A System-Wide Healthcare Transition Consult Service:

Reflections After Our First Year

Intermountain Children's Health

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Background

There are many models of care for delivering healthcare transition (HCT) support within a large health system. Given the large geographic area of our system, a centralized team of transition guides was developed to provide support to clinics on a consult basis.

Three transition guides were hired and have supported the pediatric Spina Bifida, Rheumatology, and Diabetes clinics from July 2023 to June 2024.

These three clinics gave us an opportunity to work with youth with varying levels of independence and medical complexity. Each clinic was structured differently in how they addressed HCT needs.

- Monthly transition clinic with no additional transition conversations
- Weekly transition clinic and additional transition conversations happening outside of transition clinic
- Transition conversations happening throughout clinic schedule whenever transition aged youth were seen

Method

The Got Transition® Six Core Elements™ was used as a framework for program structure with transition guides helping youth and families with the following skills:

- Build HCT skills (e.g. self advocacy, goal setting)
- Connect with relevant resources throughout the HCT journey (e.g. guardianship)
- Navigate the healthcare system (e.g. insurance, finding adult providers)
- Identify and overcome barriers
- Confirm successful transfer to an adult setting

PHASE 1: Each clinic identified a transition champion to work with the transition guide. The Got Transition® Six Core Elements™ were reviewed, and a Got Transition® Self-Evaluation Measurement Tool was used to prioritize the work. The transition guide shadowed a clinic day and created a process map of clinic workflow. Materials and resources were personalized based on clinic needs.

PHASE 2: The transition champion worked with the transition guide to identify gaps in current processes and determine where the transition guide would best fit into workflow. A process was created for identifying patients who are high risk during the HCT process and how to notify the transition guide of patients.

PHASE 3: The transition guide worked with high-risk patients between clinic visits to develop HCT related skills, connect with community resources, and provide guidance as they navigated the system.

Results

As of June 30, 2024, our transition guides supported 282 youth / families. The average age of youth was 18.8 years with a range of 12 – 38 years. Transition guides were able to confirm 34 successful transfers to adult services (average age at time of transfer was 19 years with an average time between last pediatric and first adult visit of 89 days).

The gap most commonly identified in clinic workflows where the transition guide stepped in was the process of transferring to adult services (e.g. identifying adult providers, scheduling appointments, and confirming successful transfers).

TABLE 1: Readiness Assessment Data

More Confident	Less Confident
I can name and / or describe my condition	I make my own doctor appointments
I know what to do in case I have a medical emergency	I know how to contact my health insurance company with questions or concerns
I know my allergies to medicines	I refill my medicines
I can name and / or describe the surgeries or procedures I have had	I know how to get to my doctor's office
I know the names and doses of my medications and when to take them	Before a visit I think about questions to ask
Knowledge Based	Skills Based

FIGURE 1: Transition Clinic Versus Traditional Clinic

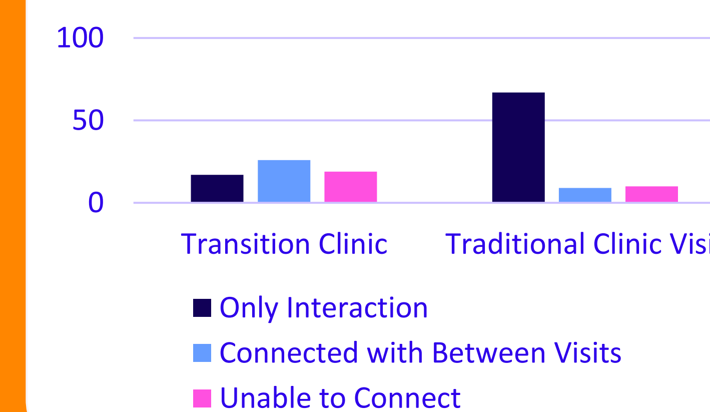
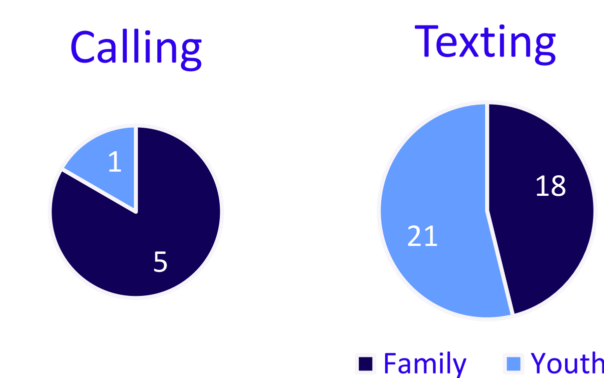


FIGURE 2: Texting Versus Calling



Lessons Learned

In one clinic, we compared supporting youth who were scheduled in a transition clinic versus traditional clinic time slot (Figure 1). The transition guide was more successful in being able to connect with them between clinic visits after transition clinic, compared to after a traditional clinic visit. During a traditional clinic visit, the transition guide was often introducing the concept of HCT for the first time - even in a clinic that had a designated transition clinic. This seems to point to the importance of a team effort when supporting HCT, even when a strong clinic champion exists. Having the support of the whole clinical team might have made the difference in perceived importance of HCT.

In another clinic, we kept track of education topics discussed during clinic visits compared to readiness assessment results (Table 1). Questions where youth answered feeling confident were knowledge-based topics like knowing the names, doses, and allergies to medications. This reflected the topics that were frequently discussed in clinic. Conversely, questions where youth requested more information were skill-based topics like knowing how to contact their insurance company or knowing how to refill prescriptions. This speaks tot he gap in education delivered in clinic settings. A gap the transition guide role can fill by working with youth and families between clinic visits with a focus on skill building.

In the final clinic, the transition guide was able to text patients and we explored whether the ability to text affected the response rate we got from youth (Figure 2). Many clinics within our system speculate that the ability to text youth would help them successfully communicate. It appears youth were more willing to text the transition guide rather than call them on the phone, however, there was a significant difference between the number of patients texted (47) versus the number called (10). This makes it difficult to compare these scenarios. While texting seems to help with the connection and relationship building when outreaching to this population, other means of communication were necessary for skill development.

References

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Acknowledgements

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Next Steps

We have spent our first year building the infrastructure and processes to support a healthcare transition program spanning our system. We have identified best practices in the specialty care space and how to support patients with different levels of independence and medical complexity.

As we look to the future our focus is on expanding support to more clinics, patients, and families - beginning to function as a centralized consult service, taking consults from the social workers within the subspecialty clinics. Keeping in mind our lessons learned from our first year, we try to meet clinics where they are in their HCT journey. We try to empower clinics to fill the knowledge gap within their clinic time and then provide support to fill the skills gap with our team of transition guides.