Welcome
Healthcare Transfer of Care
Kickoff Meeting

May 19, 2021

Agenda

Topic *Presenter(s)*	Duration
Welcome, Thank you RIDOH and Tufts Health Plan & Getting to Know each other *Deborah Garneau, MA, Maternal and Child Health Director, RIDOH* *Colleen Polselli, Special Needs Program Manager Office of Special Needs, RIDOH* *Susanne Campbell, RN, MS, PCMH CCE, , CTC-RI Senior Program Director*	30 minutes
Got Transitions Overview *Patience White, MD, MA, FAAP, MACP, Co-Project Director Got Transitions, The National Alliance to Advance Adolescent Health*	45 minutes
Review of Objectives & Video *Susanne Campbell, RN, MS, PCMH CCE, , CTC-RI Senior Program Director*	5 minutes
Review of Deliverables and Timing *Susanne Campbell, RN, MS, PCMH CCE, , CTC-RI Senior Program Director*	10 minutes

Getting to Know

Rhode Island Department of Health (RIDOH) Team & Family Voice

Colleen Polselli,
Special Needs Program Manager
Office of Special Needs
RI Department of Health

Deborah Garneau, MA
Maternal and Child Health Director
RI Department of Health

Tara Hayes,
Family Voices Manager, RIPIN

Getting to Know the CTC-RI / PCMH Kids Team

Patricia Flanagan, MD, FAAP, PCMH Kids Co-chair

Elizabeth Lange, MD, FAAP, PCMH Kids Co-chair

Pano Yeracaris, MD, MPH, CTC Chief Clinical Strategist

Susanne Campbell, RN, MS, PCMH CCE, Senior Project Director

Carolyn Karner, MBA, Program Coordinator and Data Analyst

Getting to Know your Practice Facilitators

Suzanne Herzberg, PhD, MS, OTR/L

Susan Dettling, BS, PCMH CCE

Getting to Know the Coastal Narragansett Bay / East Greenwich Internal Medicine Dyad

East Greenwich Internal Medicine Team
Kristen Hubbard, MD, Lead Physician
Luis Echeverria, Practice Manager
Abbe Shuster, NCM

Narragansett Bay Pediatrics Team
Mary E. G. Murray, MD, Lead Physician
Joanne Rodgers, Practice Manager
Future hire, NCM

Pediatric Practice		Adult Practice	
Patient Age	#	Patient Age	#
Age 12-13	621	Age 18-22	463
Age 14-15	674	Age 23-26	655
Age 16-17	688		
Age 18+	1297		
Total	3280	Total	1118
% Medicaid	15.76%	% Medicaid	7.33%

What does success look like for your practice on the Health Transfer of Care Quality Improvement project?

East Greenwich – To be successful we will need to constantly communicate with our pediatric partners as well as the nurse care managers to ensure we are able to give our best service to all pediatric patients and get them properly transferred to our care.

Narragansett Bay Pediatrics – Success for Narragansett Bay Pediatrics would like look a circle. The circular movement would include clear, concise goals for patient and providers both Pediatric and Adult. The movements would be paced and directed to achieve fluid movement to complete the circle by directives and actions created by both partners and having the patient in the center with all hands on the patient. We would like to develop strategies that induce both practice and patient satisfaction and success.

Tell us something about your practices that others might not know:

East Greenwich – We have a young and energentic staff of medical assistants and providers who are eager to help transition patients from pediatrics to adult medicine. We also held the first drive thru COVID vaccine clinic in the state of Rhode Island and look forward to remaining on the cutting edge of medicine.

Narragansett Bay Pediatrics - We have six pediatricians and one Physician Assistant accepting new patients. We conduct sick walk-in visits in the morning Mon-Friday (Pre-Covid) and late-night appointments as well as Saturday and Sunday sick appointments and newborn visits. We have a LICSW on site as well as a child Psychiatrist taking care of all patient behavioral/social needs.

Getting to Know the Coastal Waterman / East Providence Dyad

East Providence Team
Luis Osorio, MD, Lead Physician
Alda Cordeiro, Practice Manager
Michelle Cotton, RN, NCM
Tania Aguiar, Care Navigator

Waterman Pediatrics Team
Elizabeth Lange, MD, Lead Physician
Susan Royale, Practice Manager
Amy Neveu, NCM

Pediatric Practice		Adult Practice	
Patient Age	#	Patient Age	#
Age 12-13	671	Age 18-22	260
Age 14-15	630	Age 23-26	592
Age 16-17	799		
Age 18+	1681		
Total	3781	Total	852
% Medicaid	10.26%	% Medicaid	10.09%

What does success look like for your practice on the Health Transfer of Care Quality Improvement project?

East Providence - With an integrated program, emphasis will be made on ensuring a smooth transition from pediatrics to adult care for the young adult. It would be our hope that with the smooth transition that the young adult will be empowered and knowledgeable with their self care as well as being comfortable with their plan of care

Waterman – Families / patients feel well cared for and confident in ability to manage their health and have strong understanding of how to navigate the new practice and health care in the adult setting. Providers fee confident in their ability to manage patient and family and have a mutual understanding regarding expectations of each others roles.

Tell us something about your practices that others might not know:

East Providence - The office takes extreme pride on ensuring quality measures are regularly attained. Prior to the pandemic, the office ranked #1 in quality measures for 11 consecutive months across all of Coastal. In addition, all staff stemming from providers to office staff as well as the various care management teams continually work to meet this goal.

Providers are all open-minded, work well together and continually strive to ensure high quality of care and open lines of communication

Waterman - Hosts Olympic ceremonies every 2 years.

Getting to Know the Hasbro Pediatric Primary Care / Center for Primary Care Dyad

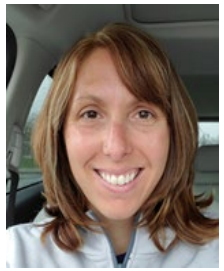
Pediatric Primary Care Team

Carol Lewis, MD

Medical Director, Hasbro Primary Care; Director, Refugee Health Program

Gail Davis, RNC

Program Administrator



Kathleen Gregory, MSN, RN

Program Manager-Care Coordination

Pediatric Practice	
Patient Age	#
Age 12-13	671
Age 14-15	630
Age 16-17	799
Age 18+	1681
Total	3781
% Medicaid	10.26%

What does success look like for your practice on the Health Transfer of Care Quality Improvement project?

Pediatric Primary Care –

- Discussion regarding transition of care to adult PCP begins at age 12 with patient and family.
- Developmentally appropriate adolescent folder provided at 12 year-old WCC and 16-year-old WCC.
- Patient is made aware of final visit with pediatrician.
- Patient has referral to adult specialist as needed.
- Patient has an appointment scheduled with new adult PCP and record release is signed.
- Warm hand-off to adult PCP when able.
- Follow up to ensure patient has become established with adult PCP.
- Obtain feedback from patient regarding transition process.

Tell us something about your practices that others might not know:

Pediatric Primary Care –

- 10,000 Patients
- >90% Medicaid
- ~65 Resident trainees and medical students
- PCMH Kids
- We have:
    - IBH-1 FT & 1 PT social worker
    - Fostering Health program
    - Refugee Clinic
    - Complex Care Clinic

Getting to Know the Hasbro Pediatric Primary Care / Center for Primary Care Dyad

Center for Primary Care Team
Meghan Geary, MD, Lead Physician
Rick Santos, Practice Manager
Ana Dickenson, RN, NCM
Jean Scambio, LPN
Yvonne Marin, LPN

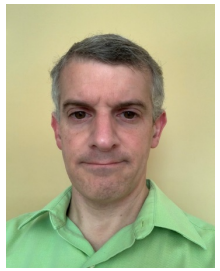
Adult Practice	
Patient Age	#
Age 18-22	260
Age 23-26	592
Total	852
% Medicaid	10.09%

Indicate rationale for selecting your partnering practice and plan for working together:
Hasbro Children's Hospital was very excited to invite the adult Center for Primary Care (CPC) to join us in this project. We are in the same system of care, share medical records and our patient populations have similar demographics and both practices are teaching sites for medical students and resident physicians in training. Many of our patients share the same social determinants of health that interfere with seamless transition. We have also had opportunity to informally transfer patients to their practice previously.

