Transition Models from Pediatric to Adult Health Care: Innovative Strategies

Patience White, MD, MA, FAAP, FACP

Got Transition
Center for Health Care Transition Improvement
Disclosures

The presenter has no disclosures, and no conflicts of interest.
Presentation Learning Objectives

After this presentation, you will be able to:

• Discuss the background need and national context for Health Care Transition from Pediatric to Adult Health Care

• Review the AAP/AAFP/ACP Clinical Report and the *Six Core Elements of Health Care Transition* through the lens of a pediatric practice transitioning youth to an Adult Practice

• Discuss the resources available at Gottransition.org and the current national activities of the Got Transition
Background Need for Transition Improvements

• There are an estimated 18 million adolescents, ages 18-21, about ¼ of whom have chronic conditions; many more millions if you count those 12-26, the population affected by transition from pediatric to adult care. All Adolescents need to transition to adult-centered care

• Emerging young adults (ages 18-25):
  – fare worse than adolescents (ages 12-17) or young adults (ages 26-35).
  – have the highest use of ER among those younger than age 75
  – most likely to report no health care visits in last 12 months even with the ACA changes in health insurance.

• Without transition support, data show health is diminished, quality of care is compromised, and health care costs are increased* 

• Majority of youth and families are ill-prepared for this change.

• Surveys of health care providers consistently show they lack a systematic way to support youth, families, and young adults in transition from pediatric to adult health care

National Context for Transition

• ACA: Insurance expansions for young adults, transition an essential health home service
• NCQA medical home standards on transition (plan of care, self-care support, transfer of medical records)
• Healthy People 2020 goals
• Title V new Transition Performance Measure
• CMS/CMMI focus on transition from hospital to home
State of Health Care Transition from Pediatric to Adult Health Care Approaches
What to do? Where to start?
AAP/AAFP/ACP Clinical Report on Health Care Transition

- In 2011, Clinical Report on Transition published as joint policy by AAP/AAFP/ACP
- Targets all youth, beginning at age 12
- Algorithmic structure with:
  - Branching for youth with special health care needs
  - Application to primary and specialty practices
- Extends through adult approach to care/transfer of care to adult medical home and adult specialists

Age 12: Youth and family aware of transition policy
Age 14: Health care transition planning initiated
Age 16: Preparation of youth and parents for adult approach to care and discussion of preferences and timing for transfer to adult health care
Age 18: Transition to adult approach to care
Age 18-22: Transfer of care to adult medical home and specialists with transfer package

“Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home” (Pediatrics, July 2011)
HCT Quality Improvement: 
Six Core Elements of Health Care Transition

• Original Six Core Elements, developed in 2011, as QI strategy 
based on AAP/AAFP/ACP Clinical Report with set of sample 
tools and transition index.
• HCT Learning Collaboratives (with primary and specialty care 
practices) 
  – Conducted between 2010-2012 in DC, Boston, Denver, 
    New Hampshire, Minnesota, Wisconsin 
  – Used well-tested Learning Collaborative methodology from 
    the National Initiative for Children’s Healthcare Quality 
    and pioneered by Institute for Healthcare Improvement 
  – Demonstrated Six Core Elements and tools feasible to use 
    in clinical settings and resulted in quality improvements in 
    transition process*

* McManus et al. *Journal of Adol Health* 56:73 2014
Models of Care Transfer

Pediatric diseases where there are both pediatric and Adult subspecialty providers available e.g. pediatric rheumatology

Pediatric  ------------------  Adult Medicine
Primary Care  <->  Primary Care

Subspecialty Care  <->  Subspecialty Care
Models of Care Transfer

Pediatric diseases where there are few adult subspecialty providers available e.g. congenital heart disease

Pediatric                   Adult Medicine

Primary Care ← — Primary Care

Subspecialty Care ← — Subspecialty Care

Models of Care Transfer

Pediatric Disease where adult primary care manages some of pediatric subspecialty e.g. pediatric type II diabetes, Pediatric leukemia
Six Core Elements of Transition 2.0

1. Transition Policy
2. Transition Tracking and Monitoring
3. Transition Readiness
4. Transition Planning
5. Transfer of Care
6. Transition Completion

- Discuss Transition Policy
  AGES 14-15-16-17-18
- Assess skills
  AGES 14-15-16-17-18
- Transfer of Care
  AGE 18-21
- Confirm completion
  3-6 months after transfer
- Track progress
  AGES 14-15-16-17-18
- Develop transition plan
  AGES 14-15-16-17-18
- Discuss Transition Policy
  AGE 12-14
- Assess skills
  AGES 14-15-16-17-18
- Transfer of Care
  AGE 18-21
- Confirm completion
  3-6 months after transfer
A further look...

