Background
Adolescent healthcare transition is increasingly an area of focus to improve health outcomes for youth with disabilities and special health care needs.

The American Academy of Pediatrics/American Academy of Family Physicians/American College of Physicians released a clinical report in 2011 stating the importance of starting the transition process earlier for youth with special health care needs (YSHCN) as they move towards the adult medical care system.

The 2009/10 National Survey of Children with Special Health Care Needs (CSHCN) Core Outcome #6: “All CSHCN receives necessary services for transition to adulthood” The survey revealed that nationally, 40% respondents met outcome criteria and in Oregon, 35.6% respondents met outcome criteria.

In 2012, The Institute on Development & Disability (IDD) Transition Committee conducted a provider survey to determine how transition services were being addressed for our CSHCN during their interdisciplinary clinic visits.

Needs Assessment Indicated:
- Lack of provider knowledge of transition issues
- Limited time for discussion during clinic visit
- Minimal documentation of transition-related concerns

Objectives
- Educate providers with introductory knowledge to initiate a discussion with all patients 12 and older
- Document the discussion in EPIC
- Track the number of patients given this information during the pilot study
- Evaluate feedback from both clinicians and CSHCN and caregivers

Methods
- Included four interdisciplinary clinics participated in the Pilot: Down syndrome, Spina bifida, Neurodevelopment, LEND
- Best Practice Advisory (BPA) “pops up” for all patients 12-26 scheduled in clinic once chart is opened (Fig. 1)
- One clinic provider chooses to provide the IDD Transition Resource Guide to families (Fig. 2)
- Designated clinic provider documents information in a document flowsheet within EPIC (Fig.3)
- Demonstrated the functionality of EPIC in sharing transition planning with all patients 12 and older
- Empowered providers to open the discussion about transition without adding too much additional time to the appointment
- Normalized the concept of health care transition for families and prompted them to start addressing the many issues related to transition
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- Highlighted the benefits of using EPIC for early identification and tracking of families of youth with SHCN in CDRC clinics who are entering transition age
- Completed the transition of families of youth with SHCN in CDRC clinics who are entering transition age
- Normalized the concept of health care transition for families and prompted them to start addressing the many issues related to transition
- Demonstrated the functionality of EPIC in sharing transition planning throughout the medical home as the youth transfers to an adult system of care

Future projects
- Expand to all interdisciplinary clinics at IDD
- Share with other departments at hospital that work with adolescents with special health care needs
- Develop Pre-clinic checklists to identify clients who require more comprehensive transition-specific clinic visit

References

For More Information:
Kim Solondz: solondzk@ohsu.edu Rhonda Eppelsheimer: eppelshe@ohsu.edu