Bridging the Gap Between Pediatric and Adult Subspecialty Care: Development of a Cardiac Transitions Program

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Disclosures

▸ No relevant financial relationships or interests

Objectives

▸ Describe the “Got Transition” Six Core Elements of Health Care Transition
▸ Overview 3 areas of pilot transition processes at MUSC
▸ Discuss the next steps of advancing transitional care at MUSC

Guidelines and Policy Statements

▸ 2007 AAP Annual Leadership Forum
  ▪ designated “transitioning youth with special health care needs to adult health care” as a top-10 priority
▸ Bright Futures
  ▪ encourages parental support of self-management and independent decision-making about health
▸ Healthy People 2020
  ▪ increase the proportion of youth with SHCN whose healthcare provider discussed transition planning
▸ Maternal and Child Health Bureau
  ▪ Youth with SHCN should receive coordinated comprehensive care within a medical home and all services necessary to make the transitions to all aspects of adult life
▸ AAP, ACP, AAFP Clinical Report on Health Care Transitions
  ▪ Published in 2011, update from 2002 consensus statement
▸ American College of Physicians
  ▪ Pediatric to Adult Care Transition Initiative

Got Transition?

▸ National Alliance to Advance Adolescent Health
  ▪ Funded by HRSA/MCHB
  ▪ www.gottransition.org
Why Six Core Elements?

- Address barriers to transition
  - Lack of planning
    - Families/providers unprepared; staff unprepared; adolescents unengaged and unprepared
  - Adult providers unprepared ...
  - ...and receive limited information
- Address issues within all primary care fields
- Lack of appropriate tools

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
- Implementation:
  - Educate staff about policy
  - Post policy and share with patients/families (beginning at age 12-14)

2. Transition Tracking and Monitoring

- Establish criteria and process for identifying transitioning youth and create registry
- Utilize flow sheet to track transition progress
- Incorporate Six Core Elements into clinical care process, utilizing EHR
3. Transition Readiness

- Conduct regular transition readiness assessments
  - Begin at age 14
  - Discuss with youth and family
  - Can bill for completion
- Jointly develop goals and actions with youth and caregiver
  - Document regularly

4. Transition Planning

- Regularly update plan of care
  - Readiness assessments
  - Medical summary and emergency plan
  - Condition fact sheet
  - Prepare patient/family for adult approach to care at age 18
    - Legal changes/decision-making support
    - Self-advocacy
    - Access to information
- Plan for optimal timing of transfer (primary and specialty)
- Obtain consent for release of medical information
- Identify adult provider(s) and communicate plan of care
- Provide resources (insurance, community supports)

5. Transfer of Care

- Confirm date of first adult provider appointment and provide DIRECT COMMUNICATION with adult provider
- Complete and send transfer packet
  - Final readiness assessment
  - Plan of care with transition goals and pending actions
  - Medical summary and emergency plan
  - Legal documents
  - Condition fact sheet
- Prepare letter to send with packet and confirm receipt
- Plan for continued responsibility of care until first adult appointment

6. Transfer Completion

- Contact young adult/caregiver 3-6 months after last pediatric appointment to confirm transfer of responsibilities to adult provider
- Elicit feedback on transition process
- Communicate with adult provider and offer consultation assistance
- Build continued partnerships with adult primary and specialty care providers
Do they work?

- 2 year learning collaborative
  - 5 large academic primary care practices in DC
    - Adolescent, pediatrics, family medicine, internal medicine
    - Patients age 14-24 years
    - Insured by Medicaid
  - Participated in 5 1.5 day learning sessions; regular "coaching sessions", on-site visits

Is it feasible?

- Six core elements and sample tools made the process possible
- Has to be team-based, not just physicians
- Unable to incorporate assessment tools into EHR
- Care plans and transfer summaries were time-consuming
- The earlier the process started, the better
- Older adolescents need an "accelerated" process
- Over time the importance of the role of adult providers became more clear

Is it feasible?

