Short Communication

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Transition Task Force: Early efforts towards comprehensive pediatric to adult transition services in an academic medical center

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Abstract

Background: The process of transitioning from a pediatric to adult health models of care is a significant challenge associated with heightened morbidity and mortality, particularly for patients with medical complexity.

Methods: Our institution has no formal standardized transition services for patients transitioning from pediatric to adult models of care. The Transition Task Force was created as a community of practice to support interprofessional teams in creating a standard, yet individualized, approach to pediatric to adult transition across multiple departments of an academic center.

Results: The Transition Task Force has been meeting for approximately 4 years, and almost three-quarters of participants report that participation resulted in changes to their clinical process, in spite of recognition of common barriers to effective transition.

Conclusions: The development of a transition-focused community of practice can effectively support implementation of quality improvement projects collaboratively in both a standardized and individualized fashion.

Keywords: community of practice; improvement science; pediatric to adult health care transition.

Introduction

The process of transitioning from a pediatric to adult health models of care is a significant challenge associated with heightened morbidity and mortality, particularly for patients with medical complexity. Patients, parents, and health care professionals uniformly report decreased satisfaction with the current state, which is associated with care fragmentation, low quality, increased costs, and poor medical outcomes [1, 2]. Patients with childhood-onset medical conditions, who are increasingly surviving to adulthood, find this transition period particularly challenging for reasons extensively documented in the literature [3–5]. Studies reviewing outcomes of transition interventions have found impacts on population health metrics as well as improvements in utilization measures [6]. Nationally, the Six Core Elements of Transition, published by the National Alliance for Adolescent Health, is a consensus, evidence-informed framework for how to integrate this work into clinical care [1]. Many institutions wish to develop comprehensive transition processes based on these standards, but find it difficult to cohesively engage multiple stakeholders within a quality improvement framework [3].

In this brief report, we describe the establishment of a community of practice (CoP) around delivering transition services in the form of a Transition Task Force (TTF). A community of practice is a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly [7]. Key features of a CoP include the longitudinal method of collaborative learning, the focused area of shared interest, and the practical implementation or activity related to the area of interest [8]. Examples have been described in a number of other settings [9]. In our setting, a CoP was formed around the area of pediatric to adult transition care. At our institution, no formal or informal associations existed between individuals who were interested in this work in 2015. We describe our institution's experience in standing up the TTF and its early impact.

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Methods

At our institution, the TTF has been meeting since fall 2016. With the support of each other, four of the authors (RH, KS, AF, RE) began this CoP in order to share experiences and build momentum towards increased interest in spreading this work throughout the institution. Membership is comprised of interprofessional team members (MD/DO, advanced practice providers, allied health services, nursing, social work, psychology, and others), representation from multiple divisions/departments, as well as representatives from institutional public health groups involved in pediatric to adult care transition improvement work. Members are recruited by word of mouth, and participation is voluntary. The Chair of the TTF keeps an email list of all members. Meetings occur approximately monthly over lunch, and typically 10–15 members attend each meeting. Individual clinical sites present ongoing quality projects for feedback. Participants are supported by others with similar improvement projects across the institution. This approach rewards individual and clinic-level efforts at the ‘grass roots’ level. The desired outcome is to provide mutual support across departments, develop a shared knowledge base about improvement in pediatric to adult health care transition, and increase the capacity for project implementation within a quality improvement framework. Participants naturally form a community of practice, empowering transition champions to make changes that meet the needs of their clinical site.

The TTF began as a voluntary group of committed individuals. It operated without administrative, departmental, or institutional support for the first 3 years after it began meeting. During the third year, one department administrator helped to book rooms for meetings. TTF updates and meeting notices were communicated by the TTF Chair. During the fourth year of existence, the Department of Pediatrics agreed to fund the purchase of lunch food for members since meetings took place at lunchtime. There has not been any formal funding of FTE for leadership or other staff time to support this endeavor.

We undertook a survey of TTF participants to understand their experience and utilization of the CoP and the impact of the TTF on participants’ transition-related work in participants’ clinical settings. A fifteen question survey was developed by one of the authors (RH) and edited in an iterative process by selected committee member and other colleagues prior to distribution. Survey questions were reviewed by the IRB at our institution and determined exempt as human subject research.