The Center for Primary Care (CPC) is looking forward to serving more young adult patients. We believe our growing services to address social determinants of health, our incredibly dedicated group of nurses and team based care within a large adult internal medicine primary care practice will be welcoming and embrace caring for young adults. Our faculty physicians, NPs and residents are eager to grow their expertise in the care of young adults transitioning to their first adult PCP. As the largest continuity clinic for the Brown Internal Medicine residency, the focus of this collaboration will enhance the training of our residents.

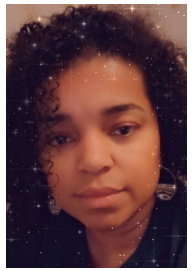
Getting to Know the Nevola / Pilgrim Park Medical Dyad

Chad Nevola, MD Team



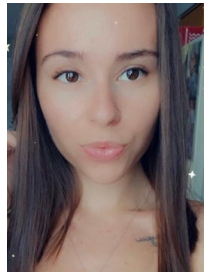
Chad Nevola, MD

Physician Champion



Romina Lima

Office Manager, Project Coordinator



Ariana Forte, Medical Assistant, Team Member

Pilgrim Park Medical Team

Joseph Grande, MD, Lead Physician

Pediatric Practice		Adult Practice	
Patient Age	#	Patient Age	#
Age 12-13	56	Age 18-22	38
Age 14-15	48	Age 23-26	49
Age 16-17	60		
Age 18+	65		
Total	229	Total	87
% Medicaid	~31%	% Medicaid	

What does success look like for your practice on the Health Transfer of Care Quality Improvement project?

Chad Nevola, MD – I think success can be measured by a safe, effective, efficient transition of our young adults to an adult practice that can seamlessly continue care.

Tell us something about your practices that others might not know:

Chad Nevola, MD – Solo practice that continues to see some patients after age 18. To date, the decision to transition care is partially rooted in the individual's specific medical conditions and whether the patient with these prioritized issues would be better served by an adult provider**.**

Pilgrim Park Medical - family practice located in Warwick, R.I. since 1991 serving patients of all ages. The principal here is Joseph A. Grande, DO who is board certified in family medicine. We are open 5 ½ days a week although COVID has impacted that, but it is our goal to return to regular hours as soon as possible. We operate as an open access practice thus we can see patients same day as well as planned appointments.

Getting to Know
Providence Community Health Center Team

Capitol Hill Health Center
Patricia Terceira - Director
Maria Moth Hallgrimmson - Assistant Director

Randall Square Health Center
Michael Leighton - Director

Chafee Health Center
Michael Spoerri
Paula Vieira - Pedi Nurse
Lisa MacDonald -Pedi Nurse

Getting to Know the National Alliance to Advance Adolescent Health Team

MARGARET McMANUS, MHS, *Co-Project Director Got Transitions*

Ms. McManus is the President of The National Alliance to Advance Adolescent Health, a nonprofit organization dedicated to improving access to comprehensive health care and insurance coverage for adolescents. Since 2013, with Dr. White, she has overseen project management for Got Transition, a program of The National Alliance. Ms. McManus has over 35 years of experience directing national, state, and private foundation projects on child and adolescent health. These projects have addressed health care transition, youth with special health care needs, health care financing, insurance coverage and benefits, mental/behavioral health workforce, and preventive care. Ms. McManus has a Masters in Health Sciences from the Johns Hopkins Bloomberg School of Public Health.

PATIENCE WHITE, MD, MA, FAAP, MACP, *Co-Project Director Got Transitions*

Dr. Patience White is an adult and pediatric rheumatologist who for over 30 years has been involved in transition issues for children with special health care needs. With Ms. McManus, she is responsible for overall project management for Got Transition and provides technical assistance to health plans, Title V agencies, pediatric and adult primary and specialty care practices and professional societies, and health professional training programs. Over her career, she has been active in academic medicine, clinical care, research, public health and advocacy and is the lead author of the 2018 AAP/AAFP/ACP Clinical Report, “Supporting HCT from Adolescence to Adulthood in the Medical Home”. Dr. White completed a doctor of medicine degree from Harvard Medical School, a Robert Wood Johnson Health Policy fellowship in the US Senate, and a master’s in Education from George Washington University Graduate School of Education and Human Development.

ANNIE SCHMIDT, MPH, *Health Research/Policy Analyst Got Transitions*

Annie Schmidt is responsible for assisting with research and policy analysis related to adolescent health and the development of transition payment options. Ms. Schmidt has been the lead staff person on a number of transition efforts related to Medicaid managed care, value-based payment, a new family transition toolkit, and a clinician toolkit for incorporating transition into adolescent and young adult preventive care. She received her master’s degree in Public Health from the University of North Carolina-Chapel Hill.

Health Care Transition Process Improvement: Pediatric to Adult Transition

May 19, 2021

Patience White, MD, MA, FAAP, MACP
Peggy McManus, MHS
Got Transition
The National Alliance to Advance Adolescent Health
Washington DC

