Update on Electronic Medical Records and Mobile Platforms in Transitional Healthcare

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Resident Physician, Greenville Health System
Disclosures

• I have no commercial relationship to disclose
Learning Objectives

• Review how the six core elements have been incorporated into Epic by other institutions.

• Identify alternative platforms for delivering transition assessments and monitoring outcomes.

• Review the current state of mHealth (mobile healthcare) in chronic medical illness.

• Identify developed and developing mobile applications to improve patient care.
Big Questions?

• What do you need your EMR to do?
• How complex do you need your report to be?
• Do you need numeric data, traceable data to report outcomes?
• Who will deliver data to your system?
• When in the visit will this occur?
“We need to innovate! Buck the status quo! Blaze a new trail! Here’s how everyone else is doing it...”
Incorporating Transition into Epic Electronic Health Record Software: A Survey of Expert Users

By Dr. Patience White and Michael Ablan
A brief online survey was developed and sent to two groups in September and November 2014.

- Expert Epic Users: 22 (100% response rate)
- Additional Users from the 15% ACIDC and AAP San Diego: 25 (40% response rate)

The survey questions included the following:

- Closet-ended questions about the current inclusion of specific core elements of the 2011 AAP/AAFP/ACP Clinical Report on Transition in Epic.
- Open-ended questions about the current functionality of this EHR in transition, needed next steps and advice for those seeking to add transition into their practice using Epic.
Transition Elements in Epic System

- Transition Policy: 0%
- Tracking & Registry: 31%
- Transition Readiness Assessment: 65%
- Transition Plan of Care: 40%
- Transfer of Care: 56%
- Transition Completion: 12-13%
Core Measures Demonstrated in Epic

1. Kaiser Permanente of Northern California – Elizabeth Hammel, MD *(Core Elements #1, 2, 3)* ..........5
2. Children’s Hospital Colorado – Jennifer Disabato, DNP, CPNP *(Core Elements #2, 3)* ..................9
3. University of Rochester Medical Center – Brett Robbins, MD *(Core Element #2)* .........................13
4. Child Development & Rehab. Center at Oregon Health & Science University – Kim Solondz, MS, OTR/L *(Core Element #2)* ..................................................................................................................14
5. Ohio State Univ. and Nationwide Children’s Hospital – Stacy Ardoin, MD & Garey Noritz, MD *(Core Element #3; Core Element #4, respectively)* .................................................................17
6. SUNY Upstate Medical University – Nienke Dosa, MD, MPH *(Core Elements #1, 3, 4, 5)* ........23
7. University of Florida – Jacksonville (JaxHATS) – Rita Nathawad, MD *(Core Element #2)* ............30
8. Children’s Medical Center (Dallas, TX) – Ashley Sadlon, MHA *(Core Elements #3, 4, 5)* ........31
9. Children’s Hospital of Wisconsin – Tera Bartelt, MS, PCNS-BC *(Core Element #2)* ...............35
10. Miller Children’s Hospital/Long Beach Memorial Medical Center – Erika Jewel, LCSW *(Core Element #2)* ...........................................................................................................................................37
Epic Key Words:

• BPA: Best Practice Advisory
• AVS: After Visit Summary
• Smart Text
• Smart Phrases
• My Chart
Examples of Core Elements
There is Definitely More than One Way to Skin a Cat
Transition Policy via AVS

We are committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making.

At age 18 youth legally become adults. This means that their consent will be required on a HIPAA Form.

For 12-14 year olds
Guidelines for Transitioning Patients to Adult Neurology Care

Introduction
Our pediatric neurology team is specialized in the care of infants, children and teens with neurological disorders. Some patients seen in our clinic will not need to see a neurologist when they become adults. Many patients will require ongoing care from a neurologist after they become adults, and we have developed these guidelines to guide this process.

What is Transition?
Transition refers to BOTH the transition of decision-making and other rights and responsibilities from caregivers to the patient AND the transfer of care from a pediatric to an adult provider.

Core Beliefs
Transition requires collaboration between the patient, the family/caregivers and our entire team. We are committed to supporting a smooth transition from adolescence into young adulthood.

