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Transition To Adulthood

Sarah Mennito, MD, MSCR
Medical University of South Carolina
Professor, Departments of Pediatrics and Internal Medicine
Program Director, MUSC Med-Peds Residency

Disclosures

- I have no financial disclosures

Objectives

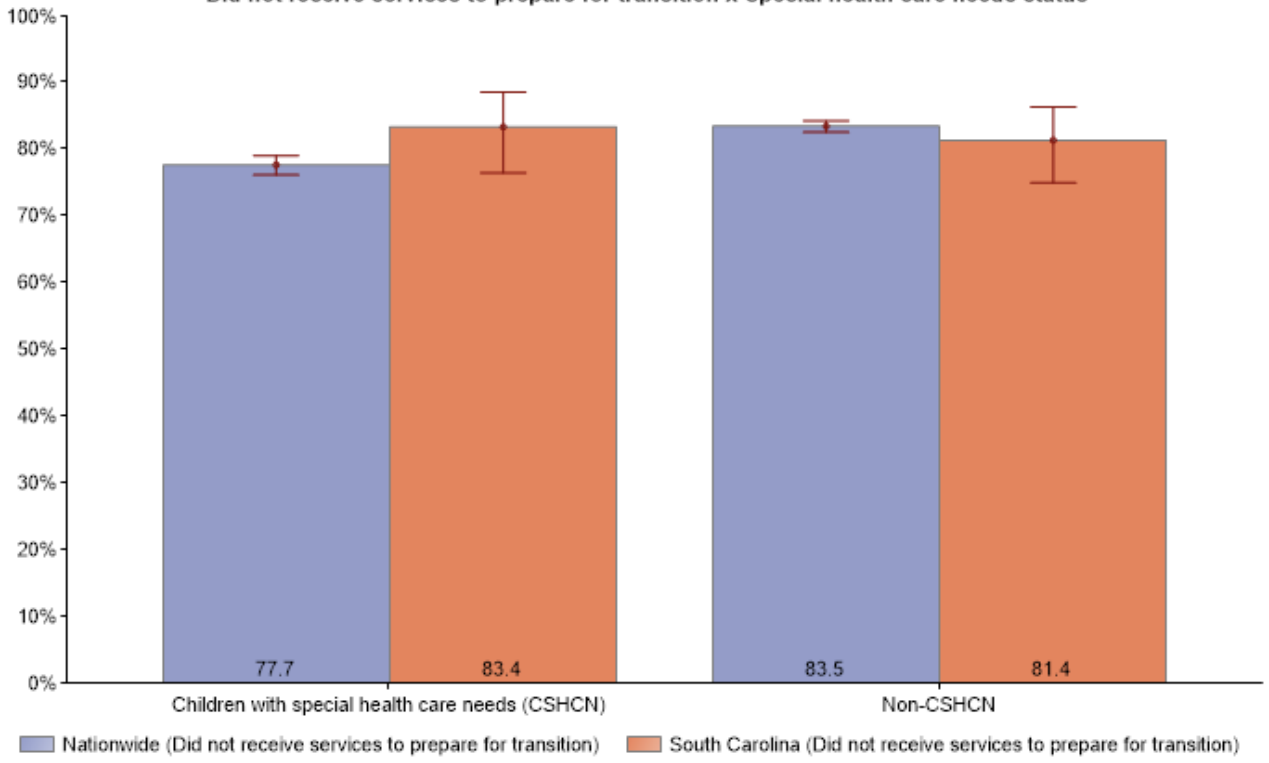
- Describe the Got Transition 6 Core Elements
- Perform process measurement of current transition activities
- Identify areas for implementation of transition activities
- Utilize available resources for implementation

Youth received necessary services for transition to adult health care

Youth age 12-17 years

Nationwide vs. South Carolina

Did not receive services to prepare for transition x Special health care needs status



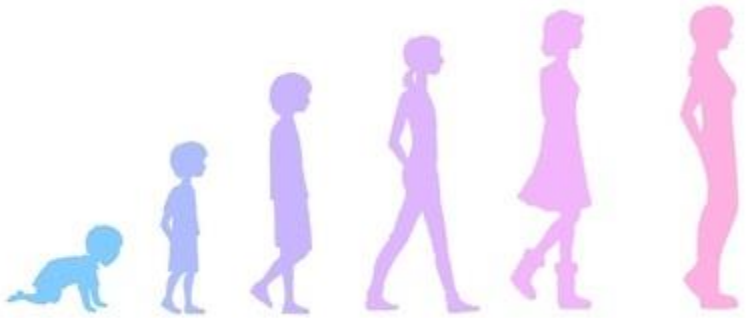
Data Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.hrsa.gov/data/national-surveys

Citation: Child and Adolescent Health Measurement Initiative. 2022-2023 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 [mm/dd/yy] from [www.childhealthdata.org].

