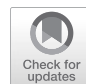

10 Mobilizing Pediatric Providers

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Mobilizing Pediatric Providers

Due to advances in medicine, pharmacology, and technology, adolescents and young adults with special healthcare needs (AYASHCN) are now living into adulthood. Pediatric providers are in an important position to guide AYASHCN through the transition to adult care. Helping youth with their transition to adult care requires knowledge of best practices and resources as well as commitment from practitioners to facilitate healthcare transition (HCT) planning. Got Transition has established guidelines for practices outlining the services they should be providing to ensure better transitions for their patients [1]. These guidelines include elements such as identifying patients most in need of support during their transition, creating medical summaries, conducting transition assessments, and ensuring a good handoff to their adult counterparts. Providers must have dedicated time to learn how to use the guidelines and work with patients and families to implement them. In addition, it takes time to plan practice-specific workflows and create useful tools. Mobilizing and incentivizing providers to facilitate interest and commitment to accomplishing these tasks is challenging, but essential.

Through two case examples (one within a regional children's hospital through the establishment of a Chronic Illness Transition Program and the other at a state level through a local chapter of the American Academy of Pediatrics [AAP]), this chapter illustrates pediatric provider roles and their importance to HCT processes and explores ideas to help motivate and mobilize providers to engage patients in HCT planning.

Case Example #1: Establishment of a Transition Program at a Regional Hospital

(See Table 10.1)

Organizing a hospital-wide transition program and mobilizing providers begins with environmental assessment and information gathering. At one tertiary care center, information on the importance and process of implementing

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Table 10.1 Key features of local hospital initiative to establish a healthcare transition program

• Created a champion with protected time
• Formed multidisciplinary, inclusive, steering committee
• Integrated tools into EMR
• Initiated innovative projects incubator with mini-grants

transitioning into practice was gathered by a small group of champions. These initial champions were self-motivated providers who embraced the topic and were passionate about improving care and strengthening pathways to adulthood for AYASCHN. Their drive was inspired by professional and personal experiences. These champions learned from presentations at the Pediatric Academic Societies, the medical literature, site visits, and consultations with leaders of established programs at other children's hospitals. One of these members reported directly to the hospital president and made the case for the importance of establishing a transition program as a leading children's hospital. This top executive-level buy-in was significant in securing institution endorsement for the program and mobilizing champions and leaders for its implementation.

Identification and engagement of a physician leader for the transition program was the first step in formalizing the program, which was further solidified with the appointment of a social worker to serve as the transition program coordinator. These were selected by a committee through an open application process. Working together, the physician leader and transition program coordinator have been the driving force around broader physician engagement with division-specific champions and clinical integration of the transition program within the medical center.

Start-up funding was also essential to launching the transition program to attract physician leaders and support the first phases of practice integration. As described above, funding from a hospital auxiliary provided the support to pilot four initial demonstration projects (in spina bifida, nephrology, cardiology, and hepatology). These demonstration projects helped to mobilize champions in each of the aforementioned divisions. The request for proposals (RFP) for funding support was structured but intentionally open-ended to encourage physicians (and their teams) to exercise creativity, innovation, and adaptation based on their unique models of care. Sustained support from a family foundation interested in the program has secured protected time for the transition program coordinator, and budgeted time allocation for the medical director has provided longitudinal stability since program start-up.

The process of provider engagement has been incremental, starting with efforts to orient and educate physicians about transitioning. Several vehicles were utilized, including Grand Rounds and other institution-wide learning structures, resident noon conferences, targeted presentations to primary and subspecialty care divisions, continuing medical education (CME) courses, and articles in medical center publications. Complementing these physician-focused strategies were educational interventions for nurses, social workers, and other staff, including pastoral care and family life specialists. This contributed to educational reinforcement within and across multidisciplinary teams. Moreover, it acculturated transitioning within the medical center, which encouraged broader engagement and participation among physician-led teams. Over time, program expansion, institutional infrastructure accommodations, and more extensive physician recruitment evolved. Several strategies contributed to this momentum. These are described next.