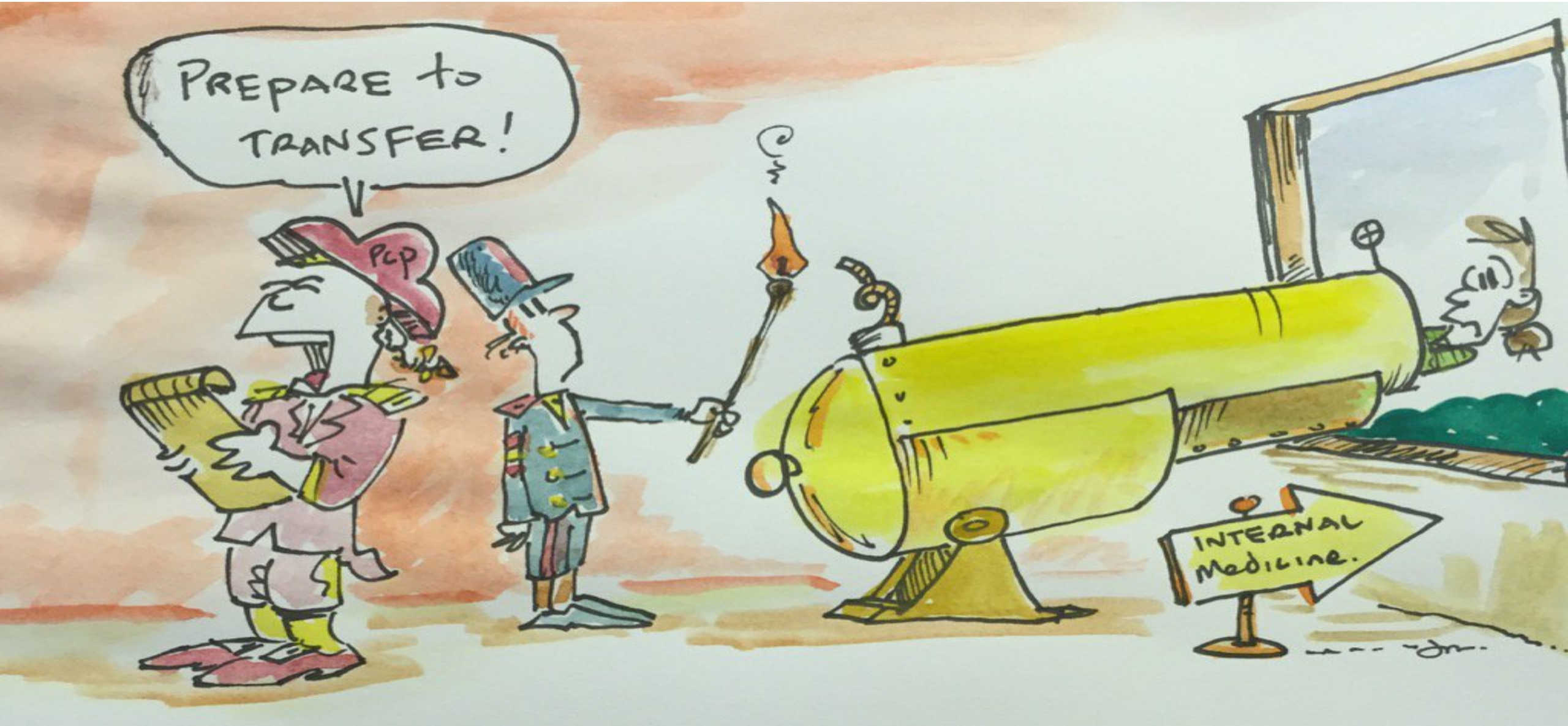
Disclosures

Patience White and Peggy McManus have no disclosures for this presentation.

Got Transition is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) (U1TMC31756). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Presentation Objectives

1. To understand the current context of health care transition (HCT) outcome evidence and the AAP/AAFP/ACP recommended structured HCT intervention
2. Describe key lessons learned from implementing HCT performance improvement program in primary, subspecialty, and children's hospital settings
3. Review new tools and resources available through updated www.gottransition.org


PREPARE to TRANSFER!
PCP
INTERNAL Medicine.

Receipt of Transition Planning Guidance from Health Care Providers (HCPs)

National Survey of Children's Health, 2018-2019*

- 22.9% of youth with special health care needs (YSHCN) received transition planning guidance from HCPs.
- 16.9% of youth without special needs received transition planning guidance HCPs.
- National Performance Measure on Transition is based on whether:
  1. doctor spoke with child privately without an adult in the room during last preventive check-up;
  2. if a discussion about transitioning to adult care was needed it must have happened; and
  3. doctors actively worked with child to gain skills and understand changes in their health care.

***Data source:** Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 12/07/20 from www.childhealthdata.org.*

Outcome Evidence for a Structured Transition Process

Systematic reviews of HCT evaluation studies between 1995-2016* and May 2016-Dec 2018** show that with a *structured* transition process, statistically significant positive outcomes for YSHCN include:

- **Population health:** adherence to care, self-care skills, quality of life, self-reported health
- **Experience of care:** increased satisfaction, reduction in barriers to care
- **Utilization:** decrease in time between last pediatric and 1st adult visit, increase in adult visits, decrease hospital admissions and length of stay
- Note: no evaluation studies on clinician experience or cost-effectiveness of HCT had been published at the time of these systematic reviews

Sources:

**Gabriel et al., Outcome evidence for structured pediatric to adult health care transition interventions: A systematic review. Journal of Pediatrics. 2017;188:263-269.*

***Schmidt, A., Ilango, S., McManus, M., Rogers, K., & White, P. (2019). Outcomes of Pediatric to Adult Health Care Transition Interventions: An Updated Systematic Review. J. Pediatr Nurs 2020: 51: 92-107.*

Pediatric to Adult Health Care Transition Definition

- **Definition:** Health care transition is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician
- **Transition Goals for Youth/Young Adults and Clinicians:**
  - To improve the ability of youth and YAs to manage their own health and effectively use health services
  - To have an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care
- Reaffirms that TRANSITION ≠ TRANSFER or PLANNING alone
- TRANSITION = planning, transfer and integration into adult care

Medical Professional Societies' Guidance

- 2011 joint AAP/AAFP/ACP Report Clinical Report (CR) on HCT*
- AAP/AAFP/ACP updated CR in **2018** with guidance on evidence informed processes**
- Both CRs target all youth, beginning at age 12
- Algorithmic structure with emphasis on planning:
  - Branching for YSHCN
  - Application to primary and specialty practices
- Extends through transfer of care to adult medical home and adult specialists
- **Recommendations: Focus on all three aspects of transition: planning, transfer and integration into adult care using a QI approach utilizing the Six Core Elements**

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)*

***White PH, Cooley WC, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. Pediatrics. 2018; 142:85-104.*

Six Core Elements of HCT Approach

- The Six Core Elements is not a model of care, but a process (road map/clinical pathway) called for in the AAP/AAFP/ACP Clinical Report recommendations
- Tested in quality improvement (QI) learning collaboratives (LC) using the Institute for Healthcare Improvement breakthrough QI research approach
- Customizable for busy practices with different models of care
- Intensity of intervention can be guided by: medical complexity of youth/YAs, social determinants of health, ACEs and availability of practice resources
- Applied in many different systems/models of care: primary* and subspecialty clinics*, Medicaid managed care*, prof org.*, state title V agencies care coordination services*, children's hospitals*, FQHCs, SBHCs, behavioral health settings. All have incorporated the Six Core Element Process and improved their HCT processes.

*Published articles available at www.GotTransition.org

There are three sets of customizable tools available for different practice settings.

Click below for information and samples of each core element and full Six Core Elements packages.

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN

For use by Pediatric, Family Medicine, and Med-Peds Clinicians

Click for details on each element.

Six Core Elements Package

Six Core Elements Package En Español

Full Implementation Guide

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS

For use by Family Medicine and Med-Peds Clinicians

Click for details on each element.

Six Core Elements Package

Six Core Elements Package En Español

Full Implementation Guide

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE

For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians

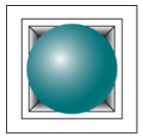
Click for details on each element.

Six Core Elements Package

Six Core Elements Package En Español

Full Implementation Guide

Click here to request a customizable version of any tools.



The National Alliance To Advance Adolescent Health

got transition

SIX CORE ELEMENTS™ APPROACH AND TIMELINE FOR YOUTH TRANSITIONING FROM PEDIATRIC TO ADULT HEALTH CARE

Summary of Six Core Elements of Transition Approach

*Roles for Pediatric and Adult Practices**

Practice/ Provider	#1 Transition Policy	#2 Tracking and Monitoring	#3 Transition Readiness/ Orientation to Adult Practice	#4 Transition Planning/ Integration into Adult Care	#5 Transfer of Care/Initial Visit	#6 Transition Completion/ Ongoing Care
Pediatric*	Create and discuss with youth/family	Track progress of youth/family readiness for transition	Transition readiness assessment (RA)	Develop transition plan including needed RA skills	Transfer of care with information and communication to adult clinician	Obtain feedback on the transition process
Adult*	Create and discuss with young adult (YA)/ guardian, if needed	Track progress to increase YA's knowledge of health and adult health care system	Share/discuss Welcome and FAQs letter with YA and guardian, if needed	Update transition plan with additional skills required	Communication with pediatric clinician/ Agree on content of the 1-2 initial adult visits/Self-care assessment	Ongoing care/referrals, as needed, with continued self-care skill building

**Providers that care for youth/young adults throughout the life span would complete both sets of core elements without the transfer process*