Transitioning Youth to Adult Health Care Providers
(Pediatric, Family Medicine, and Med-Peds Providers)

Transitioning to an Adult Approach to Health Care Without Changing Providers
(Family Medicine and Med-Peds Providers)

Integrating Young Adults into Adult Health Care
(Internal Medicine, Family Medicine, and Med-Peds Providers)

Six Core Elements of Health Care Transition 2.0
Transitioning Youth to an Adult Health Care Provider
for use by Pediatric, Family Medicine, and Med-Peds Providers

Table of Contents

Preamble 1
Six Core Elements of Health Care Transition 2.0: Side-by-Side Version 2
Six Core Elements of Health Care Transition 2.0: Transitioning Youth to an Adult Health Care Provider 4
Introduction to Each of the Six Core Elements 5
Core Element Samples
1) Transition Policy
   • Sample Transition Policy 7
2) Transition Tracking and Monitoring
   • Sample Individual Transition Flow Sheet 8
   • Sample Transition Registry 9
3) Transition Readiness
   • Sample Transition Readiness Assessment for Youth 10
   • Sample Transition Readiness Assessment for Parents/Caregivers 11
4) Transition Planning
   • Sample Plan of Care 12
   • Sample Medical Summary and Emergency Care Plan 13
   • Sample Condition Fact Sheet 16
5) Transfer of Care
   • Sample Transfer of Care Checklist 18
   • Sample Transfer Letter 19
6) Transfer Completion
   • Sample Health Care Transition Feedback Survey for Youth 20
   • Sample Health Care Transition Feedback Survey for Parents/Caregivers 22
Measurement Approaches
• Current Assessment of Health Care Transition Activities 24
• Health Care Transition Process Measurement Tool 27

Prepared by the Got Transition! team for the Health Care Transition Improvement project team, اللغات الدولية، Isabelle Valeriano, and Megan Prior, with assistance from the Center for Health Care Transition Improvement, the Health Care Transition Improvement Project team, and the National Center for Health Care Transition Improvement Project team.
Transition Policy

- Distinctive policy examples in the 3 packages
- Emphasis on adult approach to care and legal changes at age 18, including options for supported decision-making
- Clarity about support offered by practice and ages and expectation for transfer
- This core element was particularly welcomed by families and youth
Transition Policy

Sample Transition Policy
Six Core Elements of Health Care Transition 2.0

[Pediatric Practice Name] is 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. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult’s consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.
Transition Policy: Benefits

Why is it important?

• Building consensus
• Addressing fairness
• Meeting expectations of young adults
• Allowing for planning and systematic processes
• Young adults who reviewed the pilot policy said they were grateful for the information
• Now everyone understands (young adults/parents/providers):
  – What is expected in an adult model of care or a new adult practice
  – Confidentiality and consent
TRACKING & MONITORING
Tracking and Monitoring

- Support the practice to focus on initial QI for a pilot population
- Distinctive tracking issues in 3 packages
- Tools available for those with and without electronic health records for tracking documentation options
- Individual Transition Flow Sheet for use in paper chart or EHR
- Registry set up as an Excel file
TRANSITION READINESS
Transition Readiness

- Literacy level (Grade 5.7)
- Validated questions on importance and confidence
- Youth/Young adults and caregivers appreciate reviewing/learning what general skills are needed to be successful in an adult practice
### Transition Importance and Confidence

*On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

| How important is it to you to prepare for/change to an adult doctor before age 22? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 (not) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (very) |

| How confident do you feel about your ability to prepare for/change to an adult doctor? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 (not) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (very) |

### My Health

*Please check the box that applies to you right now.*

<table>
<thead>
<tr>
<th>I know my medical needs.</th>
<th>Yes, I know this</th>
<th>I need to learn</th>
<th>Someone needs to do this... Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can explain my medical needs to others.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my symptoms including ones that I quickly need to see a doctor for.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know what to do in case I have a medical emergency.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my own medicines, what they are for, and when I need to take them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my allergies to medicines and medicines I should not take.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand how health care privacy changes at age 18 when legally an adult.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Using Health Care

<table>
<thead>
<tr>
<th>I know or I can find my doctor’s phone number.</th>
<th>Yes, I know this</th>
<th>I need to learn</th>
<th>Someone needs to do this... Who?</th>
</tr>
</thead>
</table>
Transition Readiness

PEDIATRIC COMPONENT

• Assess readiness for an adult approach to care with transition skill readiness assessments several times during the transition process