Steering Committee

A steering committee comprised of hospital-wide stakeholders in HCT was formed to help motivated providers become champions and leaders within their departments. It was a centralized forum to facilitate strategic planning, information exchange, progress updates from participating transition clinics, and presentations from community organizations and partners. Physicians actively participate along with social workers, nurses, and psychologists. Consisting of

representatives from over 20 divisions, the steering committee meets quarterly and provides an open forum for consensus building and discussions of quality and process improvement. Steering committees can be useful in providing a place for motivated providers to get a start in building a transition program within their departments.

Transition Clinic

A transition clinic led by the medical director and transition program coordinator was created to help providers in the hospital with patients with complex transition needs. The addition of this service has further bolstered physician engagement by introducing an assessment of transition readiness, coordination of transfer of care to adult providers, and assessment of social needs and services, facilitating efforts to discuss HCT with patients, and providing a resource to navigate the transition process.

Electronic Medical Record Integrations

To create an infrastructure that makes it easier for providers to perform some of the recommended interventions, the transition champions created medical summaries, transition orders, and transition assessment tools within the electronic medical record (EMR). This streamlined access to concise and consolidated information in the EMR software to document patient progress through HCT preparation and planning. These electronic enhancements have supported greater ease and ability of physicians to integrate transition planning into their clinics and therefore increased physician engagement.

Mini-grants on Completion of Transfer to Adult Providers

To recruit new champions and leaders, an RFP for mini-grants to address strategies for enhancement and evaluation of the transfer of care process and development of adult provider relationships was issued by the Office of Child Advocacy (using Endowment Fund monies) to all transition program participants. In response, notably, these projects involved both the hospital pediatric providers and adult providers to whom patients would be transferred. This has resulted in an increased interest from various providers to engage in the transition process, along with program enhancements such as joint clinics for both pediatric and adult physicians at Lurie Children's prior to transfer of care and improved methods for streamlined transfer of most salient information for first patient visit to the adult provider.

Case Example #2: A Statewide Transition Initiative (See Table 10.2)
This example describes successes and challenges for engaging providers in a statewide transition improvement project, led by the state chapter of the AAP [2]. The aim of the *Transition Care Project* was to improve HCT by providing training, resources, and technical assistance to both pediatric and adult primary care providers and using a quality improvement approach to encourage and implement HCT services in their practices. Practices were assisted in building self-management skills in adolescents, developing written transition policies, preparing and maintaining medical summaries, and assisting providers to think about and incorporate transition planning into their encounters.

Recruitment

Multiple strategies were utilized for recruitment, including promoting the project to chapter members via a direct mail and email invitation, reaching out to professional contacts at teaching

Table 10.2 Key features of statewide transition improvement project

• Professional contacts used for initial recruitment
• MOC credit available to promote interest
• Quality improvement metrics to help motivate

institutions, contacting providers within the regional medical district, and contacting practices that had previously participated in a successful project with the chapter. Ultimately, five self-selecting pediatric practices signed formal agreements to participate in pilot testing; the agreement included a small stipend to support pilot activities. A lead physician at each site was identified and served as champion and determined which care teams and staff members would be required to participate. Ancillary staff members, including clerical and front desk staff, were also strongly encouraged to participate. Participants included 18 physicians, 3 nurse practitioners, 10 nurses, and 4 social workers. Each pilot site then selected the key clinical activities (KCAs) most important for their practice. The project leaders identified continuing medical education (CME) and maintenance of certification (MOC) Part 4 credit as potentially effective tools to incentivize physicians' and allied health professionals' participation and motivate continued engagement. The addition of CME and MOC credit helped to mobilize providers and increase the rate of performing these activities as shown in the tables below.

