Transitions of Care: Pediatrics to Adult Care

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Disclosure

I have no financial relationships to disclose.

Learning Objectives

1. Be able to judge when patients are ready to transition to adult primary care

2. Help prepare pediatric patients for adult primary care

3. To facilitate transfer of patients from pediatric clinics to adult clinics

Presentation Topics

1. What is Transitions of Care?
2. Why Transitions of Care?
3. How to Transition?
4. Difficulties in Transitioning

1 What is Transitions?

"The purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health care systems" (1)

- Improves youth and young adults management of their own health care
- NOT simply "transfer of care"
- NOT the same as outpatient care following recent hospitalization (Medicare)

1) American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians. Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. Pediatrics. 2011: 128; 182.

1 What is Transitions?

- NOT adolescent medicine, but can involve it
- Emphasis on preparing all pediatric patients for the adult healthcare setting
- Guided by expert opinion and consensus on practice-based implementation of transition for *all* youth, beginning early in adolescence and continuing through young adulthood

2 Why Transitions?

- 18 million U.S. adolescents, ages 18–21, are moving into adulthood (2)

- Nationally, approximately 20% of children under 18 years old, or an estimated 12.8 million children, have a chronic medical condition. (3)

- Transitioning patients with chronic medical conditions has been shown to decrease complications:
  - Improved follow-up care in congenital heart disease (4)
  - Improved self management in diabetes (5)

2) U.S. Census Bureau, Current Population Survey, 2013
3) Newacheck PW, Strickland B, Shonkoff JP, et al. An epidemiologic profile of children with special health care needs. Pediatrics. 1998;102(1 Pt 1):117-123
4) Heery, E; Sheehan AM, While AE, Coyne I; Experiences and Outcomes of Transition from Pediatric to Adult Health Care Services for Young People with Congenital Heart Disease: A Systematic Review. Congenit Heart Dis. 2015 Sep-Oct;10(5):413-27
5) Campbell F, Biggs K, Aldiss SK, O'Neill PM, Clowes M, McDonagh J, While A, Gibson F. Transition of care for adolescents from paediatric services to adult health services. Cochrane Database Syst Rev. 2016 Apr 29

3 How to Transition

- Prepare patients and their parents/caregivers for the differences between pediatric and adult health care

- Ensure that the transfer process is actively coordinated and discussed between the referring pediatric provider and the receiving adult provider

- Make sure transfer to adult care is completed and a system to monitor this is present

3 How to Transition

- Ensure the patients have knowledge and understanding of their disease
    - Need to understand future contingencies for which they need to prepare.
- Develop self-advocacy skills, learn to interact with adult health care providers, maintain insurance
    - For those with developmental disabilities, plan to include designating who will be primarily responsible for the patient's health care needs

3 How to Transition

6 Elements of Transition:

1.Transition Policy

2. Transition Tracking and Monitoring

3. Transition Readiness

4. Transition Planning

5. Transfer of Care

6. Transfer Completion

3 How to Transition

Element 1: Transition Policy

- Develop a policy with input from youth and families that describes the practice's approach to transition, including privacy and consent information

- Educate all staff about the practice's policy

- Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care

3 How to Transition

Element 2: Transition Tracking and Monitoring

- Establish criteria and process for identifying transitioning youth and enter their data into a registry.

- Utilize individual flow sheets or registry to track youth’s transition progress

3 How to Transition

Element 3: Transition Readiness

- Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care

- Jointly develop goals and prioritized actions with youth and parent/caregiver and document regularly in a plan of care

3 How to Transition

Element 4: Transition Planning

- Develop and regularly update the plan of care

- Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information

    - Determine need for decision-making supports for youth with intellectual challenges and make referrals to legal resources

- Plan with youth and parent/caregiver for optimal timing of transfer

    - Plan for subspecialty transfer, if needed

3 How to Transition

Element 4: Transition Planning

- Obtain consent from youth/guardian for release of medical information.

- Assist youth in identifying an adult provider and communicate with selected provider about pending transfer of care.

- Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.

3 How to Transition

Element 5: Transition of Care

- Confirm date of first adult provider appointment.

- Transfer young adult when his/her condition is stable.