• Locate adult practices interested in collaborating /receiving prepared youth/young adults

• Ask the Adult practice to create and share their practice policy emphasizing the Confidentiality and Consent components (modified if decision making support is needed) and welcome and orientation materials with the pediatric practice
TRANSITION PLANNING
Transition Planning

• Make sure the Y/YA HCT Plan of care incorporates health into young adult’s overall priorities (key issue for the GT young adult review panel)

• Develop combined medical summary and emergency care plan – pay special attention to the section where you can state what is special about this youth to assist the next provider in engaging the youth in a new health care relationship

• Share Medical Summary, ECP and HCT Plan of Care with youth/young adult so they have a copy to share when needed

• Youth with intellectual challenges (if needed):
  – Review supported decision making plan
  – Understand their unique communication needs
### Sample Plan of Care

**Six Core Elements of Health Care Transition 2.0**

**Instructions:** This sample plan of care is a written document developed jointly with the transitioning youth to establish priorities and a course of action that integrates health and personal goals. Motivational interviewing and strength-based counseling are key approaches in developing a collaborative process and shared decision-making. Information from the transition readiness assessment can be used to guide the development of health goals. The plan of care should be dynamic and updated regularly and sent to the new adult provider as part of the transfer package along with the latest transition readiness assessment, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis:</td>
<td>Secondary Diagnosis:</td>
</tr>
</tbody>
</table>

What matters most to you as you become an adult? How can learning more about your health condition and how to use health care support your goals?

<table>
<thead>
<tr>
<th>Prioritized Goals</th>
<th>Issues or Concerns</th>
<th>Actions</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Date Complete</th>
</tr>
</thead>
</table>

**Initial Date of Plan:**  
**Last Updated:**  
**Parent/Caregiver Signature:**  
**Clinician Signature:**  
**Care Staff Contact:**  
**Care Staff Phone:**
**Sample Medical Summary and Emergency Care Plan**

**Six Core Elements of Health Care Transition 2.0**

This document should be shared with and carried by youth and families/caregivers.

<table>
<thead>
<tr>
<th>Date Completed:</th>
<th>Date Revised:</th>
</tr>
</thead>
</table>

Form completed by:

**Contact Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Nickname:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Preferred Language:</td>
</tr>
<tr>
<td>Parent (Caregiver):</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell #:</td>
<td>Home #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-Mail:</th>
<th>Best Time to Reach:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance/Plan:</td>
<td>Group and ID #:</td>
</tr>
</tbody>
</table>

**Emergency Care Plan**

<table>
<thead>
<tr>
<th>Emergency Contact:</th>
<th>Relationship:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Emergency Care Location:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Common Emergent Presenting Problems**

<table>
<thead>
<tr>
<th>Suggested Tests</th>
<th>Treatment Considerations</th>
</tr>
</thead>
</table>

**Special Concerns for Disaster:**

**Allergies and Procedures to be Avoided**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reactions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>To be avoided</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Procedures:</td>
<td></td>
</tr>
</tbody>
</table>
TRANSFER OF CARE
Transfer of Care

Your practice responsibility when transferring to a new adult provider

Transfer letter to the new adult provider with:

- Appropriate documentation
- Statement that the youth’s care is covered by your practice until first visit
- Offer to be a consultant as needed

- Readiness assessment
- Medical summary and emergency care plan
- Plan of care & decision support documents
- Condition fact sheet, if needed
Sample Transfer of Care Checklist
Six Core Elements of Health Care Transition 2.0

Patient Name: ___________________________ Date of Birth: _________________

Primary Diagnosis: ___________________________ Transition Complexity: ________________

Low, moderate, or high

-Prepared transfer package including:
  - Transfer letter, including effective of date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including transition goals and pending actions
  - Updated medical summary and emergency care plan
  - Guardianship or health proxy documents, if needed
  - Condition fact sheet, if needed
  - Additional provider records, if needed

-Sent transfer package ____________
  Date

-Communicated with adult provider about transfer ____________
  Date
Transfer of Care to Initial Adult Practice Visit

Adult practice responsibility when accepting a Y/YA into their practice

Suggestions on what youth prefer from their provider prior to and during initial visit

• Pre-visit contact recommended
• At first 2 visits, discussion about:

- Discuss transfer concerns/orientation to adult care/practice
- Discuss young adult’s partnership with adult provider (privacy and confidentiality) and best approach to communication (phone, text, email)
- Decision making support (if needed) or review legal documents provided (guardianship)
- Review medical summary and update emergency care plan with young adult.
- Review transition readiness assessment/administer self-care assessment and review and update plan of care
Transfer Completion

