Transitioning Youth to Adult Health Care: New Strategies and Tools for Pediatricians

Presented by:
Miriam Kalichman, MD
Kathy Sanabria, MBA, PMP
Jodie Bargeron, MSW, LSW

CME Disclosure

- We do not have commercial relationships to disclose prior to presenting
- We do not intend to discuss off-label use of FDA-approved products

Learning Objectives

- State the differences between adult-oriented and child-oriented medical care
- Utilize new strategies and tools for transitioning youth
- Define the ICAAP QI model and apply it to transitions care

Project Background

- Goal:
  - To provide high quality, comprehensive, developmentally-appropriate care
  - To help implement a smooth transition from pediatric care to adult-oriented care

- Strategies: develop training curricula for….
  - Pediatricians
  - Internists/Family Physicians/Meds-Peds
  - Include Resources for Youth and Families
  - Develop School-based Curriculum

What is transition?

- The purposeful, planned movement of adolescents and young adults – with or without chronic physical and medical conditions – from a child-centered care model to an adult-oriented health care system.
- Joint Policy Statement from AAP, AAFM, ACP

Clinical Report—Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home *Pediatrics* 2011;128:182–200

National Survey of CSHCN Prevalence of CSHCN

Prevalence of CSHCN	2009/ 2010 Illinois %	2009/ 2010 National %	2005/ 2006 Illinois %	Illinois % Change to 2009/2010
Percent of children who have special health care needs	14.3	15.1	13.9	2.9% Increase
Age 0-5 years	9.2	9.3	9.4	-2.1% Decrease
Age 6-11 years	16.3	17.7	16.2	.1.0% Increase
Age 12-17 years	17.4	18.4	16.3	6.7% Increase
Male	16.2	17.4	16.0	1.3% Increase
Female	12.3	12.7	11.8	4.2% Increase

Maternal and Child Health Bureau (MCHB) Core Outcomes

MCHB Core Outcome	2009/ 2010 Illinois %	2009/ 2010 National %	2005/ 2006 Illinois %	% Increase or Decrease since 05/06
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home	44.5	43.0	45.1	- 1.3% Decrease
CSHCN whose families have adequate private and/or public insurance to pay for the services they need	62.1	60.6	59.2	4.9% Increase
Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence	45.3	40.0	44.2	2.5% Increase

Gaps in Pediatric Care

- Describe, discuss with families
- Assess youth's transition readiness
- Provide youth with necessary tools
- Identify new primary care source
- Sustainably fund transitions care

Gaps in Care: Adult-oriented Medicine

- Shift from family-centered care to patient–centered care
- Decreased emphasis on developmentally appropriate care
- Lack of familiarity with care coordination needs for YASHCN
- Lack of knowledge about youth-oriented community-based resources
- Lack of knowledge about conditions formerly unseen beyond childhood

Gaps in Care: Special Health Care Needs

- Transition planning is essential
- Patient/family: Leaving long-term provider
  - Emotional aspects
  - Developmentally appropriate care vs. continuity
- Internists/FP: Exam strategies
- Pediatrician: No referral sources
- Guardianship, special education, insurance and community services

Addressing Gaps: ICAAP'S QI Model

- Active learning prepares for improvement
- Assess needs, barriers, resources
- Identify stakeholders in practice
- Provide a menu of options to implement
- Keep it simple

Putting Model into Action

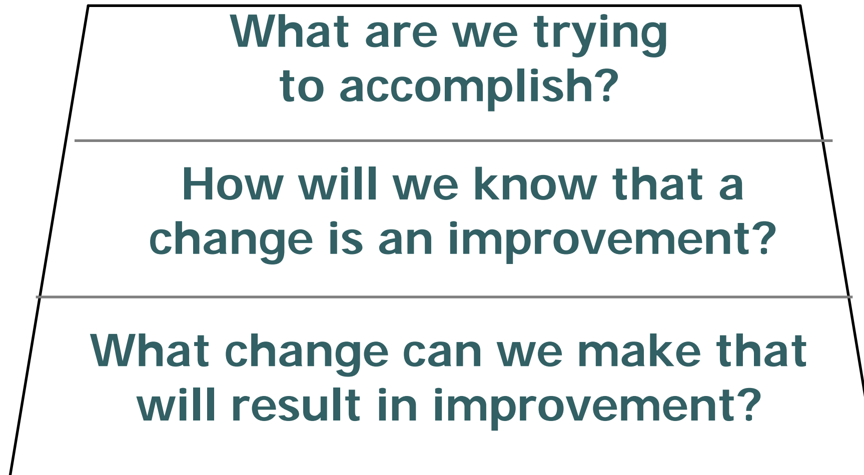
- Assemble QI Team
- Conduct Plan-Do-Study-Act cycles for improvement
  - Small tests of change
  - Re-calibrate as needed
- Emphasis on parent/patient involvement
- Goals: Improve care for patients and improve work flow for staff