Transitioning Youth to an Adult Health Care Clinician

Core Element 1 - Transition and Care Policy/Guide

Purpose

Formalize practice's approach, reduce clinician variability, offer a transparent approach to patients and their circle of support (families, caregivers and friends)

Content

- ✓ Define practice approach regarding recommended time to start transition, supports offered around HCT youth and family planning, transfer and information on new clinician choice, roles of the clinicians in transfer and post transfer (P)
- ✓ Clarify adult approach to care and legal changes at age 18
- ✓ Reading level and language should be appropriate for the pratice's population

Importance

- ✓ Builds consensus around practice's plan to assist Y/YA, transparency for youth/caregivers
- ✓ Everyone understands what is expected in an adult clinician's office including confidentiality and consent

Transitioning Youth to an Adult Health Care Clinician

Core Element 2 - Tracking and Monitoring

Purpose

Facilitate systematic data collection to improve quality at individual and population levels

Content

- ✓ Demographic and diagnostic/complexity data/social determinants of health/ACEs-this can be used to risk stratify level of youth/family needs for support
- ✓ Date of receipt of each core element (e.g., policy shared, transition readiness assessments administered)

Format

- ✓ Paper checklist, Excel spreadsheet, EHR, RedCap Survey

Transitioning Youth to an Adult Health Care Clinician

Core Element 3 - Transition Readiness

Purpose

Assess the patient's skills to manage their health and effectively use health care (especially in the new practice setting)

Content

- ✓ Assesses self-care skills related to own health and using health care services
- ✓ Several tools available, some disease specific
- ✓ Got Transition readiness assessment tool has both youth and parental assessments available and includes motivational interviewing questions:
  - Ranks importance of managing their own health
  - Ranks confidence about ability to manage their own health and the new system

Use

- ✓ Completed several times during the preparation process
- ✓ Used as a **discussion tool** to plan skill-building education
- ✓ Does **not predict** transition success
- ✓ Customized to meet the needs of the practice's population

Integrating Young Adults into Adult Health Care

Core Element 3 – Orientation to Adult Practice

Purpose

To engage young adults moving from pediatrics to practices caring for adults

Content

- ✓ Identify adult providers within practices interested in caring for YAs and YAs with SHCN
  - ✓ Establish a process within the practice to welcome and orient new YAs to the practice
  - ✓ **Develop welcome and orientation materials for the practice with FAQs**
    - **How can YA contact the practice for questions?**
    - **Can they access their medical information?**
    - **What are the missed appointment/cancelation policies?**
  - ✓ Share both the practice policy and welcome letter with pediatric practices for distribution to their transitioning YAs
  - ✓ Share before the joint telehealth visit

Transitioning Youth to an Adult Health Care Clinician

Core Element 4 - Transition Planning

Purpose

Establish agreement between youth/family/caregiver and clinicians about set of actions to address priorities and access to current medical information

Content

- ✓ Identify what matters most to the youth beyond health goals
- ✓ Define how learning about health and health care supports patient's overall goals (add assessment skill needs to the plan)
- ✓ **Complete portable medical summary and emergency care plan with "special information"** – non-medical or specifics on how to make office visit easier- for adolescent/young adult (AYA) and the next clinical team, consider adding photo

Integrating Young Adults into Adult Health Care

Core Element 4 – Integration Into Adult Practice

Purpose

To obtain the YA's medical and other information and communicate with the prior clinician

Content

✓ Prior to first visit ask the pediatric practice for a transfer package with:

1. A complete portable medical summary and emergency care plan with "special information" (non medical) about the new YA – if not available, create this with the YA

2. Decision making documents for youth with IDD (if needed):
   - Review supported decision making plan
   - Review the YA's unique communication needs

✓ Review the key next steps in plan of care that need to be attended to in the first visit (This can be covered in a joint telehealth visit)

Transitioning Youth to an Adult Health Care Clinician

Core Element 5 – Transfer of Care

Purpose

Ensure completion and sharing of transfer package with new provider and support engagement of the patient with a new team

Content / Transfer Checklist

- ✓ Transfer *letter*
- ✓ Medical summary and emergency care plan: key medical and non medical info, including latest RA
- ✓ *Communicate directly* with the new clinician(s), use of telemedicine with joint telehealth visit-see example from Got Transition
- ✓ *Clarify roles* of each provider going forward and clearly communicate the plan to the youth/family/caregiver (e.g. different roles of PCP and subspecialists in adult medicine)
- ✓ *Transfer* when chronic disease is *stable* and *stagger transitions* if many clinicians involved
- ✓ Transfer to PCP medical home first

Integrating Young Adults into Adult Health Care

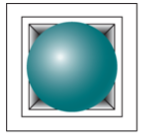
Core Element 5 – Initial 1-2 visits at Adult Practice

Purpose

Ensure completion and sharing of transfer package with new provider and support engagement of the patient with a new adult clinician/ team

Content

- ✓ Consider pre-visit call/text/nurse visit to welcome YA to the practice (this can be accomplished in a joint telehealth visit)
- ✓ Agreement on topics to be covered in first 1-2 visits among the adult clinicians seeing YA in the practice
- ✓ Review, update, and share medical summary and emergency care plan
- ✓ Review transition readiness assessment and/or administer self-care assessment to address unmet self-care skill needs
- ✓ Review and update plan of care, if needed



Transitioning Youth to an Adult Health Care Clinician

Core Element 6 – Transfer Completion

Purpose

- ✓ Confirms the beginning of care by the new clinician, starting of the new role of referring clinician and clarity of both clinicians'/teams' roles

Content:

- ✓ Communicate with new practice confirming completion of transfer (patient came to appointment with all the needed information)
- ✓ Confirm roles going forward of the referring and accepting clinicians (Pediatric specialists as a consultants as needed, adult PCP and adult specialist roles)
- ✓ **Obtain young adult and pediatric provider feedback anonymously after last referring clinician visit**
  - Customizable HCT feedback surveys available at GotTransition.org

Integrating Young Adults into Adult Health Care

Core Element 6 – Transfer Completion/Ongoing Care

Purpose

To close the loop on the "warm handoff"; communication to ensure a smooth transfer of care; complete skill building to manage health/health care

Content

- ✓ Confirm transfer completion with pediatric clinician
- ✓ Complete self-care assessments
- ✓ Offer/refer to self-care skill building education, as needed
- ✓ Ask for consultation with pediatric provider, as needed
- ✓ Assist YA to connect with adult specialists or primary care or other support services, as needed
- ✓ Elicit **feedback** from YAs about their transition and assess experience with adult care

Current Assessment of Health Care Transition Activities

for Transitioning Youth to an Adult Health Care Clinician

Instructions: Each of the Six Core Elements, Youth/Young Adult and Parent/Caregiver Feedback, and Youth/Young Adult and Parent/Caregiver Leadership sections should be scored as Level 1, 2, 3, or 4. To be scored at a certain level, all of the criteria must be met. (No partial scores.)

Measurement Option:
Current Assessment of HCT Activities

TRANSITION AND CARE POLICY/GUIDE				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Score**
Clinicians vary in their approach to HCT, including the age of transfer to adult clinicians.	Clinicians follow a uniform but not a written transition and care policy/guide about the age of transfer to adult clinicians.	The practice has a written transition and care policy/guide.	The practice has a written transition and care policy/guide.	_____ (out of 4)
		The transition and care policy/guide includes privacy and consent information, a description of the practice's approach to HCT, and age of transfer.	The transition and care policy/guide includes privacy and consent information, a description of the practice's approach to HCT, and age of transfer.	
		Clinicians sometimes discuss/share the transition and care policy/guide with youth and parents/caregivers.	Clinicians consistently discuss/share the transition and care policy/guide with youth and parents/caregivers, beginning at ages 12 to 14.	
		The transition and care policy/guide is familiar to some staff.	The transition and care policy/guide is publicly displayed and familiar to all staff.	
			The transition and care policy/guide was developed with input from youth and parents/caregivers.	