This includes a clear and deliberate:
- Transition from an approach focused on talking with the parent(s)/guardian of a younger child to an approach focused on talking directly with the young adult who is responsible for his/her own decisions and self-care.

Message to the Teen/Young Adult
We want you to have a lifetime of the best health you can have!

At 18 years of age, you become an adult, both medically and legally...

What does this mean for you?
Starting around age 14, we will begin the process of preparing you for this transition from "pediatric" care where your caregivers make decisions about you, to "adult" care where you make decisions.

During this process, we will:
- Teach and answer your questions
- Spend more time with you alone during clinic visits when appropriate
- Ask you to take on more responsibility for your care as you grow closer to reaching adulthood
Capture Your Patient: Utilize A Best Practice Advisory

4. Child Development & Rehab, Center at Oregon Health & Science University
For further information, please contact Kim Solondz (solondzk@ohsu.edu)

IDD Transition Workflow
CDR Spina Bifida, LEND and Down Syndrome Departments

Summary
A Best Practice Advisory (BPA) is now in place to alert providers within the CDR SPINAL BIFIDA, CDR LEND and CDR DOWN SYNDROME departments, for children aged 12-24, that the transition guide needs to be given and discussed during an office visit. The BPA will direct users to a Doc Flowsheet to record data regarding the transition guide.

Workflow
The BPA will appear for any scheduled face-to-face visits for the clinics listed in the summary. The BPA will continue to appear until the entire Doc Flowsheet has been completed. See step-by-step workflow below:

1. Double click on an encounter from the Schedule:
@FNAME@ and {parent/guardian: 23432} participated in a discussion about preparing for transition to adult care {Adult Transition Timing: 27030}. At this time the patient and family need {Neurology transition: 25465}

Parent/guardian: 23432 selection options:  
- Mother and Father
- Mother
- Father
- Grandmother
- Grandfather
- Foster Parent
- sibling(s)
- Guardian
- Nanny
- Caregiver

Adult Transition Timing: 27030 selection options:  
- in the next year
- at the age of 21
- at their next visit

Children’s Hospital Colorado
Readiness Assessments

7. University of Florida – Jacksonville “JaxHATS” Program
For further information, please contact Rita Nathawad (Rita.Nathawad@jax.ufl.edu)

Transition Readiness Assessment
The patient scored the following during their transition readiness assessment:

- Managing Medications: 3
- Appointment Keeping: 3
- Tracking Health Issues: 4
- Talking with Providers: 5
- Managing Daily Activities: 4

**Plan**

- Managing Medications: In Progress; Referred to set up account with MyMedSchedule (My Chart)
- Appointment Keeping: In Progress
- Tracking Health Issues: In Progress
- Talking with Providers: Achieved Competency
- Managing Daily Activities: Achieved Competency
Dot Phase/Smart Phrase
Plan of Care

TRANSITION TASKS

(Age 12-14 years)
IEP has transition plan by age 14yrs: ***
Independence expectations: ***
Sexuality issues: ***
Mental Health issues: ***

(Age 15-17 years)
IEP has transition services: ***
Inform Vocational Rehab by autumn of year before graduation: ***
Begin guardianship procedures at least 3 months before turning 18 years: ***
Check eligibility for SSI the month before patient becomes 18 yrs ***
Insurance transition-eligibility for own Medicaid/Medicare policy: ***
Evaluate and assist with forms for food stamps/additional community resources: ***
Independence expectations: ***
Sexuality issues: ***
Mental Health issues: ***
## Skills Checklist

This checklist is built for all specialties to use to assess and evaluate goals, skills, and readiness of the patient (and/or caregiver) for transition from pediatric to adult care. First, to cognitive or physical limitations. A checklist tailored for the selected option will appear. Use the checklist to document the patient’s (and/or caregiver’s) knowledge or skills, link to transition and specialty education on the Office of Patient Transition’s ChildNet site is also provided. In addition to the general checklist below used by all specialties at caregiver) to master. See Specialty Skills Checklist navigator section to access your department’s supplemental specialty checklist, if applicable.

