

2019

Creating Staff Engagement in Transition Planning Through the Use of Data

Teresa Hickam

Children's Mercy Hospital, thickam@cmh.edu

Michelle Bozarth

Children's Mercy Hospital, mrbozarth@cmh.edu

Follow this and additional works at: <https://scholarlyexchange.childrensmercy.org/posters>

Part of the [Clinical and Medical Social Work Commons](#), [Health Information Technology Commons](#), and the [Pediatrics Commons](#)

Recommended Citation

Hickam, Teresa and Bozarth, Michelle, "Creating Staff Engagement in Transition Planning Through the Use of Data" (2019). *Posters*. 113.

<https://scholarlyexchange.childrensmercy.org/posters/113>

This Book is brought to you for free and open access by SHARE @ Children's Mercy. It has been accepted for inclusion in Posters by an authorized administrator of SHARE @ Children's Mercy. For more information, please contact bpfannenstiel@cmh.edu.

CREATING STAFF ENGAGEMENT IN TRANSITION PLANNING THROUGH THE USE OF DATA

Terri Hickam, MSW, ACSW, LCSW, LSCSW, CCM; Michelle Bozarth, BA, CIS

Children's Mercy Kansas City, Kansas City, Mo.

Background

- A challenge often heard by persons working to advance transition planning and engage staff is the limited time allotted for a patient appointment and the competing topics/needs to be addressed during that visit. Coupled with the time needed for the actual appointment is time spent pre-planning.
- Demonstrated efficiency and ongoing support for any program is often driven by data. The purpose of the creation of reports is to provide both front line and management staff timely (meaningful) feedback on their efforts.

Methods

In 2017 the Children's Mercy, Kansas City Transition Program provided 14 Divisions and 28 programs with data to support their hard work. 3,768 patients were eligible to receive transition planning.

As teams determine which patient population they wish to begin providing transition planning, test reports are created to pull the data and confirm their accuracy. Once teams go-live, weekly/ monthly/ semi- annual and annual "look-back" reports are provided to the teams. Teams are asked to share their efforts quarterly at Division meetings.

To more efficiently identify patients eligible for annual transition planning, pre-visit planning reports have been created.

An annual report is available for Divisions to measure their success against others. Success is defined as completing the readiness assessment and documenting a transition discussion.

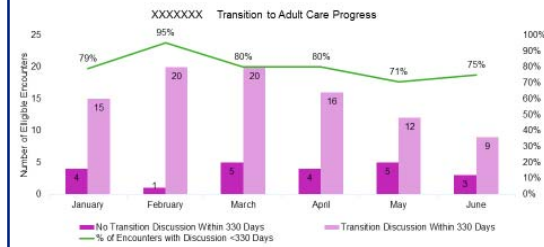
Patient Numbers

2016 vs 2017 Transition Active Clinics Total:

	2016	2017	% Increase
Total # of Patients	805	2678	333%
Total # of Patients setting Goals	523	3893	744%
Total # Staff Discussions	422	2405	570%
# Orders Transition to Adult Providers	17	73	429%



Six Month Progress Reports 1/1-6/30/ 2018



Patient Name	Financial Number	Patient CURRENT Age	Attending	Appointment Date	Appointment Type	Transition Discussion Needed
				6/29/2018 1:45:00 PM		YES
				6/29/2018 7:45:00 AM		YES
# Of Transition Discussion Needed	11					

" These reports make it so much easier! Thanks!!"

Pre-visit Planning Report

Look-back Report

Patient Name	Financial Number	Patient CURRENT Age	Attending	Appointment Date	Appointment Type	Transition Discussion Needed
				6/29/2018 1:45:00 PM		YES
				6/29/2018 7:45:00 AM		YES
# Of Transition Discussion Needed	11					

Includes: Location, Follow Up Appointment Type, Secondary Appointment Type, Age, sometimes providers and diagnosis

Results

What % of time did eligible patients complete a readiness survey?	What % of patients completing a readiness survey had a documented discussion with the provider?	What % of eligible patients received a transition discussion?
61%	93.6%	54.5%

In 2017, 2,160 of 3,768 patients (61%) completed readiness assessments and held transition-related discussions with their health care team. When patients completed an assessment, (2,162/2,309) 93% of the time staff also provided a documented transition discussion.

Conclusion

Data reports providing timely, routine feedback on staff success and missed opportunities helps keep staff engaged, their efforts visible and transition planning on a conscious level.

Current Projects and Next Steps

- Encourage staff to improve the percentage of patients completing their annual assessments by providing 6 month and annual reports using bar graphs.
- Examine and compare what goals patients and caregivers select at each age.
- Last Visit ? Question being added to EMR documentation form to remind providers to write an order to transition to adult care with transfer checklist.



What % of time did eligible patients complete a readiness survey?	What % of patients completing a readiness survey had a documented discussion with the provider?	What % of eligible patients received a transition discussion?
58.1%	93.6%	54.5%
What % of time did eligible patients complete a readiness survey?	What % of patients completing a readiness survey had a documented discussion with the provider?	What % of eligible patients received a transition discussion?
61%	93.6%	54.5%