

one-year post-implementation. We also conducted a survey of patients and families after their transfer-related goals were achieved.

Results: The Navigation Hub was launched in September 2020 with support for four subspecialty clinics. An additional four clinics were added in January 2021 and two in June 2021, with the goal of continued expansion until navigation support is available for patients across the institution. To date, 252 patients have received support. Reasons for referral include assistance with identification and transfer to adult primary care provider (61.9%) and to adult specialty care provider (80.6%); assistance with public benefits (13.1%), insurance navigation and troubleshooting (40.1%); guidance with conservatorship (11.9%), health care power of attorney (6.7%), educational accommodations (6.0%); and other (10.7%). Survey responses from clinicians and providers (n=27) indicated high levels of satisfaction with the ease of referring patients, communication with case managers, and overall quality of services. Survey responses from patients (n=9) and parents/guardians (n=6) indicated high levels of satisfaction with services, communication and time spent with the case managers, and support received. Of the patient respondents, 100% indicated increased confidence in calling their primary and/or specialty care doctors' offices, knowing where to access their medical records, knowing where to look for information about public benefits, asking their primary and/or specialty care providers questions about their health needs, and completing health care-related forms. Majority (83.3%) indicated increased confidence in knowing where to find information about their insurance.

Conclusions: The Navigation Hub fills a critical gap in the care delivery system for AYA transitioning from pediatric to adult providers by removing transfer-related care coordination activities from pediatric providers to a centralized group with coordination expertise. Ongoing evaluation will help to identify standard processes for this coordination, activities of greatest value, and mechanisms for long-term financial viability.

Sources of Support: WHH Foundation.

197.

"I FEEL LIKE WE'RE APPROACHING A CLIFF": PERSPECTIVES ON HEALTH CARE TRANSITION AMONG PARENTS OF INTERNATIONALLY ADOPTED CHILDREN WITH HIV

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Purpose: The transition of youth with HIV from pediatric to adult care is associated with multiple adverse health outcomes including poor medication and appointment adherence. However, little is known about the experience of the growing population of internationally adopted children living with HIV (IACH). IACH may have adoption-related trauma and challenges that could impact their transition readiness. This qualitative project aims to understand parents' perspectives on care and preparation for transition of their IACH.

Methods: Twenty-three parents of IACH from 14 states in the United States completed hour-long audio-recorded semi-structured phone interviews focused on view of healthcare transition. The purposive sample was recruited from two pediatric infectious disease clinics and a private Facebook group. Interview transcripts were coded for emerging themes using standard qualitative methods.

Results: Most parents identified as white (n=22), female (n=22), and Christian (n=22), with a mean age of 42.7 years. On average each parent had 2 biological children and 2.8 adopted children. Of the 29 IACH (16 male, 13 female), all were virally suppressed. Sixteen IACH were adopted from countries in Africa. The mean age at adoption was 5.5 years (range 6 months-15 years). Mean age at time of parental interview was 12.7 (range 1-24 years) and two of IACH had transitioned to care in an adult infectious disease clinic. Findings indicated that health care transition is not often discussed; 20 did not have a transition plan with their provider. Many parents expressed apprehension regarding the transition to adult care. One parent noted, "I feel like we're approaching a cliff." Anxiety over the ability to communicate with their child's health provider and lack of comprehensive "one-stop shopping" were identified as concerns. Parents also felt their child may feel out of place in the adult infectious disease clinic due to their age. Indeed, one parent tried to establish care for her adolescent at an adult clinic and was told by a clinic scheduler that "it's maybe not the place you want to be with your young child." Parents emphasized the trusting relationship with pediatric providers due to the longstanding care received. One remarked "they've been through every stage of her life." Participants acknowledged that transition to another provider could be challenging for their child as adult providers may be less aware of adoption-related trauma.

Conclusions: Health care transition is an important, and inevitable, process in the lives of IACH. Parents do not feel well prepared for the transition to adult care. The transition represents not only a loss of access to pediatric care, but also a shift in their relationship with their child. It is vital that physicians consider trauma-informed care throughout the transition process with IACH. Providers should scaffold health management-related independence of both IACH and their parents prior to transition. Coordination and communication with adult care providers is key to a successful health care transition. Future research should include longitudinal studies that follow IACH as they transition to adult care and directly account for their perspectives.

Sources of Support: Elon Summer Undergraduate Research Experience, Elon Honors Fellows.

RESEARCH POSTER PRESENTATION II: TRANSITION TO ADULT CARE/CHRONIC ILLNESS

198.

THE UTILITY OF SELF-DETERMINATION THEORY IN PREDICTING FUTURE TRANSITION READINESS AMONG ADOLESCENTS AND EMERGING ADULTS WITH SPECIAL HEALTHCARE NEEDS (AEASHCN)

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Purpose: Adolescents and Emerging Adults with Special Healthcare Needs (AEASHCN) must develop self-management skills (transition readiness) in preparation for transition to adult-based care. Health-promoting theories, such as Self-Determination Theory (SDT), may help identify factors that contribute to the development of transition

readiness over time. The purpose of this study is to utilize a SDT framework to predict transition readiness among AEASHCN participating in a longitudinal study. We hypothesized that the SDT constructs of competence, autonomy, and autonomy support at baseline would predict AEASHCN transition readiness a year or more later.