TRACKING AND MONITORING				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Score**
Clinicians vary in their process of identifying transition-aged youth, but most wait until close to the age of transfer to identify them.	Clinicians follow a uniform process to identify transition-aged youth.	The practice has an individual transition flow sheet or registry for identifying and tracking transition-aged youth, or a subgroup of youth with chronic conditions, close to the time of transfer.	The practice has an individual transition flow sheet or registry for identifying and tracking transition-aged youth, or a subgroup of youth with chronic conditions, starting between the ages of 12 and 14.	_____ (out of 4)
	Clinicians use youths' medical records to document relevant HCT information (e.g., discussed transition, future clinician name).	The practice tracks youths' receipt of some but not all of the Six Core Elements.	The practice tracks youths' receipt of all of the Six Core Elements.	

HCT - health care transition, Y/YA - youth/young adult

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Measurement Option:
HCT Feedback Surveys

- Two survey options available:
  - Clinicians
  - Youth/young adults and parents/guardians
- Clinician survey adapted from the Medical Home Feedback Survey
  - Example questions:
    - "In Your Practice" section offers 4 answer choices that range from "strongly disagree" to "strongly agree" or "don't know"
    - Open response question asks, "Do you have any ideas to better implement HCT into the clinic process?"

Sample Health Care Transition Feedback Survey for Clinicians

This survey can be completed individually or by a group of clinicians/care team members. This survey allows a more robust look at your practice's culture/style and health care transition (HCT) processes.

IN YOUR PRACTICE *Please check the answer that best applies now.*	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	DON'T KNOW
Our practice takes time to consider ways to improve the HCT process.	☐	☐	☐	☐	☐
Our practice encourages everyone (front office and clinical staff) to share ideas about their role in the HCT process.	☐	☐	☐	☐	☐
Our practice has successfully gained senior leadership buy-in for our HCT quality improvement effort.	☐	☐	☐	☐	☐
Our practice leadership makes sure that we have the time and resources to plan for and implement changes to improve the HCT process.	☐	☐	☐	☐	☐
Our practice has incorporated a structured HCT process into our workflow.	☐	☐	☐	☐	☐
Front office and clinical staff operate as a team to implement the HCT process.	☐	☐	☐	☐	☐
Youth/Young adults and parents/caregivers are valued partners in our HCT planning and quality improvement efforts.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice improves safety and quality of care.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice improves youth/young adult and parent/caregiver experience.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice improves clinician experience.	☐	☐	☐	☐	☐
The HCT process we are currently using works for our practice.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice saves time for our clinicians.	☐	☐	☐	☐	☐
Our practice has been successful in obtaining payment for HCT services.	☐	☐	☐	☐	☐
Our practice has been successful in modifying our electronic medical records to incorporate HCT.	☐	☐	☐	☐	☐

Do you have any ideas to better implement HCT into the clinic process?

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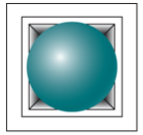
Measurement Option:

Youth/parent/caregiver feedback survey

- Includes summary questions on the Youth/Young Adult Feedback survey:
  - How ready did you feel to move to an adult doctor or other health care provider?
  - Answer: Very, Somewhat, Not at all
  - Do you have any ideas for your past doctor or other health care provider about making the move to an adult health care easier?



The National Alliance To Advance Adolescent Health

Sample Health Care Transition Feedback Survey for Youth/Young Adults

This is a survey about what it was like for you to move from pediatric to adult health care. Your answers will help us improve our health care transition process. Your name will not be linked to your answers.

DID YOUR PAST DOCTOR OR OTHER HEALTH CARE PROVIDER... *Please check the answer that best fits at this time.*	YES	NO
Explain the transition process in a way that you could understand?	☐	☐
Give you guidance about the age you would need to move to a new adult doctor or other health care provider?	☐	☐
Give you a chance to speak with them alone during visits?	☐	☐
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	☐	☐
Help you gain skills to manage your own health and health care (e.g., understanding current health needs, knowing what to do in a medical emergency, taking medicines)?	☐	☐
Help you make a plan to meet your transition and health goals?	☐	☐
Create and share your medical summary with you?	☐	☐
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	☐	☐
Advise you to keep your emergency contact and medical information with you at all times (e.g., in your phone or wallet)?	☐	☐
Help you find a new adult doctor or other health care provider to move to?	☐	☐
Talk to you about the need to have health insurance as you become an adult?	☐	☐

Overall, how ready did you feel to move to an adult doctor or other health care provider?

☐ Very ☐ Somewhat ☐ Not at all

Do you have any ideas for your past doctor or other health care provider about making the move to adult health care easier?

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Six Core Elements of Health Care Transition™

IMPLEMENTING THE SIX CORE ELEMENTS

These Implementation Guides are intended to help clinicians/practices/systems carry out and support health care transition (HCT) improvements using the Six Core Elements of HCT 3.0 for their patients transitioning to adult-centered care with or without changing their clinician. Each guide below contains practical guidance, resources, and examples for conducting HCT quality improvement (QI) in a range of health care settings, using the Model for Improvement as its framework. Each guide contains specific QI considerations, tools, and measures for each core element.

How to Implement the Six Core Element of Health Care Transition includes steps that a health care delivery system or individual practice can consider when utilizing a QI process to implement for the Six Core Elements.

For additional information about the QI framework and methods described in the Implementation Guides, please refer to the ***Quality Improvement Primer***.

How to Implement the Six Core Elements of Health Care Transition™ 3.0

A practical step-by-step supplement to the Six Core Elements

Organized into nine steps that a health care delivery system or individual practice can consider when implementing a quality improvement (QI) process for health care transition (HCT)

- Step 1: Secure Senior Leadership Support
- Step 2: Form the HCT Quality Improvement Team
- Step 3: Develop an HCT Improvement Plan
- Step 4: Raise Awareness about HCT Activities

Step 5: Implement the Six Core Elements of HCT
Step 6: Plan for Sustainability
Step 7: Plan for Spread
Step 8: Communicate Successes
Step 9: Tips for Success

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN

For use by Pediatric, Family Medicine, and Med-Peds Clinicians

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Transition Readiness
Guide | Examples

Transition Planning
Guide | Examples

Transfer of Care
Guide | Examples

Transfer Completion
Guide | Examples

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS

For use by Family Medicine and Med-Peds Clinicians

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Transition Readiness
Guide | Examples

Transition Planning
Guide | Examples

Transition to Adult Approach to Care
Guide | Examples

Ongoing Care
Guide | Examples

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE

For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Orientation to Adult Practice
Guide | Examples

Integration into Adult Practice
Guide | Examples

Initial Visits
Guide | Examples

Ongoing Care
Guide | Examples

Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Transitioning Youth to an Adult Health Care Clinician

Core Element 1 - Transition and Care Policy/Guide

I. Purpose, Objectives, and Considerations

II. Quality Improvement Considerations, Tools, and Measurement

III. Sample Transition and Care Policies/Guides

IV. Additional Resources

Considerations: Sample Questions

Content

What should be included in the transition and care policy/guide?