Results

Since our first meeting in 2016, the TTF has grown to include 63 members. Participant home departments are found in Table 1. At the time of survey administration, there were 49 members on the TTF email list, and nine participants completed the survey (18% response rate). Our survey results highlight the potential influence of a targeted community of practice towards achieving health systems transformation. The average respondent had attended task force meetings for at least 1 year. Although most participants (66%) worked in a clinic that did not have a formal transition program, the majority were at a clinical site working toward establishing a transition program. Seventy percent of TTF participants report that participation has changed their practice or clinic process. TTF participants report their biggest challenges include identifying adult providers who are equipped and willing to take on medically complex young adults (60%) and establishing a transition plan that is applicable across clinical sites (60%). TTF participants also reported challenges related to lack of hospital-wide transition policies and written guidelines for patients and need for legal support for patients seeking guardianship or other legal assistance. Lastly, participants noted the need for high-level institutional advocacy and leadership in order to establish coordinated transition pathways.

Examples of quality projects presented to the task force include establishing transition-age support groups focusing on learning about medical problems and

Table 1: Current departments and divisions represented among Transition Task Force members.

Current partners and participants	
Cardiology: adult and pediatric	General pediatrics and adolescent health
Nephrology: pediatric	Hemophilia clinic
Endocrinology: adult and pediatric	Child Development and Rehabilitation Center occupational therapy
Neurology: pediatric	Oregon Center for Children and Youth with Special Health Needs
Pulmonary: adult and pediatric	Institute on Development and Disability
Infectious disease: adult	Hospital administration
Heme/Onc: adult and pediatric	Nursing leadership
Psychiatry: adult	School of Medicine
General internal medicine	University Center of Excellence in Developmental Disabilities
Spina bifida clinic	Oregon Clinical and Translational Research Institute

Figure 1: Overview of the principles and next steps of the Pediatric to Adult Transition Task Force.

navigating the healthcare system independently and visits conducted jointly with professionals in social work or psychology. The TTF serves as a forum for testing and sharing innovations in clinical practice. TTF members have also organized sub-committees focused on writing institutional transition guidelines, electronic health record integration, creating a repository of resources, and have sponsored local conferences on this topic (Figure 1).

Beyond the results of this survey, members have informally noted that the approach of the TTF has allowed for heightened conversations, collaborations, and support to its members in approaching complex multi-specialty problems creatively within an improvement science framework.

Discussion

Communities of practice can involve all stakeholders efficiently, flexibly, and creatively. Supporting a community of practice in achieving grass-roots, individualized, yet standardized quality improvement projects is possible in an academic medical center. Our experience suggests that clinical process can change in spite of identified barriers. Our survey results reinforce the need for a CoP to allow for collaboration across departments, institutes, and professions, particularly when the topic of interest crosses multiple domains. Figure 1 highlights the relationships between the CoP and possible impacts based on our survey results. Of note is the potential for a CoP to become a visible driver of institutional work in a cross-departmental area such as transition to adult care. To achieve such a high-level impact, the CoP would need dedicated sponsorship from high levels of leadership at an institution.

Limitations of the community of practice approach include the time and effort required for longitudinal participation, required leadership support, and the effort associated with implementation of projects that are supported by the task force. By its very nature, a CoP is a knowledge and practice-dissemination tool that draws membership that is passionate about the topic. In addition to this potential source of selection bias, our survey is limited by low participation. Ideally, we would repeat this survey after some time has elapsed to learn whether any participants were able to move their clinic from theory to practice.

Next steps include formalizing the TTF as an established workgroup, with explicit administrative and multi-departmental support and sponsorship. Ongoing goals of the TTF include sharing information with those who care for this patient population but do not attend meetings, and expanding transition services and awareness amongst all professions. We also hope to closely involve patient representatives and increase our educational footprint by sponsoring more conferences and workshops. Finally, we have established institution-wide guidelines to provide guidance for transition practices, which is a process that has been successful at other large academic institutions. Continuing to collect data on outcomes from this established community of practice will be essential in disseminating best practices in our setting and moving our institution towards solutions.

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