Table 10.3 identifies three practices that had multiple participating providers working together on the same KCAs selected by those practices. Tracking these KCAs engaged providers further in these transition initiatives.

Table 10.3 Transitioning youth results by practice

Key clinical activity (KCA)	Mean change in chart review score, baseline to cycle 3[a] Practice 1 ($n = 5$)	Practice 2 ($n = 2$)	Practice 5 ($n = 5$)
Written transition policy	6.0*	7.5	8.6*
Assess healthcare and transition readiness skills	6.2*		
Identify adult provider		5.5	5.8*
Discuss insurance, benefits, social services	2.6		
Portable medical summary			5.2*

*Paired *t*-test statistically significant, $p < 0.05$
[a]Cycle 3 was 24 weeks after baseline

Project findings indicate that it is possible for a variety of medical practices to mobilize providers to improve their care for transitioning patients, given a combination of incentives and tools implemented within a team-based care setting. Between 2012 and 2016, 32 pediatric providers and their practices have participated in the training for MOC Part 4 credit. In addition, the training and resources are being utilized by health systems, and online course resources for patients and families are available for free.

Roles for Pediatric Providers (See Table 10.4)

The Champion

Each service or clinic needs a transition champion who has dedicated time and authority to oversee the planning and implementing of HCT programs and is genuinely interested and invested in their success. This individual sets the direction of the program, mobilizes others with specific knowledge and experience, and keeps the program moving forward, especially when barriers are encountered. A champion with authority would be uniquely positioned to facilitate participation from providers who are not as invested in the development of transition tools but must be involved at the implementation level in order for transition best practices to be delivered to all patients. In Case 1, this would include the medical director and the transition program coordinator, and in Case 2, this would include leaders of the statewide chapter of the AAP.

Table 10.4 Key types of providers

Providers	Key elements
Champion	• Set the direction of the program • Mobilize others • Needs to have authority • Keeps program moving through barriers
Leaders	• Bring specific expertise • Develop more specific tools
Implementers	• Majority of providers • Will need to be motivated

The Leaders

Since constructing a transition program requires the development of tools, policies, and workflows, mobilizing a variety of providers to provide oversight and expertise to address these specific tasks is also essential. These providers can bring their unique areas of expertise to develop specific transition tools and processes, such as how to conduct a transition assessment, how to work with the EMR to develop a medical summary, or how to maintain a registry. In Case 1, these may include members of the steering committee and recipients of the mini-grant program, and in Case 2, this would include the leaders at each of the pilot sites.

The Implementers

In order for a transition program to be successful, providers who are not directly involved in the development of transition tools and programs must still be motivated to use them (see Chap. 14 for additional strategies to promote HCT planning behaviors). Ultimately the goal is for transitioning to become a routine part of pediatric practice for all providers.

Supporting and Motivating Providers

Structural Support (See Table 10.5)

Structure describes the context in which care is delivered, including hospital buildings, staff, financing, and equipment [3]. Funding is perhaps the most challenging issue in establishing and sustaining a transition program. Funding for protected physician and staff time, particularly at the program leadership level, is critical to developing infrastructure [4]. In addition to academic pursuits of research and government funding, philanthropic and "donor-centric" funding from foundations, corporations, groups, and individuals with interest in transitioning should be pursued. In larger medical centers or settings, a foundation within the institution may be approached to provide support for donor identification, cultivation, and grant submissions. Parents of AYASCHN can sometimes be instrumental in connecting to funding sources. Case 1 describes how start-up of the medical center's transition program was financed by a hospital auxiliary and a child advocacy endowment fund established as part of a capital campaign. Sustained support from a family foundation interested in the program has secured protected time for the transition program coordinator. Integration of protected time within organizational administrative budgets is also significant, particularly in ensuring sustained physician leadership for the program, and allows for investment in long-term endeavors.