- At what age will your practice start the HCT planning process?
- When are youth expected to leave your practice?
- What will your practice offer youth and parents/caregivers to assist them in transition—e.g., a readiness assessment, plan of care that includes transition, medical summary, transfer package?
- What will your practice do to prepare youth for changes in privacy and consent that happen at age 18?

Process

What is the process to develop the transition and care policy/guide?

- Does it describe the practice's approach to transition, including privacy and consent information?
- Is the reading level appropriate for your youth and parents/caregivers?

What is the process to implement the transition and care policy/guide?

- Whose job is it to share and discuss the HCT policy/guide with the youth and parent/caregiver?
- Whose job is it to ask if the youth and parent/caregiver have any questions?
- Create a written document to describe the clinic approach to implement the process outlined above.
- Educate all team members/staff about the process.

Quality Improvement Tools Customized to Each Core Element in each of the three Packages

The most important QI tools to guide a team's improvement work include Tools 1-5 listed*:

- Tool 1: An aim statement
- Tool 2: Key driver diagrams
- Tool 3: Process flow maps
- Tool 4: The simplified failure mode and effects analysis
- Tool 5: Plan-Do-Study-Act (PDSA) cycles

*For more information and examples, see Tools for Improvement in the QI Primer.

Sample Transition and Care Policies/Guides

As you develop your transition policy, you should strive for a 6th grade reading level using common words with a concise message, plenty of white space, and an easily readable format.

Please see the QI Primer for in depth information about health literacy, including strategies for implementation, which are crucial to creating a transition policy that will be understandable and usable for youth, young adults, and their families/caregivers.

- Sample Transition and Care Policies/Guides from the Six Core Elements of HCT
- Sample Transition and Care Policies/Guides at Different Reading Levels
- Sample Transition and Care Policies/Guides in Different Clinical Settings
- Sample Transition and Care Policies/Guides for Youth with Specific Conditions
- Sample Transition and Care Policies/Guides in Video Format

QI Primer: Using Quality Improvement to Improve the Health Care Transition Process

A companion piece to use with the Six Core Elements of Health Care Transition™

Intended to help practices understand quality improvement (QI) and apply it to their work

Gives breakdown of Quality Improvement's:

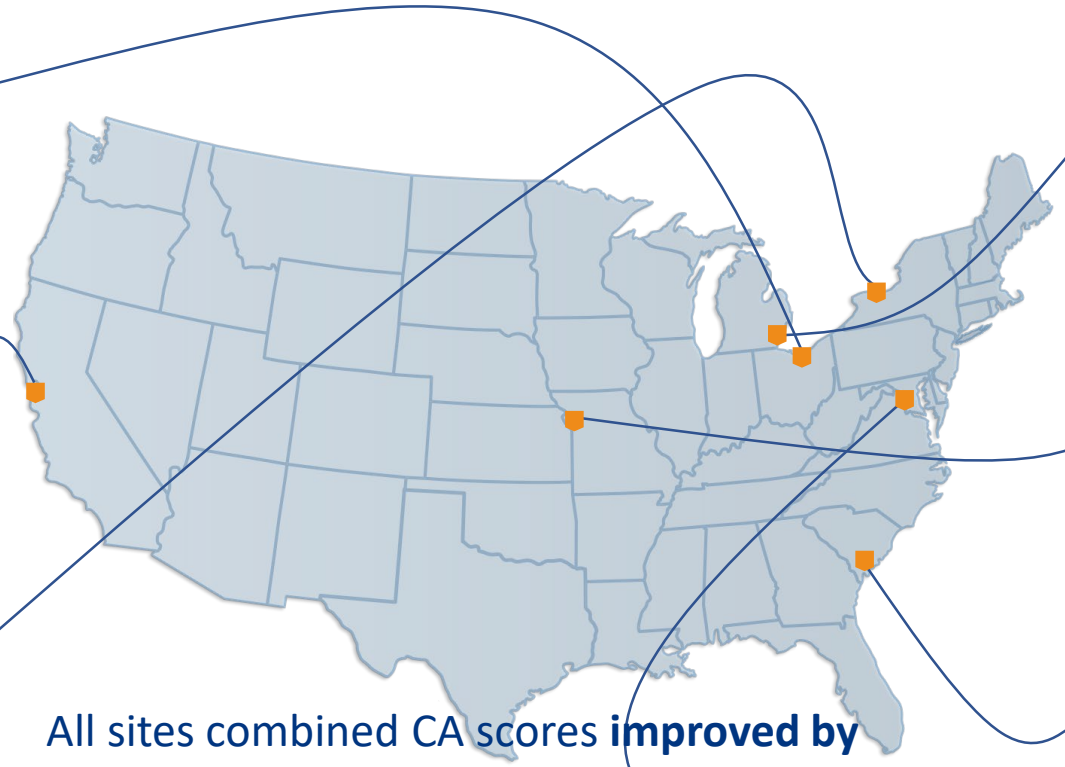
- History
- Relationship to research
- Benefit to health care teams and patients

I. What is Quality Improvement?
II. Selecting Improvement Projects
III. Successful Teams
IV. The Model for Improvement
V. Measuring for Improvement
VI. Tools for Improvement
VII. Sustaining Improvement
VIII. Spreading Improvement
IX. Health Literacy
X. Co-Production
XI. Resources and References

Example of a 7 System HCT Improvement Project

Learning Network (LN) Health Systems QI Research:
Current Assessment of HCT Activity at 18mo*

Clinic Sites & Site Leadership



1 Cleveland Clinic

Sites: 1 pediatric, 1 adult primary care
Leader: Pediatric Nurse Practitioner

2 Henry Ford Health System

Sites: 2 pediatric, 2 adult primary care
Leader: Pediatric Physician

3 Children's Mercy Kansas City

Sites: 2 pediatric primary care, 31 pediatric subspecialty clinics
Leader: Masters Level Social Worker

4 Medical University of South Carolina

Sites: 3 pediatric subspecialty clinics
Leader: Med-Peds Physician

5 Ravenswood Family Health Center (FQHC)

Sites: 1 pediatric, 1 family practice primary care
Leader: Pediatric Nurse Practitioner

6 University of Rochester

Sites: 5 pediatric subspecialty, 3 adult subspecialty, 1 pediatric primary care, 1 adult primary care
Leader: Med-Peds Physician

7 Walter Reed National Military Medical Center

Sites: 1 pediatric subspecialty clinic
Leader: Pediatric Nurse Practitioner & Physician

All sites combined CA scores **improved by 37.1%**, moving from baseline scores of 12.4 and after 12-18 months of HCT QI interventions, increased to 17.0, $p<0.01$

*Jones et. al, J Ped Nursing 2019

Lessons Learned from Primary, Specialty, and Managed Care QI Work

- ✓ **Feasible** to customize and implement Six Core Elements process in primary, specialty and managed care
- ✓ **Buy-in** of both adult and pediatric practices from the beginning is key to a successful HCT process
- ✓ **Getting started**:
  - Meld HCT work with larger system strategic plan-engage system leadership to get it started
  - Identify QI team: all needed players from both teams including patients and caregivers
  - Start with assessment and a pilot-"Choose your pilot projects wisely, the rest of the system/practice is watching". Try not to transition the most complex first until the process and roles are clear
- ✓ Outline **evaluation** (process and outcome) strategies upfront
  - Plan the QI process (clear aims statements) so everyone is on board and knows what "success looks like", use PDSA cycles and other QI tools (see www.gottransition.org) to learn what works
- ✓ Policies and assessments come far easier than trust and implementation
- ✓ Do not get lost in customizing the EMR
- ✓ HCT Progress is "rewarding and sustainable"
- ✓ A variety of care transition/transfer models evolved depending on the availability of adult subspecialty care for rare pediatric onset conditions

Additional www.Gottransition.org Resources

READY TO TRANSITION TO ADULT CARE?

