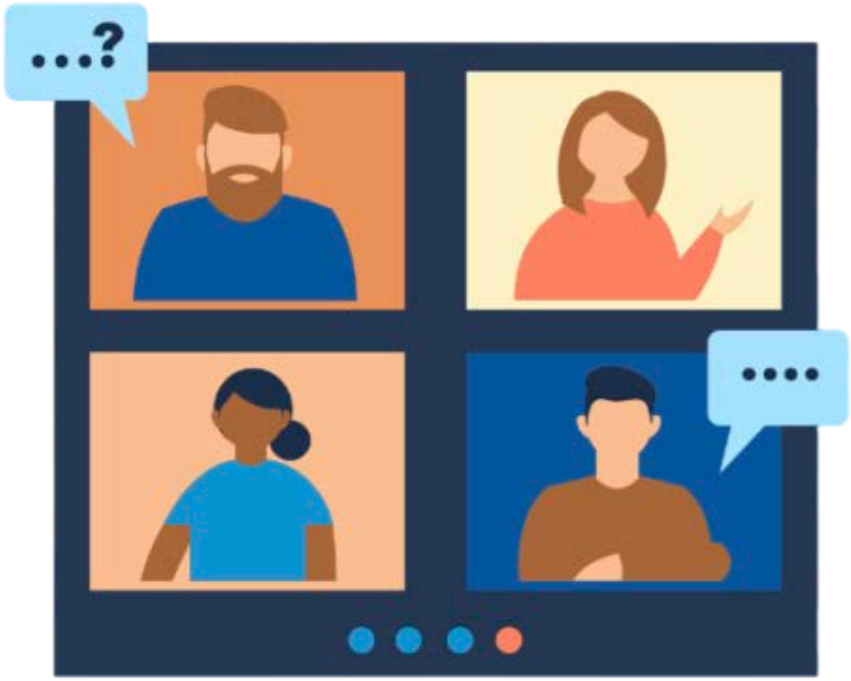
A Tri-Partnership Virtual Handover Approach to Empower Family Physicians and Facilitate Transition to Adult Care for Youth With Medical Complexity (YMC)



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DISCLOSURE OF FINANCIAL SUPPORT

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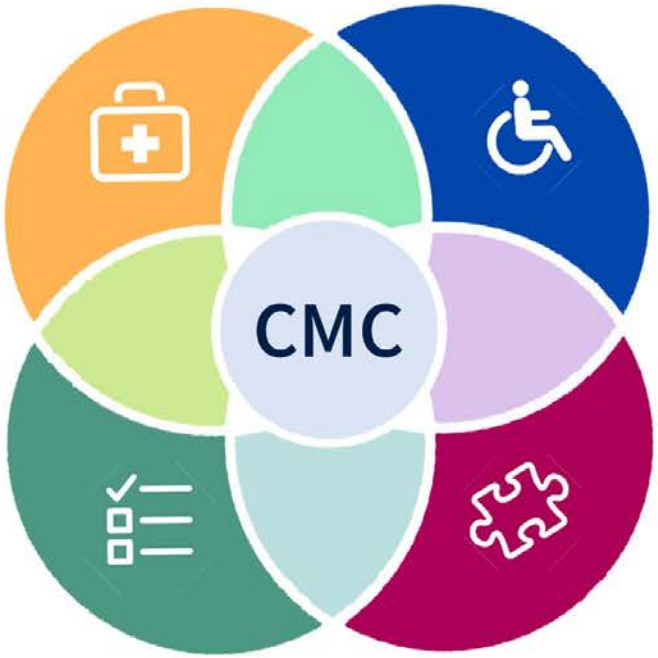
YOUTH WITH MEDICAL COMPLEXITY (YMC)

HEALTH CARE USE

- High resource utilization
- Necessitating involvement of multiple service providers

NEEDS

- Substantial family-identified needs
- Significant impact on family (e.g. financial burden)



FUNCTIONAL LIMITATIONS

- Severe
- Often associated with technology dependence

CHRONIC CONDITION(S)

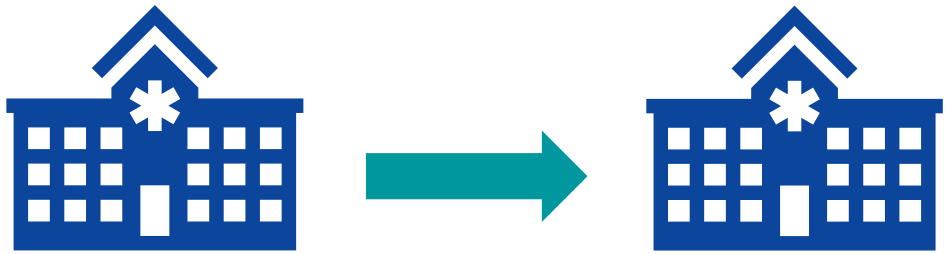
- Diagnosed **or** unknown but suspected
- Severe and/or associated with medical fragility

1. Cohen et al., 2011

TRANSITION FROM PEDIATRIC TO ADULT CARE

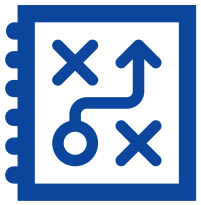
- Transition is defined as a purposeful, planned process that aims to address the medical and psychosocial needs of patients as they transfer from child-centred to adult-oriented health care systems.[2-3]

- Transitional period occurs between ages 14-18.



