And the little one said, move over, move over….
On My Way Transitional Care Pilot

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When Transition Is Ineffective…
Objectives

• Define the Six Core Elements of Transition
• Identify coding/billing opportunities and supportive documentation needed for transition encounters.
• Explain ways to increase understanding and familiarity of EHR tools which were created for pediatric providers transitioning patients from their practice.
Transitioning Youth to An Adult Health Care Provider
Six Core Elements of Health Care Transition 2.0

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

Position Statement
Position Statement

- Cleveland Clinic is committed to helping our younger patients make a smooth transition from pediatric to adult health care services. As your child grows older, Cleveland Clinic Children’s will help your family prepare for the change from a pediatric model of care—where you make health care decisions for your child—to an adult model of care, where your child will make his or her own decisions. We work with families and children as young as 12 years old. We learn more about our pediatric patients by spending time during the visit without the parent or guardian present. In this way, we can help the adolescent set health priorities and begin to take responsibility for his or her own health care.

- At age 18, adolescents legally become adults. We understand and respect that many of these young adults want to involve their families in health care decisions. However, by law, we need the patient’s consent in order to discuss personal health information with family members. If the youth has a condition that prevents him or her from making health care decisions, we will work with parents/caregivers to determine how they can help their children make these decisions.

- We will work with your family to decide when your child will move to adult health care services. We recommend age 22. We will help with this transfer process by identifying caregivers, communicating with the new care team about the needs of the patient, and sharing the electronic medical record.

- As always, if you have any questions or concerns, please feel free to contact us.
Ideas for spread
Element 2

Tracking and Monitoring
Tracking
Additional tracking options

• Adding transition to problem list in EHR – comment section can be used for goals/issues to address at next visit
• Excel spreadsheet, or office record if EHR not available
Element 3
Readiness Assessment
Transition Readiness Assessments
PED Transition Youth
Additional Transition Tools

- **TRxANSITION Index™**
  - 10-domain, 32-item questionnaire measuring transition readiness
  - Validated tool
  - **Measures**
    - Type of chronic health condition
    - Rx/Medications
    - Adherence
    - Nutrition
    - Self-management skills
    - Issues of reproduction
    - Trade/school
    - Insurance
    - Ongoing support
    - New health care providers
Additional Transition Tools

• STARx Questionnaire
  – Overall transition readiness
    • 3 Subdomains
      • Communication with medical provider
      • Disease knowledge
      • Self-Management
  – 3 Versions
    • Patients in Pediatric settings
    • Patients in Adult-focused settings
    • Parent version
Additional Transition Tools

- Transition Readiness Assessment Questionnaire (TRAQ)
  - 20 items, 5 domains
    - Managing medications
    - Appointment keeping
    - Tracking health issues
    - Talking with providers
    - Managing daily activities
Element 4
Transition Planning
Transition Plan

Sample Plan of Care
Six Core Elements of Health Care Transition 2.0

Instructions: The sample plan of care is a written document developed jointly with the transition team to establish priorities and a course of action that integrates health and personal care. It is the product of a process that includes a comprehensive patient assessment, a shared decision-making approach, and a focus on achieving optimal health outcomes. This plan is intended to guide the development of a transition plan. The plan of care should be reviewed and updated regularly and be sent to the adult provider of care at the time of the transition. The final transition assessment, written consent, and the transition care plan are legal documents.

Name: [Redacted]
Date of Birth: [Redacted]
Primary Diagnosis: [Redacted]
Secondary Diagnosis: [Redacted]

What matters most to you as you become an adult? How can I learn more about your condition and how I can help you support your goals?

Potential Goals: [Redacted]

Nurse Concerns: [Redacted]
Actions: [Redacted]
Person Responsible: [Redacted]
Target Date: [Redacted]
Data Capture: [Redacted]

Initial State of Plan: [Redacted]
Last Update: [Redacted]
Parent/Carer Signature: [Redacted]

Clinician Signature: [Redacted]
Care Staff Contact: [Redacted]
Care Staff Phone: [Redacted]

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Sample Condition Fact Sheet
Six Core Elements of Health Care Transition 2.0

Symptoms of Sickle Cells for Health Care Professionals

- Sickle cells in the sickle cell trait (heterozygous) are primarily found in blood vessels and tissues throughout the body.
- They can cause pain, fatigue, and organ damage, especially in the liver, spleen, and kidneys.
- In sickle cell anemia, the sickle cells block blood flow, leading to pain episodes called vaso-occlusive crises.
- In aplastic crisis, the bone marrow stops producing new blood cells, leading to fatigue, weakness, and bruising.
- In hemolytic crisis, the sickle cells break down rapidly, leading to anemia and jaundice.
- In transfusion complications, the sickle cells can block the circulation of blood and form clots.
- In infection, the sickle cells can cause sepsis and other infections.
- In organ failure, the sickle cells can cause damage to the organs, leading to organ dysfunction.

Caution: Sickle cells can cause pain, fatigue, and organ damage, especially in the liver, spleen, and kidneys. They can cause pain episodes called vaso-occlusive crises.

