A Team Quality Improvement Initiative for Improving Transition: Building an Infrastructure

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Comprehensive Bleeding Disorders Center at Emory University and Children's Healthcare of Atlanta (HTC# 353)

PROGRAM DESCRIPTION

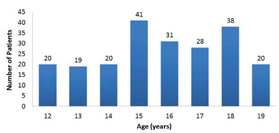
The Comprehensive Bleeding Disorders Center at Emory University and Children's Healthcare of Atlanta is located in Atlanta, GA. Although we are in an urban setting, we serve approximately 870 patients throughout Georgia as well as South Carolina, North Carolina, Alabama and Florida. The pediatric comprehensive clinic is located at Children's Healthcare of Atlanta and transitions patients by the age of 21 years to the adult comprehensive clinic held at Emory Healthcare.

Professionals

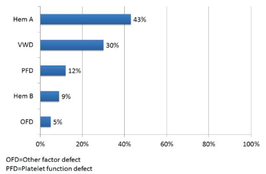
Betsy Koval RN BSN, Christine L Kempton MD MSc, Pamela Bryant, Shanna Mattis MPH, Francie Lasseter RN BSN, Jamilah Hill LMSW and Johnathan Brundidge with thanks to our Patient and Family Advisory Council for developing the transition policy letters as well as their feedback regarding ongoing efforts.

Patients

Transition Population (n=217)

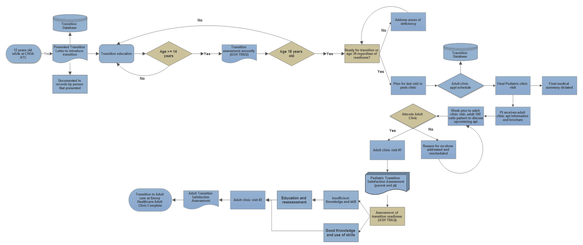


Diagnosis: 12-19 years



OFD=Other factor defect
PFD=Platelet function defect

Process: Flow Diagram of Transition Process



Patterns: National Patient Satisfaction Survey

Q10a:Satisfaction with how the HTC Staff talked to teenagers about how to care for their bleeding disorder as they became an adult

a) Always Satisfied	11	61.1%
b) Usually Satisfied	3	16.7%
c) Sometimes Satisfied	0	0.0%
d) Never Satisfied	0	0.0%
y) Not Applicable	0	0.0%
z) No Response	4	22.2%

Q10b: Satisfaction with how the HTC Staff encouraged teenagers to become more independent

a) Always Satisfied	13	72.2%
b) Usually Satisfied	1	5.6%
c) Sometimes Satisfied	0	0.0%
d) Never Satisfied	0	0.0%
y) Not Applicable	0	0.0%
z) No Response	4	22.2%

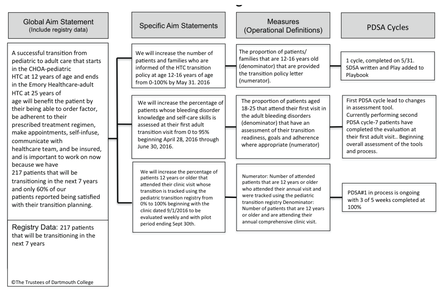
PROBLEM

Only 77% of families with 12-17 year olds were satisfied with how the HTC staff encouraged teenagers to become more independent in managing their bleeding disorder. Over the next 7 years, 217 patients will be transitioning from the pediatric to adult care setting.

TIMELINE: GANTT CHART

Name of Activity or Test of Change	Week 1	Week 2	Week 3	Week 4	Week 5
	Month # 1: March 2016				
Introducing transition policy (Specific Aim #1)					
Create letter					
Feedback on letter					
Communicate and educate team on letter and process to distribute the letter					
	Month # 2: April 2016				
Introducing transition policy (Specific Aim #1)					
Distribute letter					
Measure proportion that received letter					
	Month # 3: May 2016				
Introducing transition policy (Specific Aim #1)					
Distribute letter					
Measure proportion that received letter					
Transition Assessment at First Adult visit (Specific aim #2)					
Created Assessment Tool					
Develop standard assessment procedure					
	Month # 4: June 2016				
Introducing transition policy (Specific Aim #1)					
Create Standard Procedure					
Create Flow Chart					
Create Play for Playbook					
Transition Assessment at First Adult visit (Specific Aim #2)					
Perform Assessment					
	Month # 5: July 2016				
Transition Assessment at First Adult visit (Specific Aim #2)					
SA #2 PDSA 1					
Perform Assessment					
Evaluate Assessemnt Use					
Adapt Assessment					
Communicate and Education entire adult team					
	Month #6: August 2016				
Transition Assessment at First Adult visit (Specific Aim #2)					
SA #2 PDSA 2					
Use Updated Assessment Tool					
Transition Registry (Specific Aim #3)					
Create Pediatric Registry					
Create Adult Registry					
SA #3 PDSA 1-Planning					
	Month #7: September 2016				
Transition Assessment at First Adult visit (Specific Aim #2)					
Use Updated Assessment Tool					
Evaluation of 10 transition pt summary data					
PDSA #3 or SDSA					
Transition Registry (Specific Aim #3)					
Use Pediatric Registry					