What is Health Care Transition?

- "The process of moving from a child/family-centered model of health care to an adult/patient-centered model of health care, with or without transferring to a new clinician."

- Three stages
  - Transition
  - Transfer
  - Integration



Cooley WC et al. *Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home.* Pediatrics 128 (2011) 182-203.
Maddux et al. *Preparing Patients for Transfer of Care: Practices of Primary Care Pediatricians.* J of Community Health 40(4) (2015) 750-755

got transition®

Got Transition 6 Core Elements

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

Full Implementation Guide En Español

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

Full Implementation Guide En Español

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

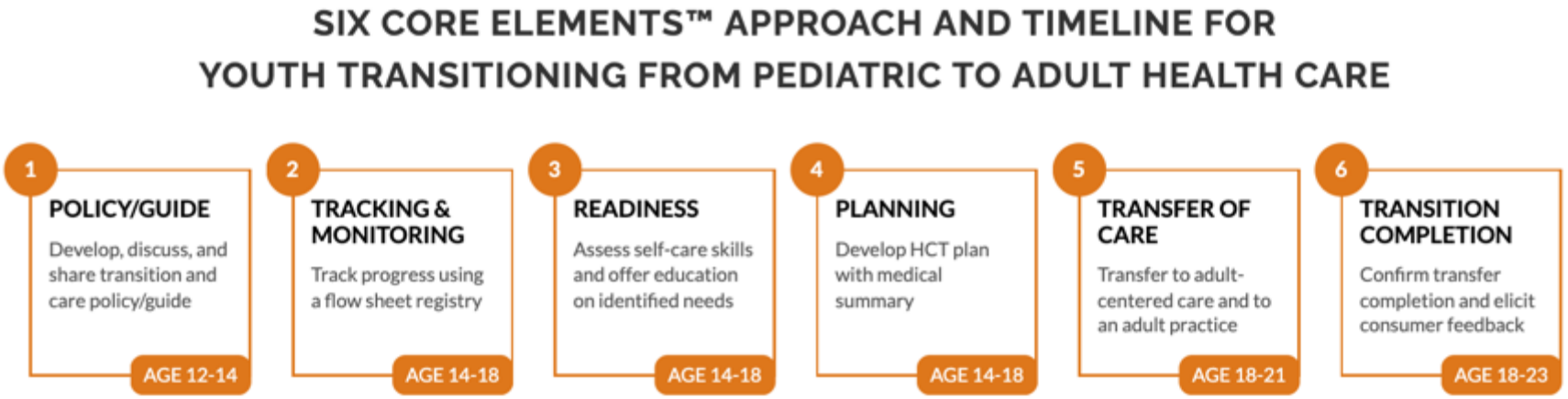
Six Core Elements Package En Español

Full Implementation Guide

Full Implementation Guide En Español

Download your free customizable Six Core Elements tools HERE!

Transition Timeline



Cooley WC et al. *Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home*. Pediatrics 128 (2011) 182-203.

1. Transition Policy

- Describe practice's approach to transition
  - Privacy and consent
  - Explicitly state age at which youth shift from pediatric to adult model of care

Examples of Process

1. Mail the transition and care policy/guide to all 12 to 14-year-olds and their parents/caregivers annually.
2. Have the front desk hand out the transition and care policy/guide when all 12 to 14-year-olds and their parents/caregivers check in for their appointment, or when they are waiting in the exam room at their annual preventive visit.
3. Display the transition and care policy/guide on the practice website and on the patient portal or make it a poster to be displayed in the clinic.
4. Include the transition and care policy/guide as part of the after-visit summary in the electronic medical record (EMR).
5. Discuss your practice's approach to transition during a lunch and learn or during a staff meeting.

Sample Transition and Care Policy/Guide

[Pediatric Practice Name] cares about you.

We will help you move smoothly from pediatric to adult health care. This means working with you, starting at ages 12 to 14, and your parent/caregiver to prepare for the change from a pediatric model of care to an adult model of care. A pediatric model of care is where parents/caregivers make most choices. An adult model of care is where you will make your own choices. We will spend time during visits without your parent/caregiver in the room to help you set health goals and take control of your own health care.