- Challenges
  - Compensation for time
  - Lack of EHR functionality for transitions
  - Lack of care coordination infrastructure
    - (particularly for adult sites)
- What works best
  - Start with a clearly defined population
  - Transfer with up to date medical summary and one-page information sheet about pediatric illness; clarify guardianship/decision-making before transfer; pediatric provider available for consultation
  - Start with a mix of ages
  - Sufficient care coordination is available

MUSC Transition Pilots

- 3 self-selected pilot sites
- Advance progress through Six Core Elements
- Monthly assessments and goal setting
- Determining/tracking outcome measures
Congenital Heart Disease

- Monthly Transition clinic
  - Age 11 and up (currently mostly older patients)
- Providers
  - Kim McHugh MD, Rochelle Judd FNP
  - Stephanie Gaydos MD
  - SW, PharmD
- Initial Assessment Score: 15/32

Rheumatology

- Building a transition clinic/services
- Currently have a multidisciplinary Lupus clinic
- Patients seen q3mo
- Providers: Natasha Ruth MD, Katherine Silver MD
- Sonia Savani MD
- Initial Assessment Score: 11/32

Congenital Heart Disease

- Transition Policy
  - Formalized and implemented
- Adult clinic welcome letter
- Transition Tracking and Monitoring
  - Established patient list in Epic for tracking
- Transition Readiness
  - Using TRAQ and PedsQoL

Congenital Heart Disease

- Transition Planning
  - Completing readiness assessments
  - Adult provider identified; adult NP addresses issues such as reproduction
- Transfer of Care
  - No set criteria
  - Trying to move older patients along
- Transfer Completion
  - Continued conversations between adult and pediatric teams
- Follow up Assessment Score: 21/32
Rheumatology

- Transition Policy
  - Drafted and beginning implementation
  - Working on adult welcome letter
- Transition Tracking and Monitoring
- Transition Readiness
  - Plan to use TRAQ

Inflammatory Bowel Disease

- Transition Clinic
  - Q3 months
  - Patients enter at age 17; exit after 2-3 visits
- Providers: Christine Carter-Kent MD, Jennifer Seminerio-Diehl
  - SW, CM, RD
- Initial Assessment Score: 16/32

Challenges/Next Steps

- If transition clinic in place, addressing all patients not enrolled
- Engaging all faculty to participate
- Engaging patients/families to review material
- Utilizing Epic capabilities
- Measuring outcomes
- Can I get paid for this?!?
Billing/Coding Tips

▸ No billing codes available specifically for transition services
▸ Available codes:
  ‣ Care Plan Oversight Services (CPT 99339)
  ‣ Prolonged services by time
  ‣ Interprofessional Telephone/Internet Consultations (CPT 99446)
  ‣ Health Risk Assessment (CPT 96160-patient; 96161-caregiver)

Where can you start?

▸ Begin talking to your patients about self-management and transition at age 12-14
▸ Meet with colleagues to discuss the development of a transition policy for your area
▸ Implement a transition readiness assessment tool
▸ Directly contact adult colleagues prior to transfer of care
  ‣ Consider introducing patient to adult provider before transfer if feasible
▸ Utilize an “adult model of care” if seen past age 18yo
▸ Contact me

Other Considerations

▸ This is not just a “pediatrician problem”
  ‣ i.e. what about those adult doctors?
▸ Use of patient-centered technology (personally-controlled health records) can support patients and families during transition
▸ AAP has developed MOC modules around transitions of care
▸ Coordination between many providers
  ‣ Collaborative; initiated by clinicians managing the main health issue or through PCP

Future Directions

▸ Formalize transitions of care from PPC to UIM
▸ Incorporate more specialty care sites
▸ Standardize checklists and transition packet components
  ‣ Use EMR resources
▸ Engage adult providers
▸ Engage patients and families
▸ Engage the community

Acknowledgements

▸ Sarah Mennito

References

McManus M, White P. Transition to Adult Health Care Services for Young adults with Chronic Medical Illness and Psychiatric Comorbidity. Child Adolescent Psychiatric Clin N Am 2011; 26: 367-380
Questions?