Methods: AEASHCN from the Gastroenterology, Rheumatology, and Renal clinical services at a large, urban children's hospital were initially recruited to participate in a randomized control trial (RCT) of an intervention to promote self-management. Eligibility for the current study included completion of the 9-month follow-up assessment (n=113). Eighty-one AEASHCN completed an additional assessment beyond the 9-month assessment an average of 17.0 months later. This additional assessment elicited transition readiness via the Readiness to Transition Questionnaire for Teens (RTQ-Teen), insurance status, school enrollment, transition status (having seen an adult provider, yes or no), and age. The SDT constructs of competence, autonomy, provider autonomy support, and parent autonomy support and demographic information (gender, race/ethnicity, randomization outcome) were extracted from the participant's 9-month RCT assessment. Bivariate analyses (t-tests and correlations) identified factors for entry into a linear regression model predicting transition readiness. Significant factors and those supported by the literature included: gender, age, race, ethnicity, insurance status, transition status, competency, autonomy, provider autonomy support, and parent autonomy support. Independent relationships between SDT constructs and transition readiness were evaluated using linear regression (simultaneous entry). Data were analyzed using SPSS, and statistical significance was tested at $\alpha=0.05$.

Results: Participants were female (67.9%); Hispanic (38.3%); African-American (27.2%); privately insured (65.4%); and receiving care from an adult provider (72.8%). Findings of the final model suggest that increased competence ($p=0.02$), increased parent autonomy support ($p<0.01$), Hispanic ethnicity ($p=0.05$), and female gender ($p=0.05$) predict greater transition readiness ($R^2 = 0.329$; F change=3.874; $p<0.001$). Factors not significantly related to the outcome included autonomy, provider autonomy support, age, race, insurance status, and transition status.

Conclusions: Findings from this longitudinal study support our hypothesis that the SDT constructs of competence and parent autonomy support predict AEASHCN transition readiness. Although hypothesized to be important predictors, autonomy and provider autonomy support did not predict transition readiness. This may be partially explained by most AEASHCN in the study having already transitioned to an adult provider; were not receiving support from their pediatric providers; were becoming more independent; and were likely to be reverting to parent support when needed. Prior to transfer, pediatric providers should target AEASHCN competency to self-manage, as well as encourage shared health self-management that ideally occurs between AEASHCN and their parents. These strategies may improve self-management among vulnerable AEASHCN as they transition from pediatric to adult-based care and could decrease the risk of poor health associated with lack of transition preparation.

Sources of Support: Health Resources and Services Administration (R40MC30764).

199.

FACTORS ASSOCIATED WITH ADOLESCENTS' SELF-EFFICACY IN MEETING WITH THEIR PROVIDER ALONE

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Purpose: Adolescents with special healthcare needs (ASHCN) preparing to transition to adult-based care must be able to independently discuss their care with providers. Opportunities to practice this behavior should occur in pediatric care, yet fewer than 50% of ASHCN meet with their pediatric providers alone. ASHCN who cannot meet alone with their pediatric providers have limited opportunities to develop independence and self-management skills that can benefit their transition to adult-based care. This study identified factors associated with self-efficacy to meet with a provider alone among ASHCN preparing for healthcare transition. Self-Determination Theory (SDT), a model of behavior change, guided selection of possible factors. Three components of SDT were used to identify self-efficacy factors: competence (confidence to perform certain behaviors), autonomy (ability to perform behaviors according to one's will), and relatedness (support from social networks).

Methods: With IRB approval, 83 18-year-olds with renal (n=19), gastrointestinal (n=20), rheumatologic (n=22), or neurologic (n=22) diseases completed a one-time assessment to measure their self-efficacy in meeting with a healthcare provider without a parent/guardian. Questions assessed perceived self-efficacy in meeting with the provider alone (6-item scale, Cronbach's $\alpha=.91$); perceived importance of being interviewed alone (scale of 1-10); whether they met with their provider alone in the past 12 months (yes, no/not sure); perceived competence in healthcare self-management (Patient Activation Measure); healthcare autonomy; and perceived support for healthcare autonomy from parents and providers. Bivariate analyses (t-tests, Chi-square, correlations) were used to identify factors ($p<0.20$) for entry into a linear regression model.

Results: Participants were 54% female, 13% African-American, 49% Hispanic, and 53% publicly insured. Fifty-two percent (n=46) reported meeting with their provider alone in the last 12 months. The mean self-efficacy score for meeting with provider alone was 4.82 ± 1.0 , with higher self-efficacy scores reported by females (5.1 ± 0.8) versus males (4.6 ± 1.1 , $p=0.031$), and among those who reported (6.3 ± 2.8) versus did not report (5.1 ± 2.8 , $p=0.052$) meeting with their provider alone in the last 12 months. In addition, self-efficacy in meeting with provider alone was correlated ($p<.05$) with perceived competence in healthcare self-management ($r=.481$); autonomous ($r=.368$) but not controlled ($r=-.050$) healthcare autonomy; and both provider ($r=.449$) and parent ($r=.413$) perceived support for healthcare autonomy. In the multivariate model, female gender ($p=0.013$), competence ($p<0.001$), and provider support for autonomy ($p=0.005$) were associated with self-efficacy in meeting with provider alone (R -square=.365, F -change=15.150, $p<0.001$). Having recently met with provider alone, perceived importance of meeting with provider alone, and perceived parent autonomy support were not retained in the multivariate model.

Conclusions: In this study, 48% of 18-year-old AYSHCN reported not meeting with their provider alone in the last 12 months. This is a missed opportunity to promote autonomy and to practice self-management. We identified three factors that independently contribute to ASHCN self-efficacy to meet with their provider alone; these provide a framework for the development of interventions to promote self-efficacy while still in pediatric care. Opportunities for ASHCN to meet with their providers alone and provider strategies to support health care autonomy should be promoted.