Transitioning to adult health care is a big step for a youth or young adult. Like going to college, getting a job, or going to live on your own, health care transition takes preparation and self-advocacy.

TAKE THE QUIZ

HEALTH CARE TRANSITION FAQ

Got Transition offers answers and helpful resources for Frequently Asked Questions you may have about your transition to adult health care.

CHECK OUT THE FAQ

TOP RESOURCES

Click into any resource or view all Youth & Family resources here.

Planning to Move from Pediatric to Adult Care? Here's How They Can Differ

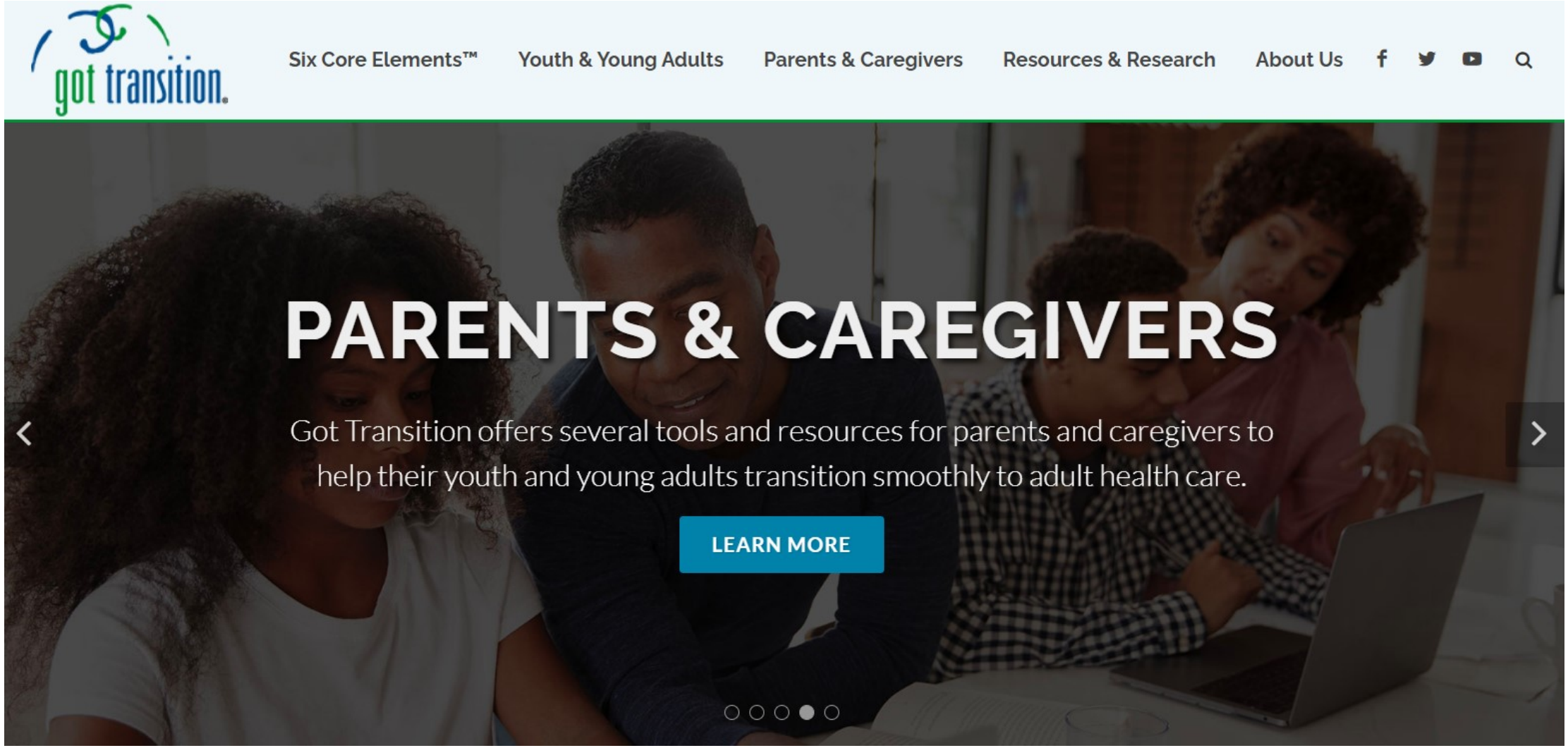
Sample Transition Readiness Assessment for Youth [En Español]

5 Steps to Prepare for Health Care Transition

A Family Toolkit: Pediatric-to-Adult Health Care Transition

Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones [En Español]

Turning 18: What it Means for Your Health [En Español]

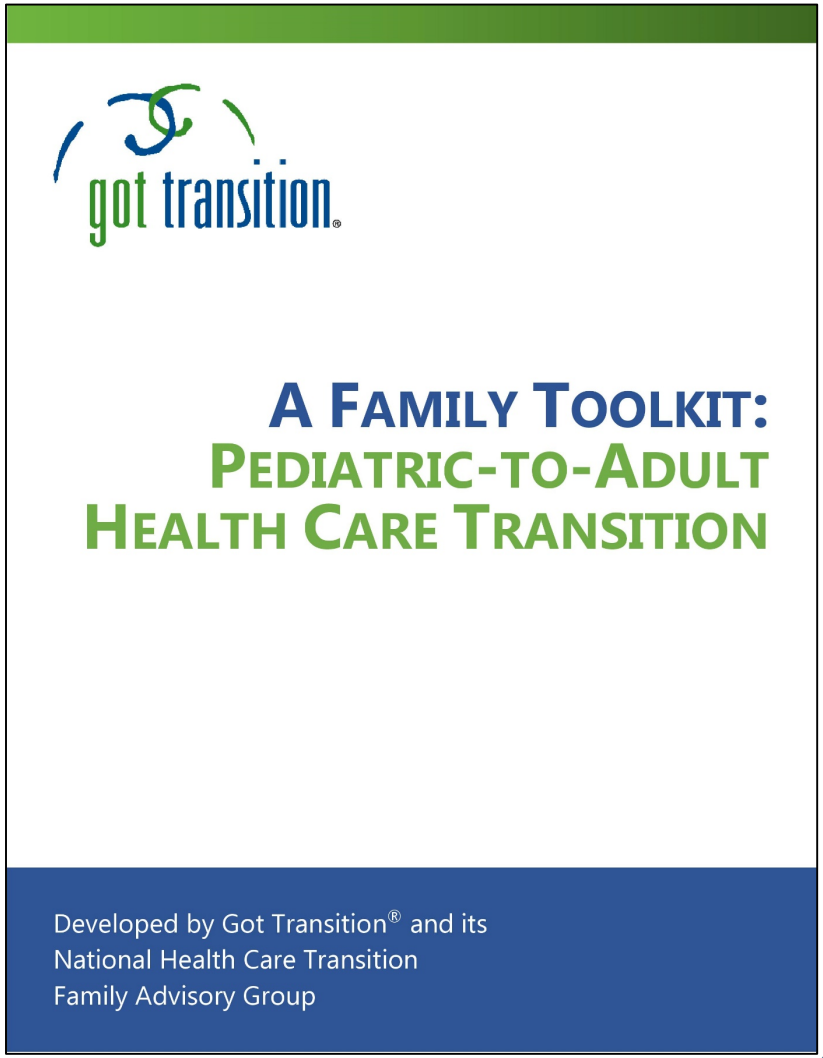

got transition.
Six Core Elements™
Youth & Young Adults
Parents & Caregivers
Resources & Research
About Us
PARENTS & CAREGIVERS
Got Transition offers several tools and resources for parents and caregivers to help their youth and young adults transition smoothly to adult health care.
LEARN MORE

Got Transition's New Family HCT Toolkit

Got Transition and its National Family HCT Advisory Group have developed a new Family HCT Toolkit to help families throughout the transition process.