Table 10.5 Structural supports

• Obtain funding for protected time for champions and leaders
• Use internal, foundation, and family funding resources
• Establish plan for long-term funding

Barriers and Facilitators

In mobilizing pediatric providers, one must consider the most common barriers pediatricians report that prevent them from providing transition services. Time, reimbursement, a steep initial learning curve, and uncertainty about the effectiveness of the program are some of the barriers to engaging pediatric providers in formal HCT programs [5, 6]. Competing priorities for provider time can also limit interest and availability to implement the program. These time constraints can be partially addressed by creating an operational infrastructure that maximizes ease and efficiencies to support provider engagement. Moreover, this also maximizes the capacity to extract provider talent and energy to advance innovation and program development.

Pediatricians also report difficulty identifying adult-oriented providers and obtaining reimbursement for transition services and time spent performing recommended transition interventions (see also Chaps. 6 and 21) [6, 7]. Pediatric providers lack familiarity with the adult service system, community resources, guardianship,

Table 10.6 Overcoming barriers

• Optimizing workflows and tools to make transition interventions easier to implement are critical in overcoming time barriers
• Ideas include
– Developing lists of adult providers
– Creating billing resources
– Integrating HCT planning tools into the EMR
– Coordinating support from interdisciplinary providers such as social workers, case managers, psychologists, and resource navigators

and insurance options for young adults with disabilities [7]. To mitigate these barriers and increase the likelihood that providers will actively participate in HCT programming, it is important to identify or create these resources and educate physicians and other practice members about their availability (see Table 10.6). This may involve developing lists of adult providers, resources, and information about billing, integrating transition planning tools into the EMR, and establishing support mechanisms from interdisciplinary providers such as social workers, case managers, psychologists, and resource navigators [8].

Highlight HCT Outcomes and Effectiveness

The implementers described above are more willing to perform interventions when their effectiveness is known or plans to be studied [5]. The effectiveness of various transition efforts to highlight when motivating providers include improvements in patient knowledge, self-confidence, and transfer rates. (See Chaps. 19–23 for different perspectives on defining successful transition.) It is also important to identify metrics—structure, process, and outcomes—that can be used to track, monitor, and evaluate HCT program activities, such as described in Case Example #2 and further elaborated in Chap. 14 [9–11]. Examples of structural outcomes include establishment of any of Got Transition's six core elements. Process outcomes could include improved patient knowledge, self-confidence, and transition readiness (see Chap. 13) [12, 13]. Finally, desired endpoints could include transition experience, successful transition to adult care, and increased quality of life (see Chap. 36).

Mobilizing Providers in the Absence of Adult Providers

While adult providers may be difficult to find or not necessary given the scope of practice for the pediatric provider (such as dually certified med-ped providers or family medicine providers), implementing transition processes in the pediatric setting should still continue. This includes creating tools described above, cultivating transition champions, and incorporating an adult model of care. Motivating providers to conduct these tasks can often be difficult in the absence of identified adult providers and need for transfer. Pediatric providers must understand how the adult model of care differs from the pediatric model and the importance of developing disease self-management and self-advocacy skills in transitioning AYASHCN (see Chap. 15). Motivating providers in these settings to implement this model will require champions, leaders, and motivators as described above.

Conclusion

Mobilizing and motivating pediatric providers to perform optimal transition-related interventions are often difficult due to lack of knowledge, time constraints, and lack of belief in the efficacy of these interventions on the part of the provider. In addition, creating a transition program within a practice or institution requires the time and effort of many providers. A transition champion with authority is essential, along with dedicated leaders, to initiate, maintain, and improve HCT programs and changes in workflows moving forward. To influence the behavior of most providers, the aforementioned barriers must be addressed. We have presented

two examples of ways in which these barriers were addressed in different settings and at different levels. Delivering education, constructing an infrastructure that simplifies HCT interventions, providing incentives such as CME and MOC credit, and tracking quality measures can help keep providers motivated and help mobilize new providers.

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