Transition to Adult Care in Hemophilia: Breaking Down Barriers for Patients and Staff

Nancy Dodson[1], Marina Bischoff[1], Saulius Girnius[2], Nina Turner[2], Cristina Tarango[1]

[1]Cincinnati Children's Hospital Medical Center, [2] University of Cincinnati College of Medicine

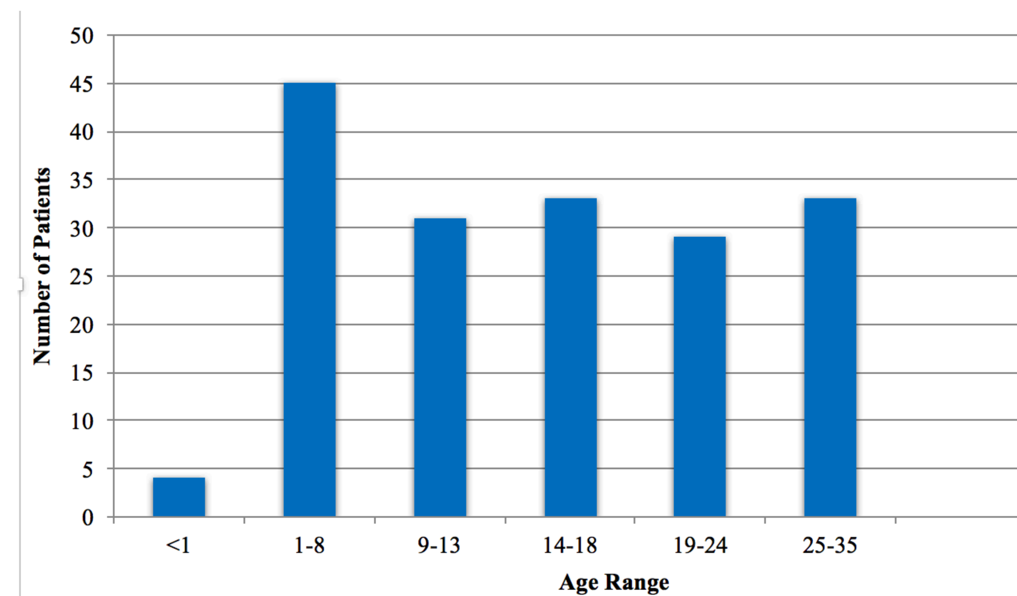
BACKGROUND:

Cincinnati Children's Hospital Medical Center (CCHMC) is a quaternary pediatric hospital located in an urban setting. Our hemophilia treatment center follows ~180 hemophilia patients and is staffed by pediatrics-trained hematologists.

LEAD TEAM MEMBERS: CCHMC (pediatric) team: Nancy Dodson BSN RN, Marina Bischoff LISW-S, Cristina Tarango MD; University (adult) team Saulius Girnius MD, Nina Turner NP