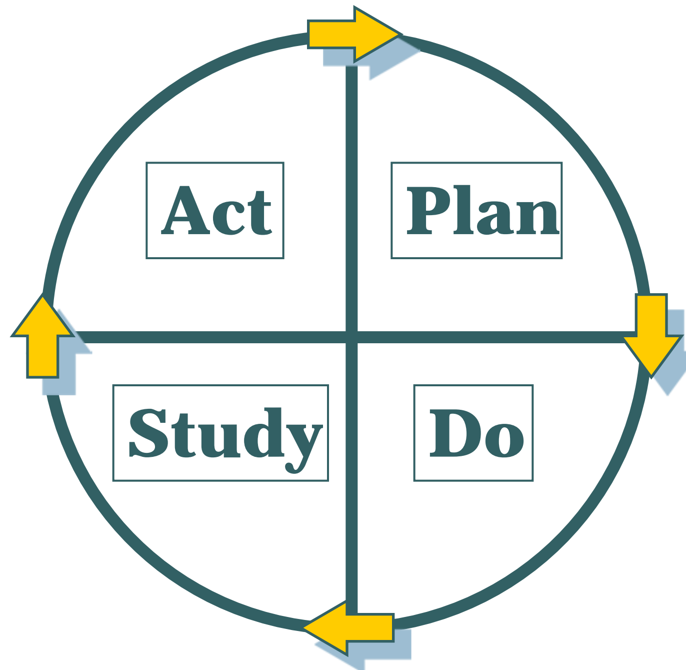
ICAAP's Evidence Base for QI Model

ICAAP lead medical home staff received formal training on the Model for Improvement from the Institute for Healthcare Improvement and NICHQ. Lessons applied to ICAAP programs:

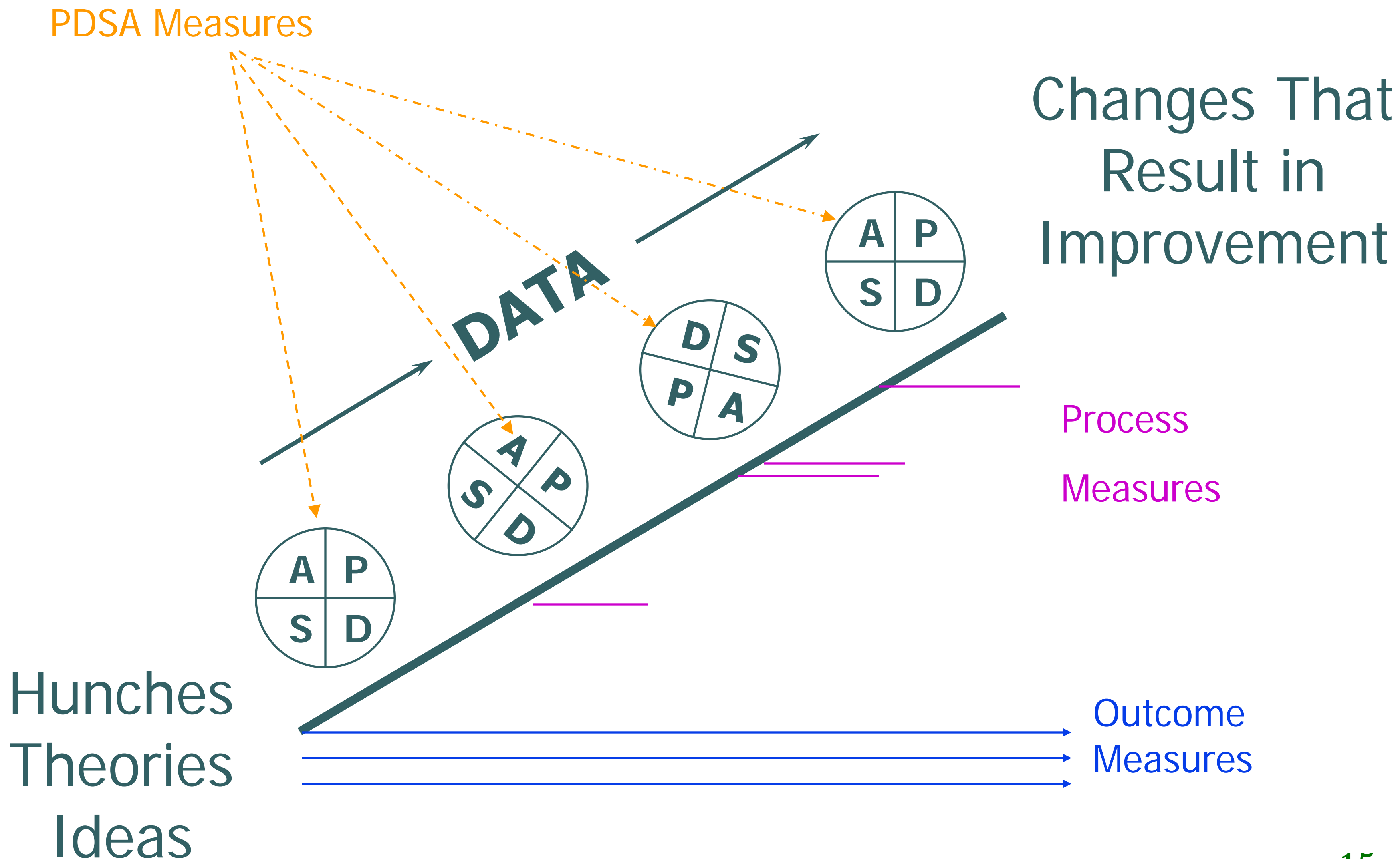
- Illinois Medical Home Project Phase 1 (2004 to 2006) and Phase II (2007 to 2009)
- Coordinating Care with Early Intervention Project (2009 to 2011)
- Building Community-Based Medical Homes for Children Program (2009-2011)
- Illinois Healthy Beginnings II Pilot (2010- present)
- Building Medical Homes for the Ambulatory and Community Health Network (2011 – present)
- CHIPRA Demonstration Grant (2010 to present)

