintaining a patient-centered medical home for youth with special health care needs (YSHCNs). We assessed practices of pediatric providers who transition YSCHNs to adult-oriented medical care in a large urban academic healthcare network.

Methods: A cross-sectional Web-based survey was distributed to 376 generalist and subspecialist pediatric providers. Survey assessed provider-reported utilization of 11 Essential Steps adapted from the 2002 Consensus Statement on Health Care Transitions for YSHCNs, and recent transitioning literature. Compliance score (CS11) was calculated as a sum of steps completed. Additional items assessed knowledge of transitioning literature and respondent demographics.

Results: Survey achieved a 28% response rate (n = 105), of whom 84 reported assisting transitioning YSHCNs. Only 16.7% of these respondents were compliant with 7 or more of the 11 Essential Steps. Respondents who identified social work or nursing were more likely to have CS11 scores ≥ 7 compared to those without and were more likely to be compliant with specific steps.

Conclusion: We found limited and incomplete utilization of recommended transitioning steps for YSHCNs by pediatric providers within a large urban healthcare network. Access to support from social work and nursing was associated with greater utilization of specific recommended steps, and with more optimal compliance. Further research needs to assess the transitioning practices of all members of the multidisciplinary team and whether operationalizing healthcare transition for YSHCNs as a multidisciplinary activity impacts the transitioning process and patient outcomes.
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Background

EACH YEAR IN the United States, approximately 750,000 youth with special health care needs (YSHCNs) survive to adulthood (National Collaborative on Workforce & Disability for Youth, 2012). Successful transition from pediatric to adult oriented health care is a vital process in maintaining a patient-centered medical home's commitment to providing comprehensive, coordinated family-centered care for youth with special health care needs (American Academy of Pediatrics et al., 2011). A multidisciplinary approach is a key component in successful transition from pediatric to adult oriented health care. A 2013 Institute of Medicine report reviewed the challenges of healthcare transitioning for young adults and noted the decreased access to care and insurance coverage in this age group.

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The report states that, “a culturally competent health care system that provides access to at least annual visits and medical homes for all young adults should include transition care to help young adults navigate the health care system” (Stroud, Mainero, Olson, & Board on Youth Children and Families, 2013).

Best practice recommendations for how clinicians should assist in the healthcare transition process have advanced over the last 25 years, from the US Surgeon General’s conference in 1989 (Koop, 1989) to the 2002 consensus statement (American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, & American Society of Internal Medicine, 2002) and, more recently, the 2011 Clinical Report (American Academy of Pediatrics et al., 2011). The Clinical Report provides a stepwise algorithm to assist the clinician in the transition process for youth with and without special health care needs, starting when youth are in early adolescence. The 2002 guidelines (which included 6 “Critical First Steps”) and a review of recent literature were utilized in a prior study (Davidson et al., 2015) to create the “11 Essential Steps” (Table 1) to assess utilization of recommended provider practices related to healthcare transitioning for youth with and without special healthcare needs.

Prior research has assessed provider practices related to preparing YSCHN for healthcare transition (Burke, Spoerri, Price, Cardosi, & Flanagan, 2008; Crowley, Wolfe, Lock, & McKee, 2011; Davidson et al., 2015; McManus, Fox, O’Connor, & MacKinnon, 2008). Challenges of provider adherence to recommended transitioning practices have also been identified (Forbes et al., 2014) which include “difficulty letting go” by patients, families, settings, and providers; poor uptake of self-care or transition plans; and patients and families remaining in crisis which makes transfer of care inappropriate. It has been suggested that a multidisciplinary approach to healthcare transitioning for YSHCNs improves outcomes (Betz & Redcay, 2005; Rearick, 2007). However, it is unknown whether the availability of multidisciplinary support, including nursing and social work, improves provider practices related to healthcare transitioning for YSHCNs.

The overall goal of this exploratory study was to assess the current practices of generalist and subspecialty pediatric providers within a large urban academic healthcare network as they transition youth with special health care needs to adult oriented health care. In addition, we assessed whether institutional resources, including support from multiple members of the multidisciplinary team, were utilized by pediatric providers and if such resources were associated with greater utilization of recommended transition practices.

Methods

Data Collection

A cross-sectional Web-based survey was distributed via SurveyMonkey® to 376 pediatric providers (279 generalists, which include primary care, family medicine, and school health providers and 97 subspecialists) affiliated with a large urban academic healthcare network, which serves approximately 36,000 youth aged 12 to 21 years in its outpatient practices each year. The survey was voluntary and included a consent statement; all questions were optional. It was distributed through departmental emails and practice administrators in May 2013; monthly email reminders were sent in June, July, and August; data collection was closed in September 2013.

IRB approval was obtained from the Einstein Human Research Protection Program at Montefiore Medical Center as an extension of investigator’s previous NYS study (Davidson et al., 2015). A copy of the survey instrument is available upon request.

Survey Development

This survey was adapted from a prior survey used to assess transition practices of American Academy of Pediatrics members across New York State (Davidson

Table 1 11 Essential steps, percentages reporting utilization, and comparison of subspecialists vs. generalists.

	11 Essential steps	Total (n = 84)	Sub-specialists (n = 49)	Generalists (n = 35)	p value	Odds Ratio (95% CI)
1.	Identify core knowledge and skills	38%	49%	23%	$p < .02$ *	3.2 (1.23, 8.5
2.	Have a designated pediatrician/or member of the practice who coordinates transition	19%	27%	9%	$p < .04$ *	3.9 (1.01, 14.75)
3.	Identify an adult medical provider	75%	78%	71%	$p < .53$	
4.	Create a portable medical summary	46%	59%	29%	$p < .01$ *	3.6 (1.43,9.18)
5.	Create an emergency plan	8%	12%	3%	$p < .125$	
6.	Create a transition plan	38%	49%	23%	$p < .02$ *	3.2 (1.23, 8.53)
7.	Assist with ongoing insurance coverage	18%	22%	11%	$p < .19$	
8.	Discuss the legal aspects of transition	30%	31%	29%	$p < .84$	
9.	Discuss realistic future goals with the adolescent alone	31%	33%	29%	$p < .69$	
10.	Discuss realistic future goals with the adolescent and family	55%	57%	51%	$p < .60$	
11.	Provide ongoing routine adolescent health care	46%	33%	66%	$p < .01$ *	1.3 (.53, 3.01)

* Indicates significance at $p < .05$.

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