- Transition feedback surveys
- Learn how the integration into the adult practice is going
- Several questions adapted from new questions under development for National Survey of Children’s Health and AHRQ survey on transition
- Asking for feedback can build a bond between the young adult and the new practice so they will return to the new adult provider
Transfer Completion

Follow up responsibilities of provider:

• Confirm transfer completion with next provider
• Reach out and offer consultation with next provider as needed
• Build ongoing collaborative relationship with adult primary and specialty care providers
• Have a list of adult specialty providers willing to care for young adults as needed
Measurement Options
Measurement Options

1. Initial Health Care Transition Assessment

- Qualitative self-assessment tool modeled after index
- Provides a snapshot of where practice is in implementing transition processes
- New questions on consumer feedback and leadership
# Current Assessment of Health Care Transition Activities for Transitioning Youth to Adult Health Care Providers

**Six Core Elements of Health Care Transition 2.0**

<table>
<thead>
<tr>
<th>Element</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transition Policy</td>
<td>Clinicians vary in their approach to health care transition, including the appropriate age for transfer to adult providers.</td>
<td>Clinicians follow a uniform but not a written policy about the age for transfer. The approach for transition planning differs among clinicians.</td>
<td>The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information and addresses the practice’s transition approach and age of transfer. The policy is not consistently shared with youth and families.</td>
<td>The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information, a description of the practice’s approach to transition, and age of transfer. Clinicians discuss it with youth and families beginning at ages 12 to 14. The policy is publicly posted and familiar to all staff.</td>
<td></td>
</tr>
<tr>
<td>2. Transition Tracking and Monitoring</td>
<td>Clinicians vary in the identification of transitioning youth, but most wait until close to the age of transfer to identify and prepare youth.</td>
<td>Clinicians use patient records to document certain relevant transition information (e.g., future provider information, date of transfer).</td>
<td>The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete some but not all transition processes.</td>
<td>The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete all “Six Core Elements of Health Care Transition 2.0,” using EHR if possible.</td>
<td></td>
</tr>
<tr>
<td>Transition Activity</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Score</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>1. Young Adult Transition and Care Policy</td>
<td>Clinicians vary in their approach to new young adult patients, and most often approach new young adults as any new patient group, requesting that they complete new patient information forms.</td>
<td>Clinicians follow a uniform, but not a written health care transition policy about the practice’s approach for accepting new young adults, assisting them in gaining knowledge of the adult health care system.</td>
<td>The practice has a written health care transition and care policy or approach, developed with input from young adults, which describes the practice’s approach for partnering with new young adult patients and explains privacy and consent in understandable language.</td>
<td>The practice has a written health care transition and care policy or approach, developed with input from young adults, and it is publicly displayed and discussed with new young adult patients. All staff are familiar with the policy.</td>
<td></td>
</tr>
<tr>
<td>2. Tracking and Monitoring</td>
<td>Clinicians have no mechanism to identify new young adults in the practice and their level of self-care skills.</td>
<td>Clinicians use patient charts to record certain relevant transition information (e.g., medical summary, self-care assessment).</td>
<td>The practice has an individual transition flow sheet or transition registry for identifying and tracking new young adult patients, or a subgroup of young adults with chronic conditions, as they progress through and complete some but not all transition processes.</td>
<td>The practice has an individual transition flow sheet or registry for identifying and tracking new young adult patients, or a subgroup of young adults with chronic conditions, as they progress through and complete all Six Core Elements of Health Care Transition, using EHR if possible.</td>
<td></td>
</tr>
<tr>
<td>3. Transition Readiness/Orientation to Adult Practice</td>
<td>Clinicians have no welcome process tailored to new young adult patients, and there is no organized process within the practice to identify clinicians interested in caring for young adults.</td>
<td>Clinicians within the practice have self-selected to accept new young adult patients, and the practice makes available general introductory information for all new patients of all ages.</td>
<td>The practice has a list of providers interested in caring for young adults that it shares with new young adult patients and pediatric practices. It also makes available general introductory information for all new patients.</td>
<td>The practice has a packet of materials tailored to young adults orienting them to the practice and including a list of providers interested in caring for young adults. The practice offers get-acquainted appointments, if feasible.</td>
<td></td>
</tr>
</tbody>
</table>
Measurement Options

2. Health Care Transition Process Measurement Tool

- Objective scoring method with documentation requirements
- Measures implementation of Six Core Elements, consumer feedback and leadership, and dissemination
- Intended to be conducted at start of QI initiative as baseline measure and repeated to assess progress
# Measurement Tool: Policy Example