Model for Improvement



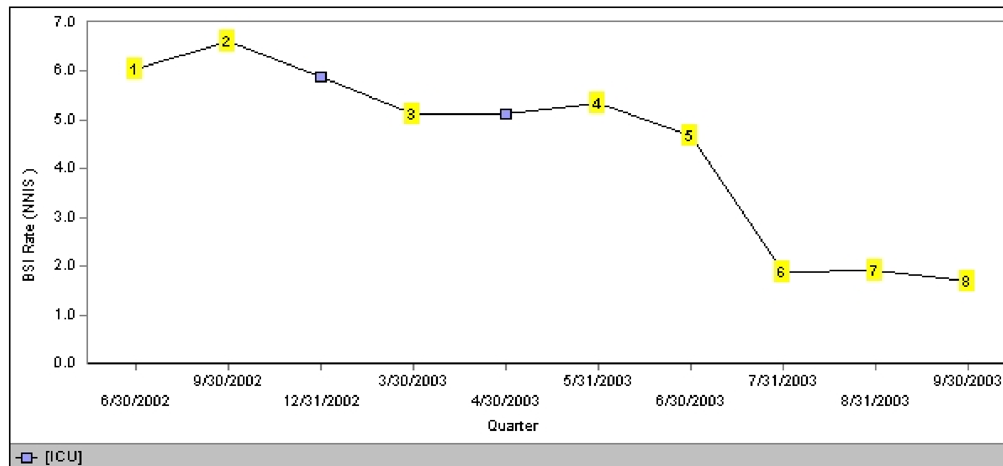


Measurement: Types & Time



Tips for Measurement

Plot data over time: "Tracking a few key measures over time is the single most powerful tool a team can use."



Building the Transitioning Youth to Adult Health Care Course

- Content developed by practicing providers, youth and families
  - Pediatric Training to Prepare for Transfer
  - Internist/FP Training to Receive New Patients
  - Tools for Youth and Families

- Applied model to create implementation tools
  - Aims Statements and QI Strategies
  - Barriers/Ideas for Change
  - Key Clinical Activities

Illinois Healthcare Transition Project Training Modules and Handouts

<u>Pediatric Provider Training</u>

- Introduction
- Develop/maintain registry
- Provide/explain written transition policy
- Assess health care skills
- Review individualized transition goals
- Provide benefit and services information sources
- Discuss need for guardianship for patients with intellectual disabilities
- Provide portable medical summary
- Help identify adult primary care physician
- Coding and reimbursement
- Conclusion

<u>Adult Provider Training</u>

Introduction

Part 1- Transitional Care

- Develop and maintain a registry
- Determine developmental level and assess health care skills
- Review individualized health care skills goals
- Request a medical summary for new patients
- Request information from other providers
- Create/maintain patient’s medical summary
- Provide information sources on adult benefits and services
- Coding and reimbursement

