

Improving Health Care Transitions for Young Adults at an Adult Cystic Fibrosis Center: A Quality Improvement Initiative

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BACKGROUND

Health care transitions (HCTs) from pediatric to adult cystic fibrosis (CF) care places young adult patients at risk for quality, safety, and cost concerns. Published best practices may increase successful transitions; however, there is a paucity of data for implementing HCT best practices into young adult CF care. Our adult CF team partnered with our pediatric CF team to improve HCTs for young adult patients with CF.

OBJECTIVE

To improve HCTs for young adult patients (18-26 years of age) at our adult CF center through implementation of Got Transition’s Six Core Elements of Health Care Transition 2.0, utilizing the Integrating Young Adults into Adult Health Care toolkit through a systematic, longitudinal quality improvement (QI) approach.

FIGURE 1: SAMPLE PAGES FROM WELCOME PACKET



METHODS

A team, including CF clinicians, QI experts, and a Pediatric-Adult Patient and Family Advisory (PFA) group, was established to guide implementation. Got Transition measurement tools (*Current Assessment of Health Care Transition Activities*; *Health Care Transition Process Measurement Tool*) were used to measure implementation through establishing baseline scores and tracking progress on a quarterly basis. The team developed a clinic “Welcome Packet” to orient and integrate young adults into adult care. Tools available from the Institute for Healthcare Improvement were used to identify current clinical processes and opportunities for testing system changes through Plan-Do-Study-Act (PDSA) cycles. We also conducted semi-structured interviews with CF clinic team members to ascertain further information about these processes and ways to improve them.



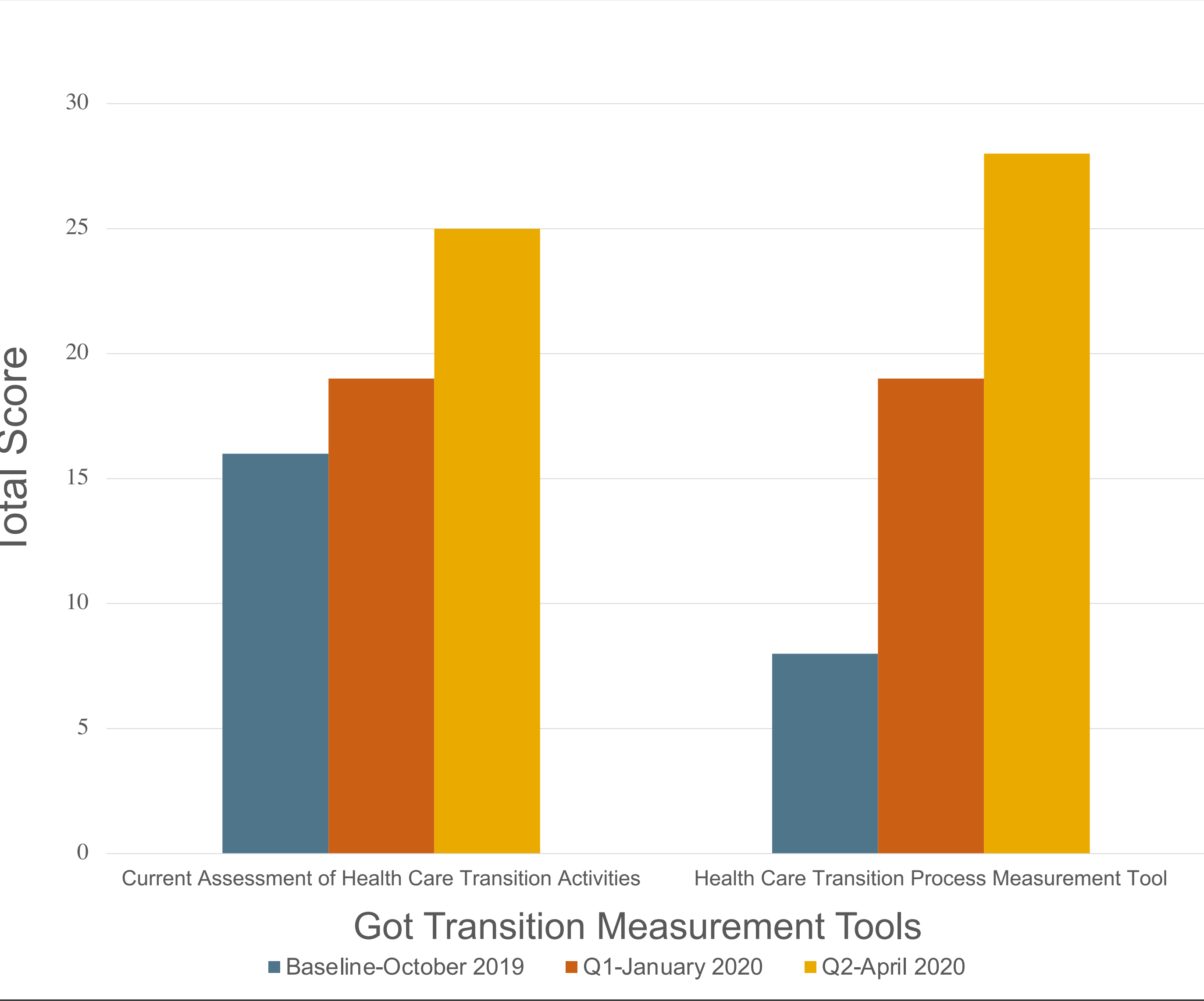
Implementation of Health Care Transition best practices can significantly improve systems of care for young adult patients with chronic illnesses.



RESULTS

From October 2019 to April 2020, scores improved on both the Current Assessment of Health Care Transition Activities by 56% (Baseline: 16; Q1: 19; Q2: 25) and the Health Care Transition Process Measurement Tool by 250% (Baseline: 8; Q1: 19; Q2: 28), respectively. PFAs provided feedback about the “Welcome Packet,” including the Transition Statement describing our center’s philosophy of collaborating with patients, as well as privacy and consent information. PDSA Cycle 1 included introducing a nursing “pre-visit” during new patient visits that oriented patients to adult CF care and covered Welcome Packet materials. Results showed patients were satisfied with the pre-visit orientation process.

FIGURE 2: IMPLEMENTATION SCORES



- Current Assessment of Health Care Transitions**
- Qualitative self-assessment tool measuring implementation of Got Transition *Six Core Elements 2.0* to determine level of health care transition clinic support for young adults
 - Total Possible Score is 32**
- Health Care Transition Process Measurement Tool**
- Quantitative scoring tool to assess implementation and dissemination of Got Transition *Six Core Elements 2.0* to young adults patients transitioning into adult health care
 - Total Possible Score is 100**

DISCUSSION

Young adult patients with CF face challenges when transitioning from pediatric to adult CF care. By implementing best practice guidelines for HCTs using rigorous QI methodology, CF centers can support young adult patients more effectively. This ongoing QI initiative seeks to fully implement the Six Core Elements and assess the impact on patient experience and clinical outcomes.

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