Parent/Caregiver advisory group members represent:

- ASK Family Services
- Autism Society of America
- Family Voices
- Genetic Alliance
- Institute for Patient and Family-Centered Care
- Jack and Jill of America
- National Down Syndrome Congress
- National Family Association for Deaf-Blind
- Sickle Cell Disease Association of America
- SPAN Parent Advocacy Network



Family Tool Kit: What's Included?

- The Family HCT Toolkit includes a set of 10 HCT resources to help youth and parents/caregivers throughout the transition from pediatric to adult health care.
- The resources help to answer questions families may have about transition.
  - *When should my child and I start to think and talk about transition?*
  - *What are the recommended HCT services?*
  - *What questions can my child and I ask our doctor about transitioning to adult care?*
  - *How does my role and my child's role change throughout the transition process?*
  - *How can I learn if my child needs help with decision-making?*
  - *What are some of the legal changes in health care that happen at age 18?*
  - *What are the differences between pediatric and adult care?*
  - *How ready is my child to transition to adult care and manage their own health and health care?*

Resources & Research

Health care transition is the process of moving from a child/family-centered model of care to an adult/patient-centered model of care. The sections below include links to national resource centers and transition-related resources selected based on their relevance to a national audience.

Click on each section for resources related to the topic.

Additional www.gottration.org Resources

- Integrating Young Adults With Intellectual and Developmental Disabilities Into Your Practice: Tips for Adult Health Care Clinicians: https://www.gottransition.org/resource/?tips-integrating-idd-into-practice
- Readiness assessment for youth with IDD and caregivers and medical summary template: https://www.acponline.org/system/files/documents/clinical_information/high_value_care/clinician_resources/pediatric_adult_care_transitions/gim_dd/idd_transitions_tools.pdf
- 2021 Coding and Reimbursement Tip Sheet with clinical vignettes: https://www.gottransition.org/resource/?2021-coding-tip-sheet
- Incorporating Health Care Transition Services into Preventive Care for Adolescents and Young Adults: a Toolkit for clinicians: https://www.gottransition.org/resource/?clinician-toolkit-preventive-care

Got Transitions 6 Core Elements – Side by side

Presentation Objectives

1. To understand the current context of health care transition (HCT) outcome evidence and the AAP/AAFP/ACP recommended structured HCT intervention
2. Describe key lessons learned from implementing HCT performance improvement program in primary, subspecialty, and children's hospital settings
3. Review new tools and resources available through updated www.gottransition.org

Thank You and Questions

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HealthCareTransition

@GotTransition2

Visit www.GotTransition.org

Healthcare Transfer of Care QI Objectives

- Pediatric and adult team ***partners will work together*** to improve transition of care for youth as they transition from pediatric to adult care.
- Teams will be asked to ***test the transfer of care concept*** on a small sample of identified “transfer of care” young adults. The first 4 months will be “start-up” with customization of content and process followed by an 8-month pilot period for the 4-5 transferring patients, including a final pediatric visit, a joint communication telehealth visit with pediatric and adult primary care providers and transferring patient, and an initial adult visit.
- Teams will apply selected Core Elements from Got Transition’s approach, using the performance improvement process, and ***develop and implement a more intentional and structured approach to the transfer of care process.***

Up Next:

Patient-family Presentation

Baseline survey results

Pediatric	Average (Range of 1-4)	Adult	Average (Range of 1-4)
Transition and Care Policy / Guide	1.0 (1-1)	Transition and Care Policy / Guide	1 (1-1)
Tracking and Monitoring	1.3 (1-2)	Tracking and Monitoring	1.5 (1-2)
Transition Readiness	2.3 (2-3)	Orientation to Adult Practice	2.5 (2-3)
Transition Planning	2.3 (2-3)	Integration into Adult Practice	2.5 (2-3)
Transfer of Care	2.0 (2-2)	Initial Visits	2.5 (2-3)
Transfer Completion	1.7 (1-2)	Ongoing Care	2.5 (2-3)
Youth/Young Adult & Parent/Caregiver Feedback	1.7 (1-2)	Young Adult Feedback	2 (2-2)
Youth/Young Adult & Parent/Caregiver Leadership	1.3 (1-2)	Young Adult Leadership	1.5 (1-2)

Pediatric Current Assessment of Health Care Transition Activities
Adult/Family Current Assessment of Health Care Transition Activities

Not all Assessments have been received, yet

Timeline

Pediatric Timeline at a glance		Adult Timeline at a glance
Start-Up Phase (months 1-4)	**Process Deliverables/ Workflows:** Practice meets monthly with PF during months 1, 2 and 3; Adult and pediatric team meets with PF during month 4;	**Process Deliverables/ Workflows:** Practice meets monthly with PF during months 1, 2 and 3; Adult and pediatric team meets with PF during month 4;
Month 1: May 19 – May 31, 2021	Pediatric/Adult practices connected, QI team completes Got Transitions HCT assessment, monthly meetings scheduled	Pediatric/Adult practices connected, QI team completes Got Transitions HCT assessment, monthly meetings with QI team and facilitator scheduled
Month 2: June 2021	Transition planning - customize tools and process **Pediatric**: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation; **Adult**: plan for tracking of patients;	Transition planning - customize tools and process **Adult**: plan for tracking of patients; **Pediatric**: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation;
Month 3: July 2021	Customize transfer/receive tools	Customize transfer/receive tools
Month 4: August 2021	Customize transfer completion process; PDSA cycles on Core Elements 4, 5, 6	Customize transfer completion process; customize process for initial visit; PDSA cycles on Core Elements 3,4,5
Pilot Phase (months 5-12)	**Putting it in place** : team meets with PF monthly, Peer Learning Meeting month 5	**Putting it in place :** team meets with PF monthly**,** Peer Learning Mtg. month 5
Month 5: September 2021	Start to test HCT Transfer Pilot with 5 Pediatric Patients (Mo.5-7)	**Pediatric**: Start to test HCT Transfer Pilot with 5 Pediatric Patients (Months 5-7) **Adult**: receive and review transfer packet
Month 6: October 2021	Joint Communication/Telehealth Call for Each Transferring Patient (Mo. 6-8)	Joint Communication/Telehealth Call for Each Transferring Patient (Months 6-8)
Month 7: November 2021	" "	" "
Month 8: December 2021	" "	" "
Month 8: December 2021	**Adult**: Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey (Mo. 8-11)	Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey (Months 8-11)
Month 9: January 2022	" "	" "
Month 10: February 2022	" "	" "
Month 11: March 2022	" "	" "
	Wrapping it up : Peer Learning Collaborative Meeting	**Wrapping it up:** Peer Learning Collaborative Meeting
Month 12: April 2022	Complete assessment of HCT activities, analyzed pre/post improvement, plan for sustainability and spread	Complete assessment of HCT activities, share/discuss pre/post improvement, plan for sustainability and spread

Milestone Document Pediatric & Adult

Pediatric and Adult Transfer of Care QI Milestone Summaries

Pediatric and Adult Transfer of Care Work Plans

Stay Safe and Healthy

Rhode Island Resources

- Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care
- Healthcare Transition Resources - Navigation Checklist for RI Individuals with Developmental Disabilities, developed by RIPIN
- Shared Decision-Making