By law, you are an adult at age 18. We will only discuss your health information with others if you agree. Some young adults choose to still involve their parents/caregivers or others in their health care choices. To allow your doctor to share information with them, consent is required. We have these forms at our practice. For young adults who have a condition that limits them from making health care choices, our office will share with parents/caregivers options for how to support decision-making. For young adults who are not able to consent, we will need a legal document that describes the person's decision-making needs.

We will work with you to decide the age for moving to an adult doctor. We suggest that this move take place before age 22. Our office policy is to prepare you to move to an adult doctor. This includes helping you find an adult doctor, sending medical records, and talking about any special needs with the adult doctor. We will help you find community resources and specialty care, if needed.

Your health matters to us. As always, if you have any questions, please feel free to contact us.

2. Transition Tracking and Monitoring

- Establish criteria and process for identifying transitioning youth and create registry
  - Practice assessment and improvement

- Utilize flow sheet to track individual transition progress

Transition Registry

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Sample Transition Registry

A transition registry can be used to track and monitor youth throughout the pediatric-to-adult health care transition period. This sample registry can be customized as needed. A registry can be on paper, an Excel spreadsheet (see below), or — if possible — integrated into the electronic medical record.

Name	DOB	Appt	Age	Primary Diagnosis	HCT Policy/ Guide Shared with Y/YA/ Parent/ Caregiver	HCT Readiness Assessment Conducted	HCT Readiness Education/ Counseling Provided	HCT Plan of Care Shared with Y/YA/ Parent/ Caregiver	Medical Summary and Emergency Care Plan Shared with Y/YA/Parent/ Caregiver	Age 18 Privacy and Consent Changes Discussed	Supported Decision-Making Discussed (If Needed)	Adult Clinician Selected	Adult Clinician Contacted	Transfer Package Sent to Adult Clinician	Feedback About HCT from Y/YA/ Parent/ Caregiver	First Appt with Adult Clinician	Initial Adult Appt Attended
(Instructions)		(Date or Blank)	(At Time of Appt)		(Yes or Blank)	(Date or Blank)	(Date or Blank)	(Date or Blank)	(Date or Blank)	(Date or Blank)	(Date or Blank)	(Yes or Blank)	(Date or Blank)	(Date or Blank)	(Yes or Blank)	(Date or Blank)	(Date or Blank)
Mary Smith	03/04/03	06/01/20	17 Y	Asthma	Yes	06/01/20	06/01/20	06/01/20	06/01/20	06/01/20		Yes	06/15/20	06/15/20	Yes	04/01/21	
Mary Smith	03/04/03	04/01/19	16 Y	Asthma	Yes		04/01/19	04/01/19	04/01/19								
Mary Smith	03/04/03	04/01/18	15 Y	Asthma	Yes		04/01/18	04/01/18									
Taye Davis	01/17/01	01/10/20	19 Y	Epilepsy	Yes	01/10/20	01/10/20	01/10/20	01/10/20	01/10/20	01/10/20	Yes	01/21/20	01/21/20	Yes	06/07/20	
Taye Davis	01/17/01	01/21/19	18 Y	Epilepsy						01/21/19							
Sasha Jones	02/14/01	03/01/20	19 Y	Autism	Yes	03/01/20	03/01/20	03/01/20	03/01/20	03/01/20	03/01/20	Yes	03/24/20	03/24/20	Yes		
Sasha Jones	02/14/01	03/01/19	18 Y	Autism													
Sasha Jones	02/14/01	04/01/18	17 Y	Autism													
Sasha Jones	02/14/01	03/01/17	16 Y	Autism													
Jesus Garcia	11/03/05	12/01/20	15 Y	Diabetes	Yes	12/01/20	12/01/20	12/01/20	12/01/20								