- Patient is cognitively intact and expected to eventually resume independent care for his or her condition.
- Patient has cognitive or physical limitations which may preclude them from caring for his or her condition independently

### Name of the Caregiver Participating in Checklist Assessment:

<table>
<thead>
<tr>
<th>Patient can describe medical condition:</th>
<th>Education materials were provided</th>
<th>Teaching / counseling performed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action/Intervention:</td>
<td>Hyperlink1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to education materials on ChildNet:</td>
<td>Description of Education / Counseling</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Description and date of education / counseling:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Knowledge of Health Condition & Medications

<table>
<thead>
<tr>
<th>Patient able to independently give medical history:</th>
<th>Education materials were provided</th>
<th>Teaching / counseling performed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action / Intervention:</td>
<td>Hyperlink2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to education materials on ChildNet:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient able to describe important symptoms of worsening condition:

<table>
<thead>
<tr>
<th>Action / Intervention:</th>
<th>Education materials were provided</th>
<th>Teaching / counseling performed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to education materials on ChildNet:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Epic My Chart

- Records
- Messages
- Pre-visit surveys
- Upcoming visits
- Visit reminders
Does your EMR lack the complexity or support to accommodate Transition?

What is an alternate application?
REDCaps: Vanderbilt

• Research Electric Data Capture
• Secure web application for building and managing online surveys and databases.
• 1455 active institutional partners
• Allows users to build and manage online surveys and databases
Healthcare Gone Mobile: mHealth

I wonder if someday smart phones will be smarter than us?

What do you mean, someday?

I think we may need a mobile strategy.

Sorry, did you say something?
Peer Support Intervention Through Mobile Application: An Integrative Literature Review and Future Directions

Logan D. McColl, Pamela E. Rideout, Tasha N. Parnar, and Adam Abba-Aji
Alberta Health Services, Alberta, Canada

Peer support is an important component of client-centered care. However, there are numerous barriers faced by traditional peer support delivery that have limited its role, such as timeliness and location of service. Smartphone technology may provide a cost-effective mode of delivery that overcomes many such barriers, offering immediate and accessible service. Such a mobile application may play a role in alleviating experiences of distress. This paper reviews literature relevant to the use of mobile applications in peer support. Investigators conducted an integrative literature review utilizing online databases and triangulation. No literature evaluating the use of mobile application in peer support was discovered. As such, investigators included literature regarding the efficacy of technology-based peer support and the efficacy of health intervention through mobile applications. These studies highlighted both the health outcomes associated with peer support and the limitations specific to mobile application healthcare interventions. Of note, these limitations include the intergenerational gap in use of mobile applications, as well as ethical and privacy considerations. Findings suggest that a mobile application for peer support may provide effective intervention for distress, in turn alleviating stress on other healthcare system resources. Peer support delivered in this manner should complement and not replace the usual face-to-face support or direct crisis intervention.

**Keywords:** peer support, mobile application, mHealth, distress, intervention, technology

Peer support plays a prominent role in healthcare delivery with services available proliferating in the past 3 decades (Davidson, Bellamy, & Miller, 2012). Peer-to-peer intervention offers a two-way street; the peer offering support may validate his or her lived experience while simultaneously instilling hope in others (Deegan, 1996; Jacobson & Greenley, 2001). The reciprocity of personal, lived experiences with others who relate is integral to effective peer support intervention, creating opportunity for positive experiences of self-disclosure (Davidson et al., 2012; Repper & Carter, 2014). Peer support intervention, in turn, increases hope in recovery, self-esteem, self-efficacy, socialization, and self-management of difficulties (Repper & Carter, 2011). Such positive effects also include an increased likelihood of crisis stabilization (Landers & Zhou, 2011). An additional benefit is the development of natural supports before a crisis occurs (Landers & Zhou, 2011).

Secondary to having a positive impact on health outcomes, peer support has been shown to have significant economic impact. A randomized controlled trial by Simpson et al. (2014) revealed that
mHealth tools

- Informative – alerts, reminders
- Educational – narrative training, videos
- Communication – survey, 2-way talk
- Disease management – data input, tracking, and gamification
- Psychosocial support – mobile network/meetup
Is texting a way to encourage disease-specific self management?

