Slide 1

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

Carrie Cuomo, DNP, CPNP
Julie Corder, RN, MSN, PNP- BC

Slide 2

When Transition Is Ineffective…

Slide 3

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.

Slide 4

Transitioning Youth to An Adult Health Care Provider
Six Core Elements of Health Care Transition 2.0

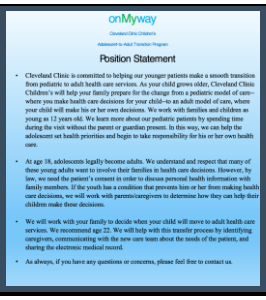
1. Transition Policy
2. Transition Tracking and Monitoring
3. Transition Readiness
4. Transition Planning
5. Transfer of Care
6. Transfer Completion

Slide 5

Element 1

Position Statement

Slide 6



onMyway

Cleveland Clinic Children's

Adolescent to Adult Transition Program

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.

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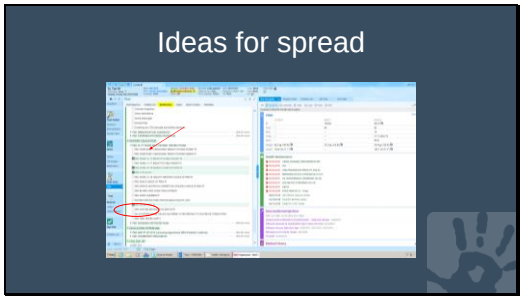

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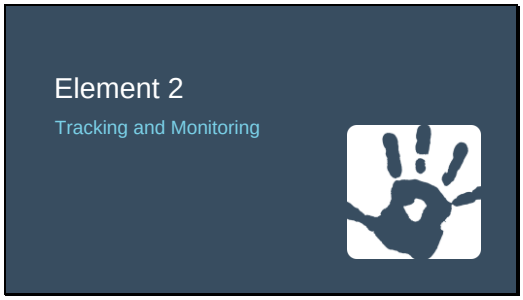

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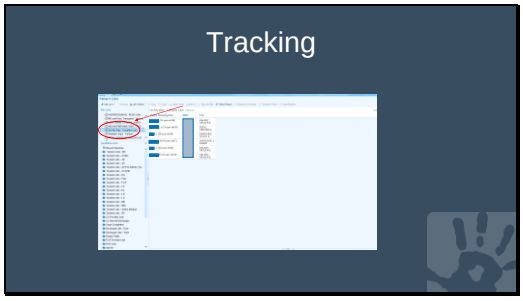


Slide 10

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

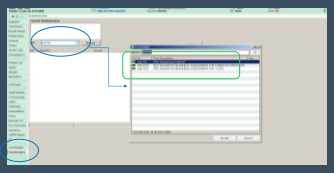
Slide 11

Element 3

Readiness Assessment

Slide 12

Transition Readiness Assessments



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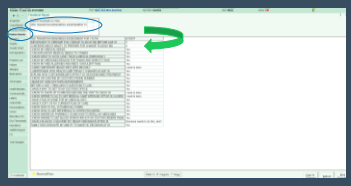
PED Transition Youth



Slide 14

Additional Transition Tools

- TRxANSITION Index ™
  - **10-domain, 32-item questionnaire measuring transition readiness**
  - **Validated tool**
  - **Measures**
    - **T**ype of chronic health condition
    - **Rx**/Medications
    - **A**dherence
    - **N**utrition
    - **S**elf-management skills
    - **I**ssues of reproduction
    - **T**reats/school
    - **I**nsurance
    - **O**ngoing support
    - **N**ew health care providers

Slide 15

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

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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

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Element 4

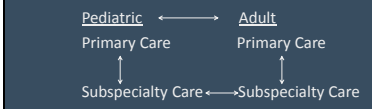
Transition Planning

Slide 18

Transition Plan

Slide 19

Models of Care Transfer
Pediatric diseases where there are both pediatric and adult subspecialty providers available (e.g. pediatric rheumatology)



Cleveland Clinic Children's

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Element 5

Transfer of Care

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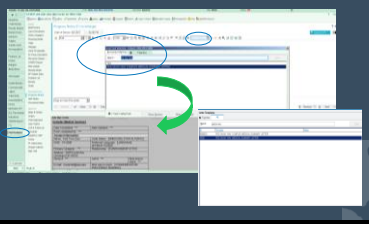
EMR Transition Documentation Tools
Complex Medical Summary Letter



Slide 22

Transfer Documents

Slide 23

Transfer Completion

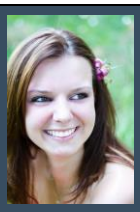
Transition Feedback Survey

Slide 24

Example

Slide 25

Vignette



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

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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

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Vignette

- 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

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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. "

Cleveland Clinic Children's

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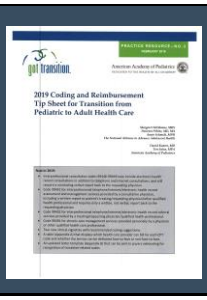
got transition

American Academy of Pediatrics

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

Resource for documenting and coding transition services

Slide 30

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

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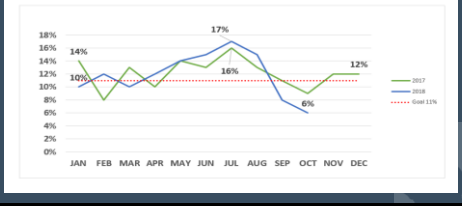
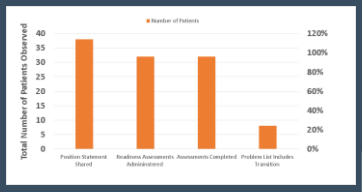
Pilot 2 Outcomes
Percentage of Gen Peds Patients ≥ 18 Yrs.
2017 & 2018



Slide 32

Pilot 2 Outcomes
Completion of Elements 1, 2 and 3



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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

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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 $\geq$ 18 yrs of age
  - Registry of transitioning patients embedded in EMR to enhance identifying transitioning youth and where they are in process

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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

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References

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  - 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/5bb676f515fcc077b763fb18/1538684662430/Value-Based+Payment+for+Health+Care+Transition+Report+FINAL+10.4.18.pdf
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- UNC STARx Program
  - https://www.med.unc.edu/transition/

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