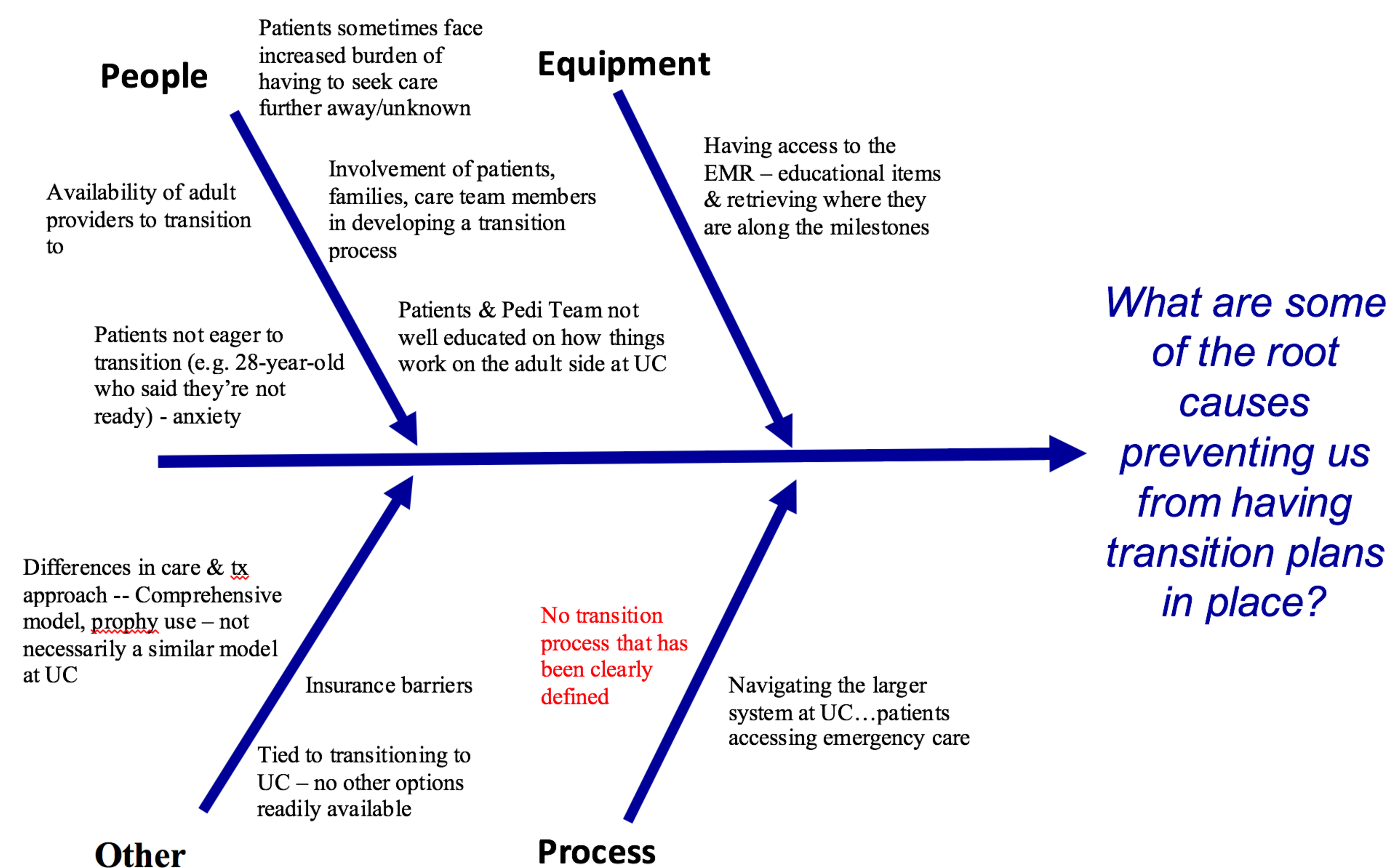
PROBLEM DESCRIPTION: The HTC at CCHMC historically has not had a transition policy or plan for our young adult patients. Many patients will stay at our pediatric center until their early 30's. Due to a new hospital-wide policy, we will have to transition patients to adult care by age 25 years. We have approximately 33 patients aged 25 and older.

Figure 1: Number of CCHMC patients by Age



GLOBAL AIM: We aim to improve the readiness of patients to transition to independent care by age 18 years, with the process beginning at age 13 years.

SPECIFIC AIM: We will increase the percentage of documented transition plans in place for CCHMC patients aged 25 years and over from 0% to 100% by March 2017



METHODS:

Table 1: Timeline of Work

Month # 1: June 2016

Name of Activity or Test of Change	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Transition Criteria Checklist																															
Educate/communicate use of new checklist																															
Test #1 new checklist reviewed with two patients in CCV																															
Revise checklist																															
Explore alternatives for those who cannot transfer to UC																															
Buy-In activities																															

Month # 2: July 2016

Name of Activity or Test of Change	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Test #2 new checklist reviewed with three patients in CCV																															
Continue to evaluate checklist implementation																															
Educate/communicate checklist to team																															
Develop brochure introducing adult team																															
Create Excel sheet to track transition patients																															
Explore alternatives for those who cannot transfer to UC																															
Buy-in activities																															

Month # 3: August 2016

Name of Activity or Test of Change	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Test #3 milestone checklist reviewed with two patients in CCV																															
work with IS team to design transition guidelines in EMR																															
Test #4 Test combined transition clinic with one patient																															
Discuss expectations of transition clinic for CCHMC/UC																															
Buy-in activities																															