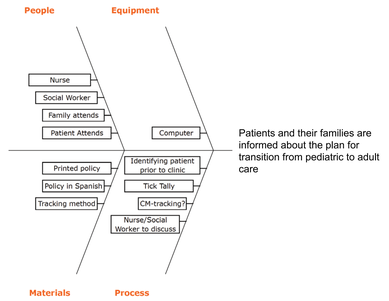
AIMS: DRIVER DIAGRAM



SPECIFIC AIM #1

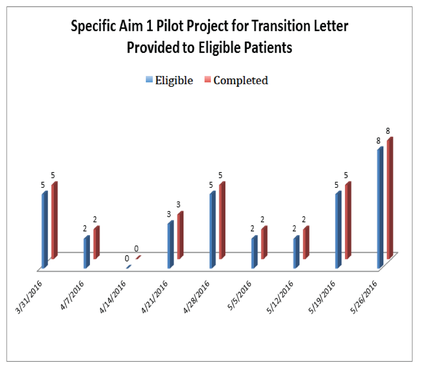
We will increase the number of patients and families who are informed of the HTC transition policy at 12-18 years of age from 0-100% beginning April 7th to May 31st, 2016.

Fishbone



Patients and their families are informed about the plan for transition from pediatric to adult care

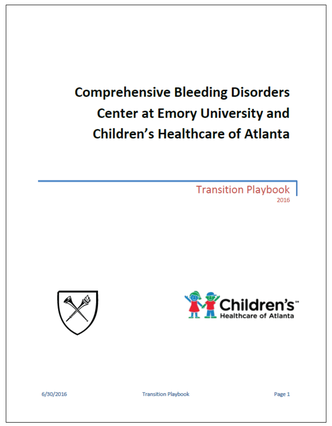
Data



Measurement Plan

WHO?	The nurses and social worker will present the letters to patients and collect the data.
WHAT?	The number of age eligible patients who attended clinic and the number of patients to which the transition letter was presented. The proportion of age eligible patients that received the letter will be calculated. The denominator will be age eligible –clinic attendees and numerator will be the number of clinic attendees to whom it was presented.
WHERE?	Data is to be collected on the White Board used in clinic. Eligible patients will be marked on the White Board by placing a marker in the transition area and an "X" will mark that the task was completed.
WHEN?	At each Comprehensive Clinic visit patients from 4/7/2016 to 5/31/2016. Pre-intervention number is known to be ZERO and over the 2 months our goal is to be 100% of eligible patients.
HOW?	Data will be obtained from the pre-clinic visit summary of eligible patients, and be denoted on the Clinic Flow White Board, and an "X" will be evidence of completion. This information will then be transferred to and Excel spreadsheet and presented to the QI team when completed by QI team member. Feedback on the Letter will be as summary statements in a word document separate from the Excel Spreadsheet.

Playbook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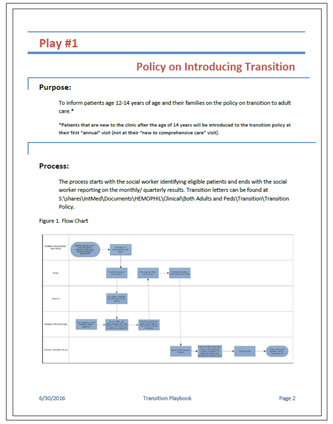
Transition Playbook
2016

6/30/2016 Transition Playbook Page 1


Play #1
Policy on Introducing Transition

Purpose:
To inform patients age 12-14 years of age and their families on the policy on transition to adult care.*
*Patients that are new to the clinic after the age of 14 years will be introduced to the transition policy at their first "annual" visit (not at their "new to comprehensive care" visit).

Process:
The process starts with the social worker identifying eligible patients and ends with the social worker reporting on the monthly/ quarterly results. Transition letters can be found at S:\shares\IntMed\Documents\HEMOPHIL\Clinical\Both Adults and Peds\Transition\Transition Policy.

Figure 1. Flow Chart

6/30/2016 Transition Playbook Page 2

LESSONS LEARNED

- Defining our population, processes, and patterns helped the team gain a full understanding of our program.
- Using the process improvement tools, defining our aim and measurement plan led to more efficient solutions.
- Our Patient and Family Advisory Council was instrumental in developing our letter that outlined our policy and increased our awareness of the role that they can play in our program.
- Having the Playbook with our first play gives us confidence that the gains made with specific aim 1 will be sustainable and can be used to orient new team members.
- The collaborative process of working together using effective meeting skills strengthened working relationships.
- The process and tools developed can be implemented or adapted by most hemophilia treatment centers.
- After completion of specific aim 2 and 3, including creation of new plays for the Playbook, future work includes focusing on promoting acquisition of specific knowledge, skills and attitudes for successful self-care in adulthood.

Results and Key Findings

Specific Aim 1: We are able to implement new process that standardize the introduction of transition from pediatric to adult care to our patients and their families. Many families were grateful to have the information and now feel more prepared to discuss and implement self-care skills at home. Taking this aim from the beginning to completion of the Playbook was an introduction to the process as a whole.

Specific Aim 2: The expected date to have the quantity of data to analyze had to be extended as the number of patients who had a transition visit did not occur as expected. We also found a different tool that would be more useful in looking at the desired information so the original knowledge assessment tool was replaced by a modification of the transition assessment tool that was distributed by ASH in conjunction with ACP in May of this year.

Specific Aim 3: We continue to utilize the registry. After 2 weeks of use we found that we needed additional columns of information to be added in order to track the information relevant for each adolescent patients transition journey.

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