## Health Care Transition Process Measurement Tool for Transitioning Youth to Adult Health Care Providers (continued)

### Six Core Elements of Health Care Transition 2.0

<table>
<thead>
<tr>
<th>A) Implementation in Practice/Network</th>
<th>Yes or No</th>
<th>Possible</th>
<th>Actual</th>
<th>Possible Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transition Policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed a written transition policy/statement that describes the practice’s approach to transition</td>
<td>Yes = 4</td>
<td>14</td>
<td></td>
<td>Transition policy</td>
</tr>
<tr>
<td>Included information about privacy and consent at age 18 in transition policy/statement</td>
<td>Yes = 2</td>
<td></td>
<td></td>
<td>Transition policy</td>
</tr>
<tr>
<td>Posted policy/statement (public clinic spaces, practice website etc.)</td>
<td>Yes = 2</td>
<td></td>
<td></td>
<td>Photo</td>
</tr>
<tr>
<td>Educated staff about transition policy/statement and their role in transition process</td>
<td>Yes = 2</td>
<td></td>
<td></td>
<td>Date(s) of program</td>
</tr>
<tr>
<td>Designated practice staff to incorporate <em>Six Core Elements</em> into clinical processes</td>
<td>Yes = 4</td>
<td></td>
<td></td>
<td>Job description</td>
</tr>
</tbody>
</table>

**Transition Policy Subtotal:** 14

<table>
<thead>
<tr>
<th>B) Youth and Family Feedback and Leadership</th>
<th>Yes or No</th>
<th>Possible</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included youth and families in developing policy</td>
<td>Yes = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C) Dissemination in Practice/Network</th>
<th>Possible</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Patients in Practice Receiving Transition Elements:</td>
<td>1–10%</td>
<td>11–25%</td>
</tr>
<tr>
<td>Score Points:</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**1. Transition Policy**

| Sharing policy with families and youth ages 12–21 (letter or visit) | 0 to 5  |

**Transition Policy Subtotal:** 5
New Got Transition Center for HCT Improvement Goals: 2014-2018

1. Build on Transition Quality Improvement work and disseminate to larger populations and practices
2. Transition education and training
3. Young adult and family engagement
4. Transition policy interventions
5. Transition information dissemination
Integrated Care Systems working with Got Transition on HCT QI

- Partnership in implementing and evaluating new *Six Core Elements* packages
- Pediatric and adult provider (includes Med-Peds and Family Medicine) teams participating
- Coaching support to networks by Got Transition
- **Goal:** to learn about dissemination of transition QI and ROI

Cleveland Clinics
Primary Care

Health Partners (MN)
Primary Care

Henry Ford Health System (MI)
Primary Care

Kaiser Northern California
Primary Care

University of Rochester
Specialty Care

Walter Reed National Military Medical Center (MD)
Specialty Care
Examples of Got Transition’s National Efforts

• ACP Council on Subspecialty Societies and GT Transition Project:
  – 11 subspecialty societies signed up to (at a minimum) customize three of the Six Core Elements tools, Readiness and Self Care Assessment and Medical Summary, for several of their diseases
  – SGIM/SAHM customizing for youth with ID/DD and Physical Disability
  – Products will be reviewed by AAP
  – ACP will launch all the specialty Societies’ tools at the IM meeting in 5/2016

• Updating the 2011 Clinical Report for AAP/AAFP/ACP

• Support States Title V Maternal and Child Health programs on statewide HCT efforts who have chosen transition as one of their focuses for their block grant
Examples of Got Transition’s National Efforts

• Develop HCT payment strategies
• Building Young Adult/Family/nursing leaders for HCT
• Tip Sheets available at Gottransition.org
  – Starting a Transition Improvement Process
  – Coding and Reimbursement Strategies
  – Incorporating Transition into EPIC HER
  – Integrating Young Adults with Intellectual and Developmental Disabilities into Your Practice: Tips for Adult Health Care Providers
Presentation Learning Objectives

After this presentation, you will be able to:

• Discuss the background need and national context for Health Care Transition from Pediatric to Adult Health Care

• Review the AAP/AAFP/ACP Clinical Report and the **Six Core Elements of Health Care Transition** through the lens of a pediatric practice transitioning youth to an Adult Practice

• Discuss the resources available at Gottransition.org and the current national activities of the Got Transition
Thank You and Questions

gottransition.org
See link to new Transition CME sponsored by HSCSN, download the Six Core Element 2.0 packages and start making HCT quality improvements in your practice

pwhite@thenationalalliance.org
Please provide us with your contact information so that we can add you to our mailing list.

HealthCareTransition

@gottransition2