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

3. Transition Readiness

- Conduct regular transition readiness assessments
  - Begin at age 14

- Jointly develop goals and actions with youth and caregiver

Transition Readiness Assessment

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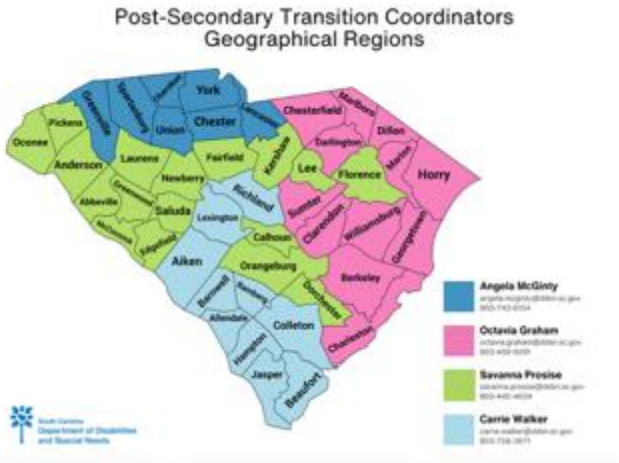
Sample Transition Readiness Assessment for Youth

Transition Readiness Assessment Questionnaire (TRAQ)

4. Transition Planning

- Update medical summary/ emergency plan
- Prepare patient/family for adult approach to care
- Legal considerations
- Work through health knowledge goals
- Consent for release of information
- Identify adult provider(s)
- Provide resources



Family Connection SOUTH CAROLINA

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PLANNING

Develop HCT plan with medical summary

AGE 14-18

Transition Planning

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Sample Plan of Care

This sample plan of care is created jointly with youth and their parent/caregiver to set goals and outline a plan of action that combines health and personal goals. Information from the transition readiness assessment can be used to develop goals. The plan of care should be updated often and sent to the new adult clinician as part of the transfer package.

Preferred name	*Legal name*	*Date of birth*
Primary diagnosis	*Secondary diagnosis*	

WHAT MATTERS MOST TO YOU AS YOU BECOME AN ADULT? HOW CAN LEARNING MORE ABOUT YOUR HEALTH NEEDS AND LEARNING HOW TO USE HEALTH CARE SUPPORT YOUR GOALS?

Youth's Prioritized Goals	Transition Issues or Concerns	Actions	Person Responsible	Target Date	Date Completed

Clinician/Care staff name	*Date plan created/Updated*
Clinician/Care staff contact information	*Clinician/Care staff signature*
Youth signature	*Parent/Caregiver signature*

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5. Transfer of Care

- Confirm date of first adult provider appointment
- Provide direct communication with adult provider
- Complete and send transfer packet
- Plan for continued responsibility of care until first adult appointment

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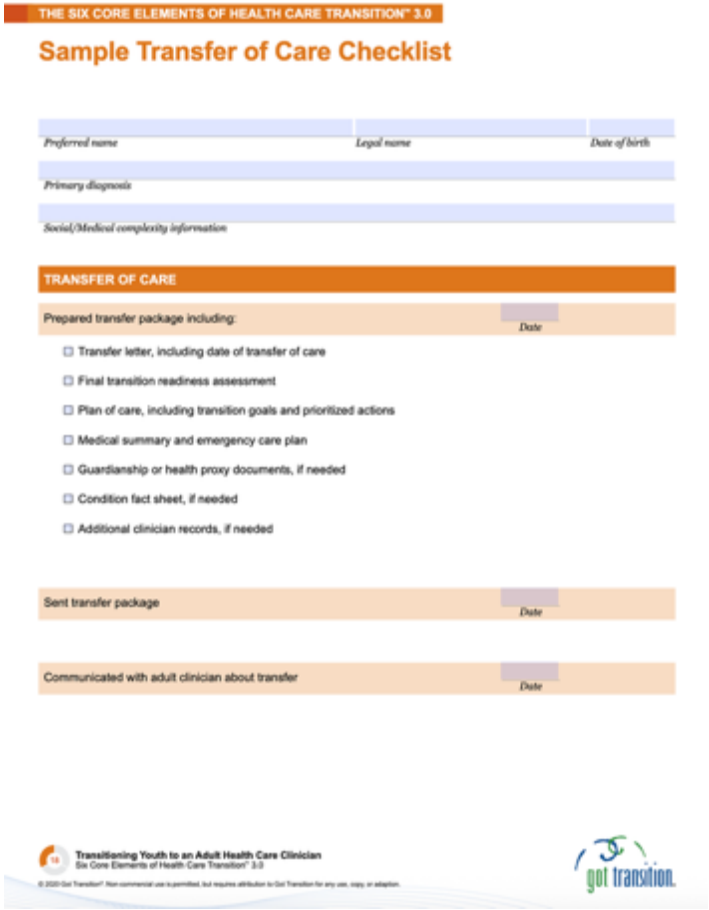
TRANSFER OF CARE