Reference: [Redacted]

Sickle cell crisis occurs when the sickle cells become more rigid and less flexible, leading to the blocking of blood vessels. This can cause pain, fatigue, and organ damage. Additionally, sickle cells can cause anemia, which can lead to fatigue and weakness. They can also cause organ damage, leading to organ failure. Treatment for sickle cell crisis includes pain medication, oxygen therapy, and blood transfusions.
Models of Care Transfer
Pediatric diseases where there are both pediatric and adult subspecialty providers available (e.g. pediatric rheumatology)
Element 5

Transfer of Care
EMR Transition Documentation Tools
Complex Medical Summary Letter
Transfer Documents

Sample Transfer of Care Checklist
Six Core Elements of Health Care Transition 2.0

- Patient Name: ___________________________
- Date of Birth: __________________________
- Primary Diagnosis: _______________________
- Transition Complexity: ___________________
- Prepared transfer package including:
  - Transfer letter, including effective date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including transition goals and pending actions
  - Updated medical record and emergency care plan
  - Quarterly or health care documents, if needed
  - Condition fact sheet, if needed
  - Additional provider records, if needed
- Sent transfer package: _____________________
- Communicated with adult provider about transfer: ____________

Sample Transfer Letter
Six Core Elements of Health Care Transition 2.0

Dear [Adult Provider],

[Name] is an [age]-year-old patient of our pediatric practice who will be transferring to your care on [date] this year. [Name] has a primary diagnosis of [condition], and [Name] has [secondary condition(s)] [condition(s)]. [Name] had medications and specialists outlined in the enclosed transfer package that includes [details of medication and plans].

I have had [name] as a patient since [date] and am very familiar with [Name's] health condition, medical history, and specialists. I would be happy to provide any consultation assistance to you during the initial phase of [name's] transition to adult health care. Please do not hesitate to contact me by phone or email if you have any further questions.

Thank you very much for your willingness to assume the care of this young [name].

Sincerely,
Transfer Completion
Transition Feedback Survey
Example
Vignette

- 14 yo female presents for WCC
- No chronic conditions
- Vaccines up to date
- Presents to office with mother
Vignette

MD/APN performs the following:

- Update problem list and medical history
- Complete PE
- Provide Anticipatory Guidance and risk factor reduction counseling
- Teen and mother separately complete a score able Transition Readiness Assessment form
- MD/APN reviews scale and discusses a few youth specific self-care skill needs as identified by youth and parent and documents same in note
• Examples of self-care skill needs to discuss:
  - Before a visit, I think about what questions to ask
  - I can provide my medical information to healthcare staff
  - I know what I am allergic to
Documentation and Coding Tips

- Health Risk Assessments (96160/96161)
- Used to evaluate the young adults’ understanding of their own health and how to effectively use health care
- Can be used for new and established patients, with and without chronic conditions
- Performed at age 14 and up and results will be visible in chronologic format under the flowsheet tab
- Documentation should include:
  - Interpretation of the rating scale
  - Discussion of results of the scale with the patient/caregiver
  - Notation of any consults or referrals made as a result of findings

“Transition readiness assessment completed by Patient and/or Parent/Caregiver. Results interpreted and discussed with Patient and/or Parent/Caregiver by myself. Results can be found in the PED Transition Readiness Flowsheet.”
Resource for documenting and coding transition services
Cleveland Clinic Transition Pilots

Pilot 1
Patient Population
• Typical pediatric practice at regional family health center

• Providers
  • 3 General Pediatricians
  • 1 Nurse Practitioner

Pilot 2
Patient Population
• Typical pediatric practice at main campus of tertiary care hospital
  • Children with medical complexity
  • Adolescent Medicine
  • Eating disorders

• Providers
  • 5 General Pediatricians
  • 1 Nurse Practitioner (Complex Care)
  • 2 Adolescent Specialists
Pilot 2 Outcomes
Percentage of Gen Peds Patients ≥ 18 Yrs.
2017 & 2018

[Graph showing percentage of Gen Peds patients ≥ 18 yrs. for 2017 and 2018, with a goal line at 11%.]
Pilot 2 Outcomes
Completion of Elements 1, 2 and 3
Lessons Learned

Pilot 1
• If **all** providers are not engaged/committed, the project is likely to fail
• 1 MA was responsible for identifying potential patients for transition vs entire office staff
• Support from upper level management is critical- motivation to change cannot rely on individual choice alone

Pilot 2
• All providers were informed of pilot at staff meeting by Section Head
• Formal education was provided to entire medical staff at staff meeting
• Root cause analysis and process mapping were employed prior to initiation of pilot.
• 3 PDSA cycles were performed during the 12 week pilot
Sustainability Plan

• Transition Position Statement – ensure consistent message across all providers and locations for age of transition
• EHR tools – user friendly
• Expectation for all providers to adhere to same practice
• Wish list
  – Automatic “pop up” alert that triggers for every child ≥ 18 yrs of age
  – Registry of transitioning patients embedded in EMR to enhance identifying transitioning youth and where they are in process
Sustainability Plan

- Dissemination and posting of position statement across all practice sites
- Inclusion of transition position statement in all after visit summaries/well templates starting at age 14 yrs.
- Uniformity of Readiness Assessment tool across all practice sites
- Addition of Transition to Problem List by all providers by age 17 yrs
- Transition best practice alerts
References

• Got Transition
  – https://www.gottransition.org/

• Recommendations for Value-based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report, Sept 2018
  – https://static1.squarespace.com/static/5871c0e9db29d687bc4726f2/t/5bb676f515fcc077b763f6b18/1538684662430/Valu__Based+Payment+for+Health+Care+Transition+Report+FINAL+10.4.18.pdf

• 2019 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care

• American College of Physicians - Pediatric to Adult Care Transitions Initiative
  – https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/pediatric-to-adult-care-transitions-initiative

• UNC STARx Program
  – https://www.med.unc.edu/transition/