Texting Teens in Transition: The Use of Text Messages in Clinical Intervention Research

Monitoring Editor: Gunther Eysenbach
Reviewed by Stephanie Kelly, Judith Cornelius, Kristien Vandeyk, and Jennifer Filo

Abstract

Background
The rapidly growing population of young adults living with congenital heart disease (CHD), can population in which to consider the use of mHealth. This methodological study was part of a larger intervention to prepare teens for transfer from pediatric to adult cardiology care. The intervention (message service) text messages between the intervention nurse and study participant.

Objective
Our aim was to determine (1) the preference of teens with CHD to be contacted via text message, (2) collect data regarding the use of MyHealth Passport after participation in the intervention, (3) the texting

Methods
Participants were recruited through the intervention study (n=24) by either choosing to receive a question to the study nurses. Inclusion criteria were age 15-17 years, diagnosed with moderate or Cardiology at Stollery Children’s Hospital. Exclusion criteria were heart transplantation and/or 1 or more transcripts were analyzed by qualitative inductive content analysis.

Results
Two-thirds of teens (16/24, 67.9%) chose text messaging as their preferred contact, making them a regarding the MyHealth Passport, all but one teen had their MyHealth Passport on them, and most showing their MyHealth Passport to at least one person. Seven themes were identified in the text interaction with health care providers, texting teens in transition, texting as a mechanism to initiate educator. Benefits of texting were identified as flexibility, ability to respond over time, informative patient questions. Risks of texting were identified as the possibility that interactions may not be.

Conclusions
Text messaging was useful in collecting data regarding the use of the MyHealth Passport. Texting requires more study and may benefit from protocols and the use of solid theoretical frameworks could be drawn.
Welcome to MyHealth Passport, a service of the SickKids Good 2 Go Transition Program. MyHealth Passport is a customized, emergency room or any time you need to access your medical information. Start by filling out the information below.

**CREATE PASSPORT**

1. **Cardiac:**
   - Select Passport
   - Congenital Heart Defect
   - Transplant

2. **Respiratory:**
   - Asthma
   - Inhaler or Nebulizer
   - Chronic Obstructive Pulmonary Disease (COPD)

3. **Allergies:**
   - Penicillin
   - Peanut
   - Tree Nuts

4. **Diabetes:**
   - Insulin
   - Oral Hypoglycemic A Agents

5. **Neurological:**
   - Seizures
   - Head Injury

The Hospital for Sick Children is not responsible.
Patients Welcome the Sickle Cell Disease Mobile Application to Record Symptoms via Technology (SMART)

Nirmish Shah, Jude Jonassaint, and Laura De Castro
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Abstract

The widespread use of mobile phones among patients provides a unique opportunity for the development of mobile health intervention designed specifically for sickle cell disease, which will improve self-management as well as health care delivery. Our objective was to determine the receptiveness of patients with sickle cell disease to technology and a mobile application (app) designed for sickle cell disease. Phase I included 100 patients who completed a survey inquiring about receptiveness to technology and use of mobile devices to self-manage and communicate with providers. Phase II surveyed 17 additional patients who tested a newly developed sickle cell disease app, to report its usability and utility. In Phase I, on a 0–10 Likert scale where 0 is not comfortable, and 10 is extremely comfortable, 87.0% of participants reported >5 comfort level using a mobile device for health care management. Participants were comfortable with texting (81.0%) and emailing (77.0%) but not with social media (40.0%). Most participants (84.0%) owned computer devices (desktops, laptops, tablets, or iPads), and 92.0% owned mobile devices. In Phase II, participants reported that the app tested was useful to track pain (88.0%), and 94.0% reported that it was easy to use, practical, and useful for health self-management. All reported that the app was useful to help one communicate with providers. Following the use of our app, patients found it an extremely valuable tool for tracking pain, health management, and communicating with providers. We conclude that mobile technology might provide an appropriate venue for sickle cell disease healthcare management.
Gamification

Results: Thematic analysis findings were the role of data collecting rather than decision making; the need for fast, discrete transactions; overcoming decision inertia; and the need for ad hoc information sharing. Design aspects of the resultant app emerged through the user-centered design process, including simple, automated transfer of glucometer readings; the use of a social community; and the concept of gamification, whereby routine behaviors and actions are rewarded in the form of iTunes music and apps. Blood glucose trend analysis was provided with immediate prompting of the participant to suggest both the cause and remedy of the adverse trend. The pilot evaluation showed that the daily average frequency of blood glucose measurement increased 50% (from 2.4 to 3.6 per day, \( P = .006, n = 12 \)). A total of 161 rewards (average of 8 rewards each) were distributed to participants. Satisfaction was high, with 88% (14/16 participants) stating that they would continue to use the system. Demonstrating improvements in HbA1c will require a properly powered study of sufficient duration.