Part 2- Caring for YSHCN

- Identifying special needs and planning accommodations
- Examining youth with behavioral and/or cognitive impairments
- Examining youth with mobility limitations
- Discussing the need for guardianship
- Clinical information on common conditions
- Conclusion

Illinois Healthcare Transition Project Training Modules and Handouts

Patient/Family Handouts	
Teen Checklist	Portable Medical Summary
Caregiver Checklist	Transition Brochure
Differences in Care	Managing Medications
Do You Understand Insurance	Medical Emergency
Filling a Prescription	Transition Timeline
Finding Adult Providers	Transition to Adulthood-Parents and Caregivers
Guardianship	Transition to Adulthood-Teens and Young Adults
Healthcare Transition	Working with Your Doctor
How Well Do You Know Your Healthcare Needs	

Example of an Aim and Measure

Measuring Your Practice's Transition Planning Performance

Suggested Aim	Data Collection Question	Measure	Suggested Goal
Provide/explain the practice's transition policy to the patient and family for 90% of patients ≥14 years. The written policy should include the suggested age and process by which the youth will shift to an adult model of care.	For youth ≥14 1. Has the practice's transition policy been provided/explained to the patient and family? (Note: AAP recommends that this is done at age 12): ○ Yes ○ No	Name: Provide/explain written transition policy Source: Question 1, shown at left Numerator (x): Total number of patients ≥14 years who have received a written transition policy that has been explained to them (Yes answer to question 1) Denominator (y): Total number of charts in chart set	90%

Example of an Aim and Measure

Use the Transition Checklist for Teens and/or Transition Checklist for Parents/ Caregivers to assess the health care skills of 70% of youth ≥14 years every 12 to 24 months.	For youth ≥14 1. Have the patient's and/or caregiver's health care skills been assessed using a tool such as the Transition Checklist for Teens and/or or Transition Checklist for Parents/Caregivers within the past 12 to 24 months? (Note: AAP recommends that this is done annually.) ○ Yes ○ No	Name: Assess health care skills Source: Question 2, shown at left Numerator (x): Total number of patients ≥14 years or caregivers who have had their health care skills assessed within the past 12 to 24 months (Yes answer to question 2) Denominator (y): Total number of charts in chart set	70%

Transition Planning Checklist

Patient Name: ______________________________________ **Date of Birth:** __________________________ **Anticipated age of transition:** _____

Directions: Attach this checklist to the patient's chart (or consider how to adapt into your EHR) to guide transition planning efforts and ensure milestones are met in a timely manner. Use the Notes column to record information such as dates, names, information provided, or next steps.

Recommended Action	By Age	✓ If Complete or N/A	Notes
1. Provide/explain written transition policy	12	☐	
2. Assess health care skills	14, then annually	☐	
3. Set/prioritize/review individualized transition goals	14, then annually	☐	
4. Discuss need for adult insurance; provide information sources as needed	17	☐	
5. Discuss need for adult benefits and services; provide information sources as needed	17	☐	
6. Discuss need for guardianship if patient has intellectual disabilities	14	☐	
7. Create/update/maintain patient's portable medical summary	17, then at routine visits	☐	
8. Identify adult physicians	17	☐	

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UIC DIVISION OF SPECIALIZED CARE FOR CHILDREN UNIVERSITY OF ILLINOIS AT CHICAGO

American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN Illinois Chapter

Transitions Web-Based Courses

- Available any time, for any provider
- CME and MOC tracks
- Track improvement as individual or as practice
- Designed to support doing

Tools Unique to Web

- QI Planning Course Document
  - Learner applies concepts to their practice
  - Identify practice-specific barriers/resources
- Videos
  - Multiple experts
- Resource library
- Interactive communication with other participants

Pediatric Training

- Offers 15 CME credits
- Offers 25 Pediatric Maintenance of Certification Part IV credits
- Open to all late 2012
- Utilizes proven, successful strategies from ICAAP QI Model

Adult-Oriented Provider Training

- Scheduled to go live late 2012
- Exam strategy demonstration videos
- Goals:
  - Increase number of providers who accept YASHCN
  - Help prepare adult-oriented providers to care for YASHCN

Using On-Line Course

- Complete presentations
- Determine activities to implement
- Begin activities
- Periodic progress review