Transfer to adult-centered care and to an adult practice

AGE 18-21

Transfer of Care



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Sample Transfer of Care Checklist

Preferred name | *Legal name* | *Date of birth*

Primary diagnosis

Social/Medical complexity information

TRANSFER OF CARE

Prepared transfer package including: *Date*

- ☐ Transfer letter, including date of transfer of care
- ☐ Final transition readiness assessment
- ☐ Plan of care, including transition goals and prioritized actions
- ☐ Medical summary and emergency care plan
- ☐ Guardianship or health proxy documents, if needed
- ☐ Condition fact sheet, if needed
- ☐ Additional clinician records, if needed

Sent transfer package *Date*

Communicated with adult clinician about transfer *Date*

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Sample Transfer Letter

[Date]

Dear [Adult Clinician Name],

[Name] is a(n) [age] year-old patient of our pediatric practice who will be transferring to your care. Their primary chronic condition is [condition], and their secondary conditions are [conditions]. [Name's] related medications and specialists are outlined in the enclosed transfer package that includes their medical summary and emergency care plan, plan of care, and final transition readiness assessment. [Name] acts as their own guardian and is currently insured under [insurance plan].

The needed next steps in [Name's] plan of care are _____. [Name] would like you to know the following non-medical information about them: _____.

I have had [Name] as a patient since [age] and am very familiar with their health condition, medical history, and specialists. Our practice will provide care for them, such as refilling medications, until they come to the first visit in your practice. Please send us a note or call when [Name] has attended their first appointment in your practice. I would be happy to provide any consultation assistance to you during the initial phases of [Name's] transition to your practice. Please do not hesitate to contact me by phone or email if you have any questions.

Thank you very much for your willingness to care for [Name].

Sincerely,

Pediatric Clinician Name

Email *Phone*

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6. Transfer Completion

ACP American College of Physicians®
Leading Internal Medicine, Improving Lives

Pediatric to Adult Care Transitions Initiative

This American College of Physicians (ACP) Initiative is a collaborative effort to develop a toolkit to facilitate more effective transition and transfer of young adults from pediatric to adult care, with a major focus on providing a framework for the adult care clinicians.

- Confirm transfer with patient/family
- Elicit feedback
- Offer consultation to adult provider
- Build partnerships with adult primary and specialty care providers

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TRANSITION COMPLETION

Confirm transfer completion and elicit consumer feedback

AGE 18-23

Transition Outcomes

- Continuity of care
  - Engagement in adult care
  - Retention in adult care
- Triple Aim
  - Population health, patient experience, costs of care
- Better outcomes with more components in place

Rachas A et al. *Evaluating Continuity During Transfer to Adult Care: A Systematic Review.* Pediatrics 138(1) (2016) e20160256.
Gabriel P et al. *Outcome Evidence for Structured Pediatric to Adult Health Care Transition Interventions: A Systematic Review.* J Pediatr 188 (2017) 263-9.
Schmidt A et al. *Outcomes of Pediatric to Adult Health Care Transition Interventions: An Updated Systematic Review.* Journal of Pediatric Nursing 51 (2020) 92-107.

Got Transition Process Measurement Tool

THE SIX CORE ELEMENTS OF HEALTH CARE TRANSITION™ 3.0

Health Care Transition Process Measurement Tool

for Transitioning Youth to an Adult Health Care Clinician

Instructions: Each of the Six Core Elements, as well as Youth/Young Adult and Parent/Caregiver Engagement, can be scored according to whether some or all of the implementation steps have been completed. For example, developing and publicly displaying a written transition and care policy/guide has a possible score of 5; that is, if this step is completed with the appropriate documentation listed below (Yes), a practice or system would receive a score of 5. If it is not completed (No), the score is 0. (No partial scores.)