- Complete transfer package, including final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional provider records.

- Prepare letter with transfer package, send to adult practice, and confirm adult practice’s receipt of transfer package.

- Confirm with adult provider the pediatric provider’s responsibility for care until young adult is seen in adult setting.

3 How to Transition

Element 6: Transfer Completion

- Contact young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm transfer of responsibilities to adult practice and elicit feedback on experience with transition process.

- Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed.

- Build ongoing and collaborative partnerships with adult primary and specialty care providers.

3 How to Transition

Recommended Transition Timeline

AGE	
12	Make youth and family aware of transition policy
14	
16	
18	
18-22	
23-26	

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Prominently displayed and explicitly state practice's expectations

Expected age of transfer, patient's responsibilities, parent/family/care giver responsibilities, medical provider's responsibilities

Identify patients at risk of having complicated transitions

3 How to Transition

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Formal transition plan documented in chart and referenced at all future office visits

Identify needs and assess intentions and motivations for youth independence

Document youth's current readiness

3 How to Transition

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12	Make youth and family aware of transition policy
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16	Prepare youth and parents for adult model care and discuss transfer
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23-26	

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Review plans regularly and update as necessary

Surveillance for changes in youth's medical status and family concerns that may warrant changes in transition goals

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“Pre-transfer” visit to the adult medical home could be conducted during the year before the transfer

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18	Transition to adult model of care
18-22	Transfer care to adult medical home and/or specialists with transfer package
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Ideally, transfer by age 22

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23-26	Integrate young adults into adult care

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Needs to be a priority

Ideally, this should have been done be age 22

3 How to Transition

http://www.GotTransition.org

4 Difficulties in Transitioning

- Limited staff training and lack of an identified staff person responsible for transition
- Financial barriers, lack of appropriate coding
- Anxiety on the part of pediatricians, adolescents, and their parents about planning for their future health care. (6)
- Lack of developmentally appropriate tools
- No information or not enough information is transmitted to the receiving provider

6) Campbell F, Biggs K, Aldiss SK, O'Neill PM, Clowes M, McDonagh J, While A, Gibson F. Transition of care for adolescents from paediatric services to adult health services. Cochrane Database Syst Rev. 2016 Apr 29

4 Difficulties in Transitioning

- Many adult providers feel unprepared to care for young adults with complex chronic conditions

- In pediatrics, the parents are the focus in the patient decision-making process, whereas in the adult heath care world, the decision-making is focused on the patient, and not necessarily the family (7) Young adults must be much more active in their own case management

- Pediatric specialty- or primary care-based medical homes tend to be better resourced, which allows for extensive multidisciplinary care in a singular location, a situation that is often not mirrored in the adult care system

7) Transitions in Adolescent Medicine; Commentary by Megumi J. Okumura, MD, MAS, and Roberta G. Williams, MD; Cases & Commentaries Published May 2015

4 Difficulties in Transitioning

Dealing with difficulties:

- Start early with implementing the idea of transitioning for patients with and without chronic diseases

  ▶Integrate adult model early, when possible

- Assist patients and families to find an adult provider. Once chosen, it is the pediatric medical home's responsibility to ensure appropriate communication to receiving provider

- Need for identified medical sub-specialists to help with management decisions

- Adult providers should not expect a "handoff" from pediatrics but, rather, a "handshake."

Conclusion

- Well-timed, well-planned, and well-executed transition from child- to adult-oriented health care enables youth to optimize their ability to assume adult roles and activities

- Beginning discussions about transitioning around 12 years old with goal of transitioning between 18-21

- Continually assess needs of each patients along the way

- Transition planning should be a standard part of providing care for all youth and young adults

Coding

- 99241-99245 Office or other outpatient consultations
- 99339, 99340 Care plan oversight services
- 99366-99368 Medical team conference
- 96160, 96161 Health risk assessment (eg., transition readiness/self-care assessment)
- 99441-99443 Telephone services
- 99444 Online medical evaluation
- 99446, 99449 Inter-professional telephone/Internet assessment and management services
- 99487, 99489 Complex chronic care management services
- 99490 Chronic care management services
- 99495, 99496 Transitional care management services
- 99860-99862 Education and training of patient self-management services