Highlights from Web Course

American Academy of Pediatrics
Illinois Chapter

eLearning Center

Logout | Help | Training Menu | Tools | Notes | FAQ | Assessment

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14

15

Review Previous Questions

5 Which of the example policies can you adapt for your practice?

Save Response

6 List any potential barriers to implementing a transition policy in your practice:

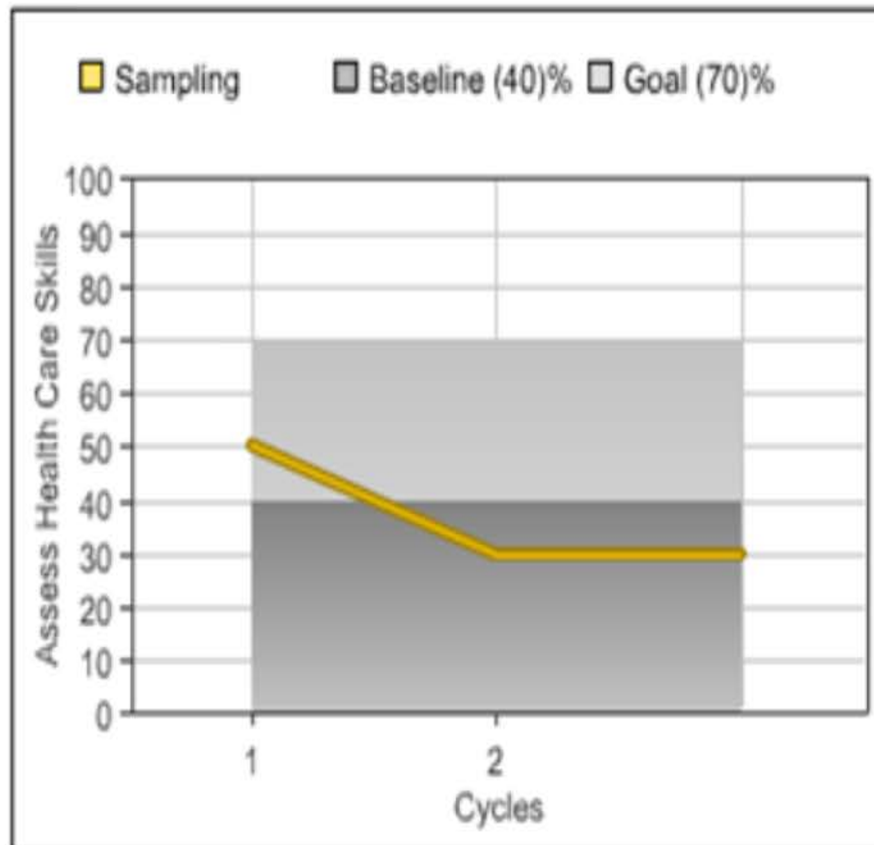
No Response entered for this question.

7 How will you ask families to complete the checklist?

Ideas include e-mailing the checklist to them before an appointment, asking them to complete in the waiting room before an appointment, or scheduling a separate visit with office staff to complete.

Highlights from Course

Transitioning Youth to Adult Health Care for Pediatric Providers



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Highlights from Course

A1 | fx | Assess Health Care Skills

	A	B	C	D	E	F	G
1	Assess Health Care Skills	Cycle 1	Cycle 2				
2		5/7/2012	5/7/2012				
3	Chart Data: Improvement	5	3				
4	Chart Data: No Improvement	5	7				
5	Chart Data: Not Applicable	0	0				
6	Denominator	10	10				
7	% Change	50%	30%				
8	Discuss Need for Insurance, Benefits, and Services Information	Cycle 1	Cycle 2				
9		5/7/2012	5/7/2012				
10	Chart Data: Improvement	9	8				
11	Chart Data: No Improvement	1	2				
12	Chart Data: Not Applicable	0	0				
13	Denominator	10	10				
14	% Change	90%	80%				
15	Create or Update/Maintain a Portable Medical Summary	Cycle 1	Cycle 2				
16		5/7/2012	5/7/2012				
17	Chart Data: Improvement	7	9				
18	Chart Data: No Improvement	3	1				
19	Chart Data: Not Applicable	0	0				
20	Denominator	10	10				
21	% Change	70%	90%				

MOC_REPORT

Citations

- Reiss and Gibbson, 2002; 2: 2004 NOD/Harris Survey; Kentucky HRTW project
- National Survey for Children with Special Health Care Needs, 2009/10 and 2005/06, Maternal and Child Health Board, Health Resources and Services Administration
- Cooley, W. C., et al - Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home. *Pediatrics* 128 (1): 182-200, July 2011
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Contact us for more information or assistance

- Miriam Kalichman, MD
  DSCC
  312-996-7202
  mkalich@uic.edu

- Kathy Sanabria, MBA, PMP
  ICAAP
  312-733-1026 x 208
  ksanabria@illinoisaap.com

- Jodie Bargeron, MSW, LSW
  ICAAP
  312-733-1026 x 209
  jbargeron@illinoisaap.com