Conclusions: This mHealth diabetes app with the use of gamification incentives showed an improvement in the frequency of blood glucose monitoring in adolescents with type 1 diabetes. Extending this to improved health outcomes will require the incentives to be tied not only to frequency of blood glucose monitoring but also to patient actions and decision making based on those readings such that glycemic control can be improved.
My Transition Apps
As a medical resident, John O. Moore, MD, PhD, was frustrated by the lack of opportunity to help his patients manage their chronic diseases between office visits.

“We're still treating them as if we just need to figure out the diagnosis and tell them the treatment, and that's magically going to fix things,” he said. “But people don't want to simply be told what to do. That is why there is such a disconnect between medical recommendations and actual behavior when it comes to chronic diseases. What people need is a way to be involved in creating the plans for their care ... and they need tools that help [them] to learn and self-reflect and experiment and see for themselves the benefits and the drawbacks of different approaches.”

After he left medical practice to be a researcher at the Massachusetts Institute of Technology Media Lab in Cambridge, Mass., he tried to develop such a tool. “We explored everything from games to intelligent avatars to automated systems that really just tell you what you need to do and you do it,” said Dr. Moore. However, patient autonomy turned out to be a critical component of the solution he and his colleagues eventually developed.
Technology-Supported Apprenticeship in the Management of Hypertension: A Randomized Controlled Trial

John O. Moore, MD, PhD, Mary Ann Marshall, RN, INCH, BC, David C. Judge, MD, Franklin H. Moss, PhD, Scott J. Gilroy, BSc, J. Basjanus Crocker, MD, and Randall M. Ziman, MD

ABSTRACT

- **Objective:** To compare technology-supported apprenticeship in hypertension management with a successful coaching model at Massachusetts General Hospital.
- **Methods:** A randomized controlled trial was conducted. Adult patients with uncontrolled essential hypertension (average blood pressure [BP] 148/87 mm Hg) were recruited in a staggered fashion for a 12-week study period. Intervention subjects received apprenticeship support from a nurse health coach through the CollaboRhythm application on a tablet computer. Patients self-reported medication adherence and blood pressure via wireless devices, and the coach helped them to continuously progress through lifestyle change and medication adjustment using integrated messaging. Control subjects received support from the same coach but through traditional channels of office visits, phone calls, and e-mail.
- **Results:** 42 of 44 subjects completed the study. Intervention subjects achieved a greater decrease in systolic BP at 12 weeks than control subjects (26.3 mm Hg vs. 16.0 mm Hg, *P* = 0.009). A greater percentage of intervention subjects achieved goal BP ≤130/80 mm Hg (75.0% vs. 31.8%, *P* = 0.003) and 100% of them achieved goal BP ≤140/90 mm Hg. They also rated the experience higher, although this finding was not statistically significant (8.9 vs. 7.6, *P* = 0.12). There was a trend toward increased cost for intervention subjects ($87.50 vs. $59.41, *P* = 0.15), but the projected cost is much less than standard care ($248/patient/year).
- **Conclusion:** This study provides encouraging evidence that technology-supported apprenticeship can improve the outcomes, cost, and experience of care.

Hypertension affects approximately 33% of the U.S. adult population [1]. Antihypertensive treatment has been shown to be effective at preventing complications [2,3]. Unfortunately, estimates suggest that the majority of those diagnosed with hypertension do not have their blood pressure controlled [1]. This failure is due to both clinician and patient factors. Mean adherence of clinicians to guidelines is estimated at 53.5% [4]. An electronic monitoring study showed that half of patients who are prescribed medications stop taking them within 1 year [5]. Of those who take their medications, about 10% have adherence issues on any given day and about 50% have significant adherence issues in the course of their treatment [5]. Adherence to diet and exercise self-management is even more dismal, with rates below 20% [6]. Hypertension is an expensive problem with direct medical costs (treatment and complications) greater than $100 billion a year and equally high indirect costs (lost productivity) [7–9].

