

# Care Coordination and Comprehensive Electronic Health Records are Associated With Increased Transition Planning Activities

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## ABSTRACT

**OBJECTIVE:** Youth with special health care needs (YSHCN) require assistance from their pediatricians to transition to adult care. There are few data on what transition resources pediatricians have. In this article we discuss whether care coordination and/or comprehensive electronic health record (CEHR) implementation are associated with improved transition processes.

**METHODS:** Using the American Academy of Pediatrics Periodic Survey #79, we report whether practices generated written transition plans, assisted in finding adult providers, and discussed confidentiality issues. Descriptive statistics and a logistic regression model were done to evaluate whether CEHR, care coordination, or practice and physician characteristics were associated with improved transition planning.

**RESULTS:** Transition planning support in practices is low. Pediatricians with any care coordinator report more written transition plans for YSHCN (23% vs 6%;  $P < .001$ ), assistance identifying adult providers (59% vs 39%;  $P < .001$ ), and discussing confidentiality issues (50% vs 33%;  $P < .001$ ). Pediatricians with a CEHR compared with those without are more

likely to report written transition plans for YSHCN (24% vs 12%;  $P < .05$ ) and discussing confidentiality issues (51% vs 39%;  $P < .05$ ). In the logistic regression model, having care coordination (adjusted odds ratio, 11.1; 95% confidence interval, 5.9–21.3) and CEHR (adjusted odds ratio, 2.6; 95% confidence interval, 1.5–5.0) were independently associated with higher odds of having a written transition plan.

**CONCLUSIONS:** Only 1 in 5 pediatricians have a transition coordinator in their practice and just 15% have a CEHR, even as these resources are associated with improved transition processes for YSHCN. Policy decisions should be made to help practices with supports, such as care coordination and electronic health record implementation, to improve transitions to adulthood.

**KEYWORDS:** care coordination; electronic health records; meaningful use; transition; youth with special health care needs

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## WHAT'S NEW

Current American Academy of Pediatrics recommendations call for pediatricians to assist in transition planning and preparedness for youth with special health care needs. Pediatricians in practices with a transition coordinator or care coordinator and a comprehensive electronic health record are more likely to report improved transition processes.

YOUTH WITH SPECIAL health care needs (YSHCN) face numerous challenges as they transition from pediatric to adult-centered care.<sup>1–5</sup> To address these barriers, the American Academy of Pediatrics (AAP) has recommended that pediatricians assist their patients in this transition and transfer process.<sup>6–8</sup> Inadequate transition planning and

health care coordination can lead to increasing morbidity and mortality.<sup>9,10</sup> In a national survey of YSHCN and their families only 24% reported receiving sufficient counseling about transition.<sup>11</sup> The AAP, in cooperation with other professional societies, has twice published guidelines calling for improved transition services.<sup>6,12</sup>

Many national organizations (AAP, Center for Health Care Transition Improvement, American Heart Association) have also established practical processes to assist practices in transitioning patients.<sup>6,13–15</sup> Steps include writing a practice transition policy statement and patient transition plans, which would include addressing issues such as confidentiality.<sup>16</sup> Ultimately, these protocols include identifying and transferring pediatric patients to an adult provider. These structured processes for engaging youth and families in transition might be most successful

when implemented within a medical home with available care coordination. Despite the guidelines and processes, it remains unclear how much practices are achieving these goals or can implement higher degrees of care coordination with existing resources.

Electronic health records (EHRs) might also facilitate care transitions.<sup>17,18</sup> In 2009, the Centers for Medicare and Medicaid Services established a set of core measures for EHRs, known as ‘meaningful use’ (MU), which created a benchmark for the effective integration of EHRs into medical practice.<sup>19</sup> Through MU implementation, EHRs should be better able to promote coordinated, safe, efficient care. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was legislated to move MUEHRs beyond the implementation of technology in practices and move toward provider payments that focus more on the quality of care delivered, with EHR utilization being one aspect of high-quality care.<sup>20</sup> Although use of the MUEHR is being phased out in its purest form, provider experience with MUEHRs provides an opportunity to investigate how their use affects patient care. Whereas EHRs have been used for other forms of medical transition, such as hospital to home and between facilities, few studies have been performed to investigate the effect of the EHR on the transition from pediatric to adult health care. This type of transition is unique because pediatric to adult health care transition requires more longitudinal planning, case management, and developmental considerations.<sup>21,22</sup> Because of the potential for improving communication between providers, health screening, and clinical care delivery, the EHR has the potential of systematically improving transition planning and care delivery for patients.