2. Blum et al., 1993; **3.** Blum, 2002

TRANSITIONING YMC



labour-intensive

involves various medical and psychosocial elements

years of proactive planning

requires partnership to ensure transfer of care is complete

should involve the family

4. Joly, 2015**; 5.** Li et al., 2020; **6.** Roy et al., 2022

CURRENT PRACTICE

- Pediatric teams often fax YMC's medical records to family physicians,[7] however, this alone is inadequate in relaying the unique needs of YMC and their families.[8]

- Disconnect between the pediatric team, family physician and family are ongoing barriers to transition for YMC, frequently leading to gaps in care.

7. Chouteau and Allen, 2019**; 8.** Li et al., 2022

STUDY RATIONALE

- Collaborative handovers including the pediatric team, family physician, and family are needed to share clinical information, encourage partnership, promote clarification and ultimately, improve the transition process for YMC.

STUDY OBJECTIVES

1. Evaluate the feasibility and acceptability of implementing tri-partnership virtual handovers.

2. Explore experiences with tri-partnership virtual handovers.

STUDY DESIGN

Design: Mixed-methods, descriptive, prospective study.

Setting: Complex Care program at a tertiary care pediatric hospital in Toronto, Canada.

STUDY PARTICIPANTS & TIMELINE

Inclusion Criteria:

- Caregivers of transition-age YMC (16-17 years old) in the Complex Care program.
- Family physicians of transition-age YMC (16-17 years old) in the Complex Care program.

Exclusion Criteria:

- Cannot complete the study measures in English.

Pre-Intervention Questionnaire

Post-Intervention Questionnaire + Interview

6m Post-Intervention Questionnaire + Interview

TRI-PARTNERSHIP VIRTUAL HANDOVER

- Consisted of a 45-60 minute meeting involving the:

pediatric team

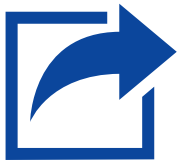
caregiver/YMC

family physician

TRI-PARTNERSHIP VIRTUAL HANDOVER (*n* = 20)

- Served as a platform to prepare for transition and encompassed a comprehensive review of several key elements:

YMC's clinical care plan, medications, technologies, etc.



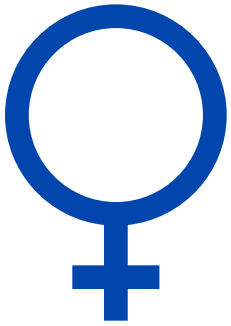
sub-specialist referrals

allied health and community resources

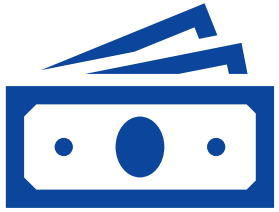
funding applications

questions and action items

DEMOGRAPHICS
CAREGIVERS OF YMC (*n* = 17)



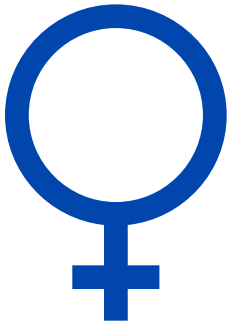
86% identified as a woman



71% indicated household income <$80,000

52% attended university

DEMOGRAPHICS
FAMILY PHYSICIANS (*n* = 15)



56% identified as a woman

47% were part of a family health team

63% previously cared for YMC

ACCEPTABILITY
CAREGIVERS OF YMC (*n* = 17)

100%

felt satisfied overall

94%

felt their concerns and questions were addressed

ACCEPTABILITY
FAMILY PHYSICIANS (*n* = 15)

93%

felt satisfied overall

87%

felt confident in their ability to care for YMC as a result

SEMI-STRUCTURED INTERVIEWS (*n* = 24)

1

Enhanced Communication

"It allowed us to give the information that we needed to, it allowed us to ask difficult questions, it allowed us to problem-solve." [PT6]

2

Encouraged Mutual Understanding

"It was an eyeopener for me to understand the struggles of the family." [FP16]

"It was excellent…I felt everyone was on the same page." [C2]

3

Fostered Confidence

"I've noticed the family feels a lot more comfortable and confident in the care that they are going to receive. The family can see the family physician being able to deal with these issues." [PT6]

IMPLICATIONS & NEXT STEPS

- Tri-partnership virtual handovers are now standard of practice in the Complex Care program at a tertiary care pediatric hospital in Toronto, Canada.

- Informed the development of a CIHR-funded randomized controlled trial: ***PITCare***
  - Transition support led by a transition navigation team that will bridge the paediatric and adult health care systems, following YMC for 2 years from ages 17.5 until 19.5.

FAMILY PHYSICIAN PARTNERSHIPS

- Our team aims to expand our research partnerships with family physicians to continue to work towards improving the transition process for this population.

please feel free to reach out: natasha.bruno@sickkids.ca

THANK YOU FOR LISTENING!

We would also like to thank the study participants for their time and our funders!

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