IMPLEMENTATION REQUIREMENT		SCORE
1. Transition and Care Policy/Guide	**Documentation**	**Yes = 5 / No = 0**
Developed a written transition and care policy/guide that describes the practice's approach to health care transition (HCT) and displayed it publicly (e.g., waiting room, practice website)	Copy/screenshot of transition and care policy/guide; photo of public display	
Included information in transition and care policy/guide about privacy and consent at age 18 and age of transfer	Copy/screenshot of transition and care policy/guide	
Obtained and incorporated input from youth and parents/caregivers into transition and care policy/guide	Number of youth and parent/caregiver reviewers	
Established a clinic process to discuss/share the transition and care policy/guide with youth and parents/caregivers	Description of clinic process	
Educated staff about transition and care policy/guide and their roles in the HCT process	Date(s) of education; educational content	
	Transition and Care Policy/Guide Subtotal	*(out of 25)*
2. Tracking and Monitoring	**Documentation**	**Yes = 5 / No = 0**
Established criteria and implemented a clinic process for identifying transition-aged youth	Description of population and clinic process	
Developed individual transition flow sheet or registry to track youths' receipt of all of the Six Core Elements	Flow sheet or registry template	
	Tracking and Monitoring Subtotal	*(out of 10)*

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Health Care Transition Process Measurement Tool *(Continued)*

Instructions: The practice/system can be scored according to the percentage of youth that receive each of the Six Core Elements. Possible scores range from 1-5.* If a practice/system starts with a subset of youth with special needs, they would likely be reaching 20% or less of eligible patients for a score of 1 point. If they are implementing the Six Core Elements for all eligible youth with and without chronic conditions, they would score at the maximum level of 5 points. (No partial scores.)

PERCENT OF TRANSITION-AGED PATIENTS RECEIVING SIX CORE ELEMENTS	SCORE 1 to 5
1. Transition and Care Policy/Guide Sharing transition and care policy/guide with youth and parents/caregivers beginning at ages 12-14 (letter or visit)	
2. Tracking and Monitoring Tracking youth beginning at ages 12-14 with an individual transition flow sheet or registry	
3. Transition Readiness Administering transition readiness assessments periodically to youth beginning at ages 14-16	
4. Transition Planning Regularly updating and sharing medical summary and emergency care plan and plan of care with readiness assessment findings, goals, and prioritized actions	
5. Transfer of Care Preparing and sending a transfer package for youth/young adults leaving their practice	
6. Transfer Completion Eliciting feedback from youth/young adults who have transferred to adult care about HCT supports received	
Communicating with adult clinicians to confirm transfer and offer, if needed, consultation	
TOTAL DISSEMINATION SCORE	*(out of 35)*

*SCORING KEY

SCORE	1	2	3	4	5
Percent of transition-aged patients receiving Six Core Elements	(1-20%)	(21-40%)	(41-60%)	(61-80%)	(81-100%)

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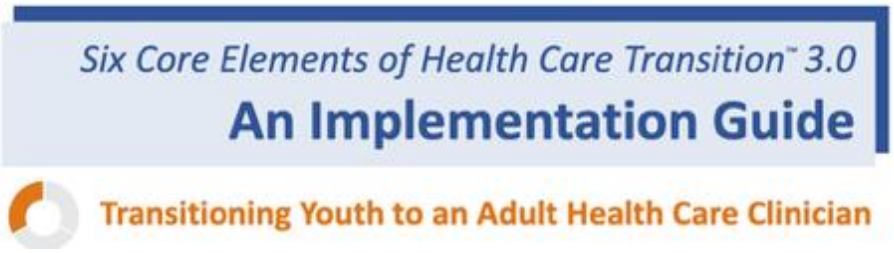
Implementation



Helping Patients Plan the Transition from Pediatric to Adult-Based Care

Texas Children's Hospital®

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Transition Billing and Coding

PAYMENT FOR TRANSITION SERVICES

Payment for health care transition (HCT) services is a major issue for clinicians who are providing HCT services to their patients. There are several payment approaches described below that can be used to assist health care clinicians in implementing recommended pediatric-to-adult HCT services, including fee-for-service coding and reimbursement options and value-based payment options.

New in 2023:

- A new ICD-10 diagnosis code has been added for pediatric-to-adult transition counseling: Z71.87 (encounter for pediatric-to-adult transition counseling). Report code Z71.87 when pediatric-to-adult transition counseling is provided as the sole reason for an encounter or in addition to other services (e.g., management of a chronic condition). Code Z71.87 may be the first-listed or a secondary diagnosis code depending on the circumstances of the encounter. Any applicable codes for chronic conditions that support the need for pediatric-to-adult transition counseling should be reported in addition to code Z71.87. Evaluation and management of the chronic conditions is not required at the encounter.

Questions?

5 First Steps

1. Talk to adolescents alone
2. Mention transition to an adult provider starting at age 14y (if complex), 16-17y if healthy
3. Educate all office staff on goals for transition
4. Establish relationships with adult PCPs in your area
5. Reach out to “graduated” patients/families for feedback