In the management of chronic diseases, there is a significant trend toward empowering patients with more control and toward providing more longitudinal coaching from clinicians and from peers [10–15]. Technology-supported apprenticeship is a model of chronic disease management that builds on the success of self-management and coaching, but it is more ambitious in that its goal is for patients to lead their care with the support of health coaches and supervising clinicians. It is informed by the field of learning science, particularly in how technology can be used effectively to support learning [16–20].

From the Massachusetts Institute of Technology (Dr. Moore, Dr. Moss, and Mr. Gilroy) and the Massachusetts General Hospital (Ms. Marshall, Dr. Judge, Dr. Crocker, and Dr. Ziman).
Healthy Transitions App

University of Delaware Disability Studies
Healthy Transitions App

- Being Assertive
- Deciding About Guardianship
  - Decision Making with a Circle of Support
  - Alternatives to Guardianship

Home  Contact  Checklist  About Us
Social Skills Sampler
Health Provider Toolkit

Adolescent and young adult (AYA) males - those between the ages of 12 and 26 - receive minimal health care; for them health care consists largely of sports physicals and an occasional visit to the emergency room. Yet, according to the most recent data from the US Centers for Disease Control and Prevention, AYA males are at higher risk than their female contemporaries for: death by suicide, ADHD diagnosis, substance abuse, homicide, risky behaviors, accidental injury, certain sexually transmitted infections.

If we care about the health of future generations, male and female, we need to start addressing the unmet health care needs of AYA males. The Partnership for Male Youth has been formed to
How can patient’s be motivated to change to change their behavior and increase their autonomy and independence with respect to their condition?
TransitionMate: A Mobile Application for Chronic Illness Transition Support

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Abstract
Adolescent patients with a chronic illness eventually undergo the transition from paediatric to adult health care. This transition typically occurs simultaneously with other changes in the surrounding environment and patients need to develop skills such as independence and autonomy to improve their overall health. Although these patients have the support of medical personnel, barely any information has been collected to understand this transition and the way it can be better supported. In this paper we describe “TransitionMate”, a mobile phone application that aims at collecting data from patients during the transition to adult care using a variety of interaction modes.

Author Keywords
Mobile application; intervention; chronic disease; behaviour change; self-determination theory

ACM Classification Keywords
HCI: Miscellaneous.

Introduction
Chronic illnesses are long term conditions that might affect a person for her whole life, and if left untreated or incorrectly addressed, they may cause numerous complications that seriously affect the overall wellbeing. The management of the illness can be divided into different stages that differ significantly based on the condition and the age of the patient.
Thank You to Our Speakers

For your time
For your education
For you exhaustless energy and dedication to transitional care research and implementation
Thank you to our Committee

Dr. Russ Kolarik, MD
Faculty Sponsor
GHS Med-Peds Program Director

Dr. Manisha Patel, MD
Faculty Sponsor
Director of Adult Congenital Heart Disease Clinic at GHS

Dr. Jill Sullivan
Conference Co-Chair

Dr. Sen Ravindran
Conference Co-Chair

Dr. Shannon Burgess
Conference Coordinator

Dr. Burnadette Wood
Conference Coordinator
A Special Thank You To Our Sponsors
Reminders

• Please do not forget to submit your CME forms online: you will have 6 days from the completion of this event to submit.

• As part of our support through the South Carolina Developmental Disabilities Council we will be contacting you in 6 months to assess how this conference has impacted the care of patients affected with childhood-onset chronic illness in your practice.
Upcoming Meetings:

7th Annual Health Care Transition Research Consortium Symposium **September 30, 2015**

16th Annual Chronic Illness and Disability Conference on Transition from Pediatric to Adult-based Care **October 1 and 2, 2015.**

Houston, Texas

https://www.baylorcme.org/search/detail.cfm?cme=979
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May 15-16, 2015

670 Verdae Boulevard, Greenville, SC 29607