Drawing on a national survey of primary care pediatricians from the Periodic Survey of Fellows (PS), this study examined how transition processes for YSHCN are shaped by the resources that pediatricians have available to transition patients. In particular, we investigated if practice-based care coordination and implementation of a comprehensive EHR (CEHR) are positively associated with recommended transition procedures such as written health care transition plans. Exploring the effect of care coordination and CEHRs provides insight into the issues that should be the focus of advocacy for future requirements and for practice change.

## METHODS

In this analysis we used data from the PS, a nationally representative survey of randomly selected, nonretired US members of the AAP. PS #79 (2012) was sent to 1631 post-residency members. Seven mailed contacts were made from September 2011 to February 2012 to nonrespondents (in addition to 2 e-mails with a link to complete the survey electronically). The final survey response rate was 59.4%. The content of survey questions was guided by members of the National Center for Medical Home Implementation Project Advisory Committee and the AAP Council on Children with Disabilities. The purpose of this particular PS was to investigate practice resources, EHR capacity, and various

other practice domains on caring for pediatric patients in practice. The full contents of the survey are available from the AAP.<sup>23</sup> The survey was approved by the AAP institutional review board.

There was no specific definition of or question asking whether participants had a MUEHR in practice in the survey. Rather, participants were asked whether they use the EHRs for specific clinical activities (eg, ordering, reviewing laboratory results, and communicating with patients). We then created a measure called CEHR for practices that indicated they had components of a MUEHR.<sup>19</sup>

## PRIMARY OUTCOME VARIABLES

The question being studied was the effect of care coordination and CEHR on practice transition processes. The outcome variables addressed in this study were if a pediatrician’s practice had the following transition process measures for YSHCN: writing a transition plan, assisting in identifying adult providers for transition to adult care, and discussing consent/confidentiality issues. These were dichotomized to these services being provided in 2 ways. The first, as our primary reporting measure, we dichotomized these variables as “all/most YSHCN” versus “some/none/unsure” (1 = all/most YSHCN, 0 = otherwise) to evaluate whether or not practices had a high level of transition quality of care. As a secondary measure, to investigate whether any transition measure was done in practice more broadly, we also dichotomized these variables as “all/most/some YSHCN” versus “none/unsure” (1 = all/most/some YSHCN, 0 = otherwise). The primary outcome variable for the regression model was having a written transition plan for all/most YSHCN. We chose to focus on having a written transition plan as the outcome for the logistic regression model because this is a recommended transition service and measurable outcome for practice-based quality improvement activities. Finally, we report whether or not providers reported having a written transition policy in their practice.

## INDEPENDENT VARIABLES

Pediatrician personal characteristics included age in years, gender, and race (white vs all other). Practice level variables included practice setting (urban noninner city, urban inner city, suburban, rural), practice type (solo/2-physician, pediatric group/multispecialty group/health maintenance organization, hospital/clinic/medical school/nonprofit community health center/other), and percentage of patients with public health insurance.

Pediatricians’ practices were noted to have a CEHR if the respondents indicated they performed prescription ordering, patient/family access to medical records, clinical notes that include medical history and follow-up notes, and patients’ prescribed medication list—all exclusively via EHR. Any missing value for the subcomponents for each EHR item was considered “no.”

Care coordination was measured using the question, “Is there a person or team in your practice with specific responsibility for: 1) care coordination (yes vs no/unsure); and/or, 2) coordinating transition planning for adolescents with

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