Table 2: PDSA Cycles

Tasks to be completed to run test of change	Who	When	Tools/Training Needed	Measures
Continue to evaluate checklist implementation	Care managers and social workers	During comprehensive clinic	Bright green paper	**Is checklist comleted? Yes or No**
Educate/communicate checklist to team	Nancy oMarina	Pre-clinic meeting	Checklist	**Education completed? Yes or No**
Develop brochure introducing adult team	Marina and Elizabeth	Ongoing	PowerPoint	**Brochure completed? Yes or No**
Create Excel sheet to track transition patients	Nancy	Ongoing	Excel	**Tracking sheet completed? Yes or No**
Explore alternatives for those who cannot transfer to UC	Marina	Per Patient seen in CCV	Options for alternative providers	**Options available? Yes or No**
Educate medical staff and ensure ongoing buy-in to improve transition process	Cristina	Ongoing during staff, team and collaboration meetings	Process improvement tools (fish bone, key driver diagram, etc.)	**Attending MD's will have transition conversations in comprehensive clinic**
Explore possibilities to improve charting in the medical record	**Cristina and Nancy**	**To be scheduled with IT staff**	**MASAC Guidelines and transition criteria. EMR flowcharts and/or LPOC template**	**Milestones will be documented in a defined template in the EMR.**

RESULTS:

Figure 2: Process for Transitioning 25 and older patients was established

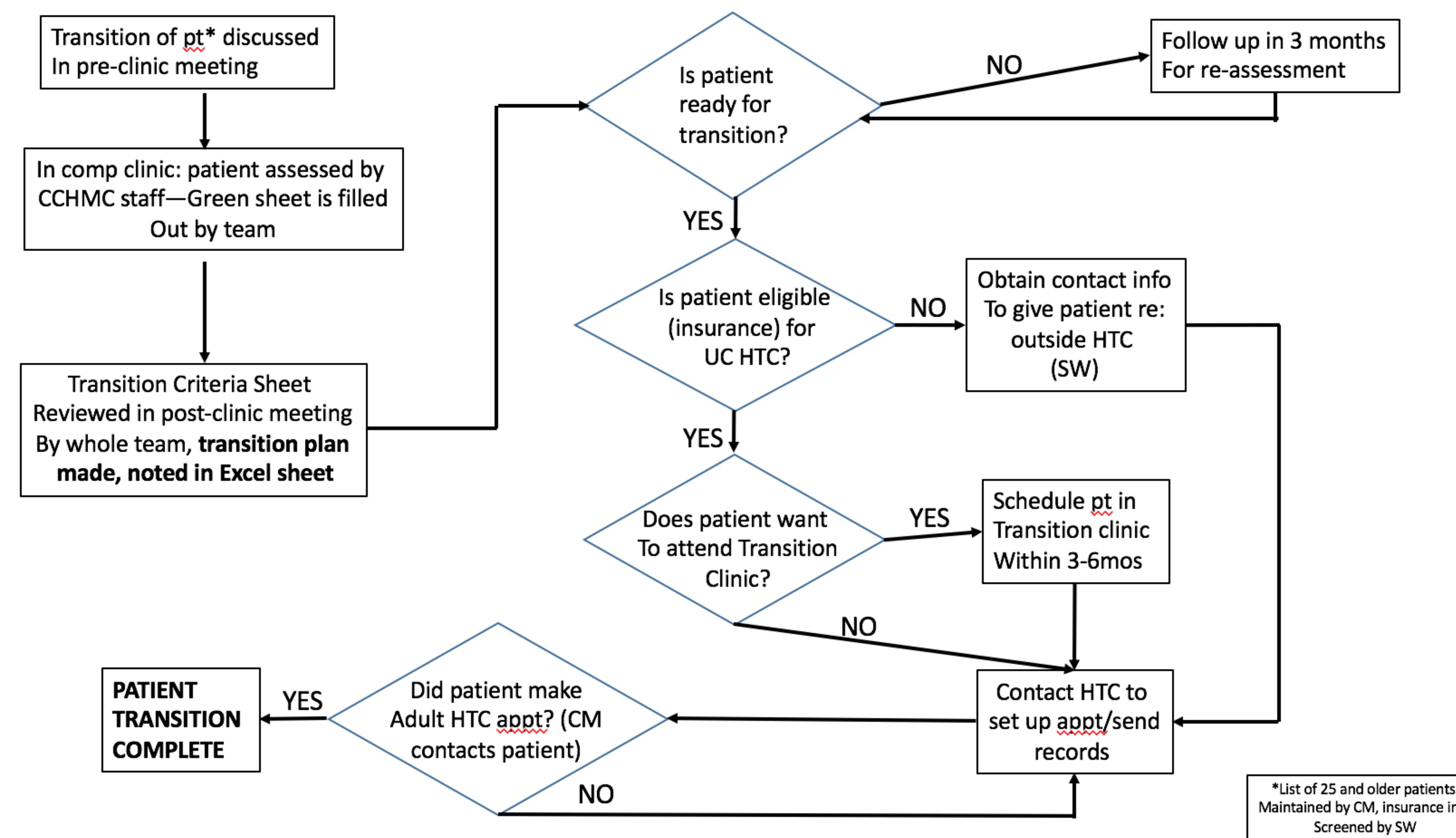
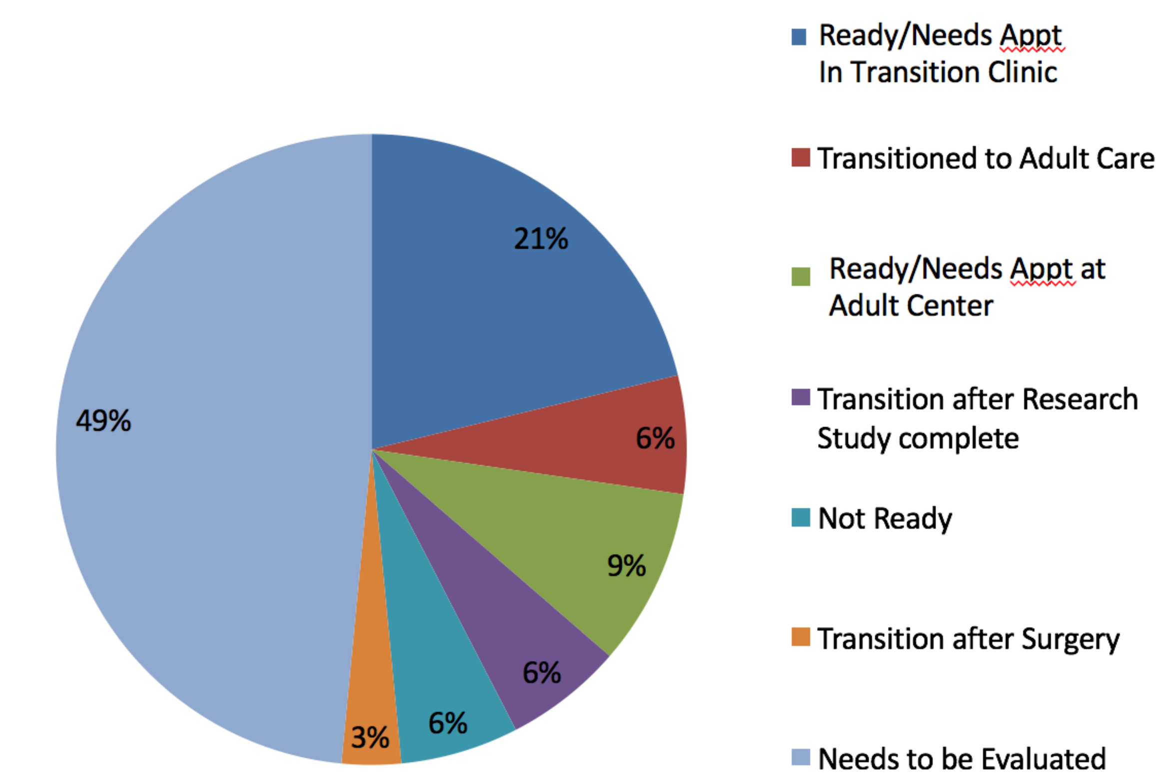


Figure 3: 25 yr and Older Transition Status as of 9/21/16, n=33



Per process in Figure 2, patients were assessed for readiness to transition. 7 patients ready for transition have asked for appt in Transition clinic prior to first appt with adult center; those appts still pending. 2 of 3 patients ready for transition have appts at adult center. Two patients have transitioned to Adult center.

CONCLUSIONS:

- The first step in transitioning patients is preparing both pediatric and adult teams for transition. Regular meetings between the groups helped address concerns and dispel misconceptions.
- By increasing pediatric team's knowledge of adult center's processes, our team is better able to minimize patients' fears and foster patients' confidence in transition process.
- Active communication with patients and between pediatric team members allows for better assessment of patients' readiness for transition.

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