Health Care Transition

- A purposeful, planned movement of adolescents and young adults from a pediatric primary care physician to an adult physician

- The goals of health care transition are to improve the ability of youth and young adults to manage their own health care and effectively use health services.

- Clinicians are uniquely positioned to assist adolescents and young adults with preparation efforts.

Preparation to leave pediatric health care
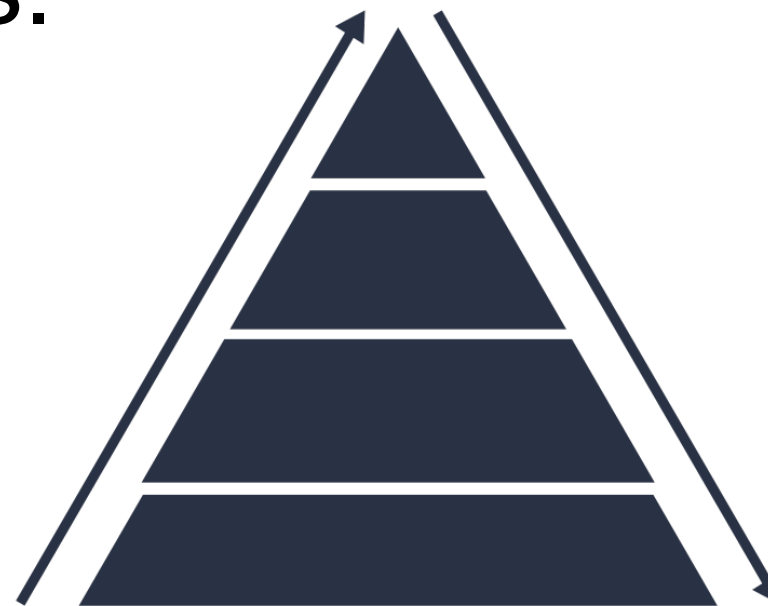
Integration into adult health care

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Adolescent Transition Involves:

- Helping teens develop self-care skills
- Fostering effective communication by assisting adolescents in learning to explain health care needs to the clinician without the presence of a parent or caregiver
- Encouraging adolescents to build skills that will help with managing their health
- Taking responsibility for scheduling appointments
- Knowing their medications and taking them on their own
- Educating on health care privacy that changes at age 18
- Care coordination between pediatric and adult clinicians

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Barriers for the patient and family

- Fear of a new healthcare system or office
- Not wanting to leave their current physician/office
- Anxiety of not knowing the adult doctor, the office or the logistics of transferring practices (scheduling, finding out if the office takes their insurance or is accepting new patients)
- Difficulty in finding adult clinicians that have an understanding of chronic illnesses of pediatric onset
- Not having seen clinicians alone, without a parent present
- Lack of coordination/transfer of medical records from pediatric to adult office
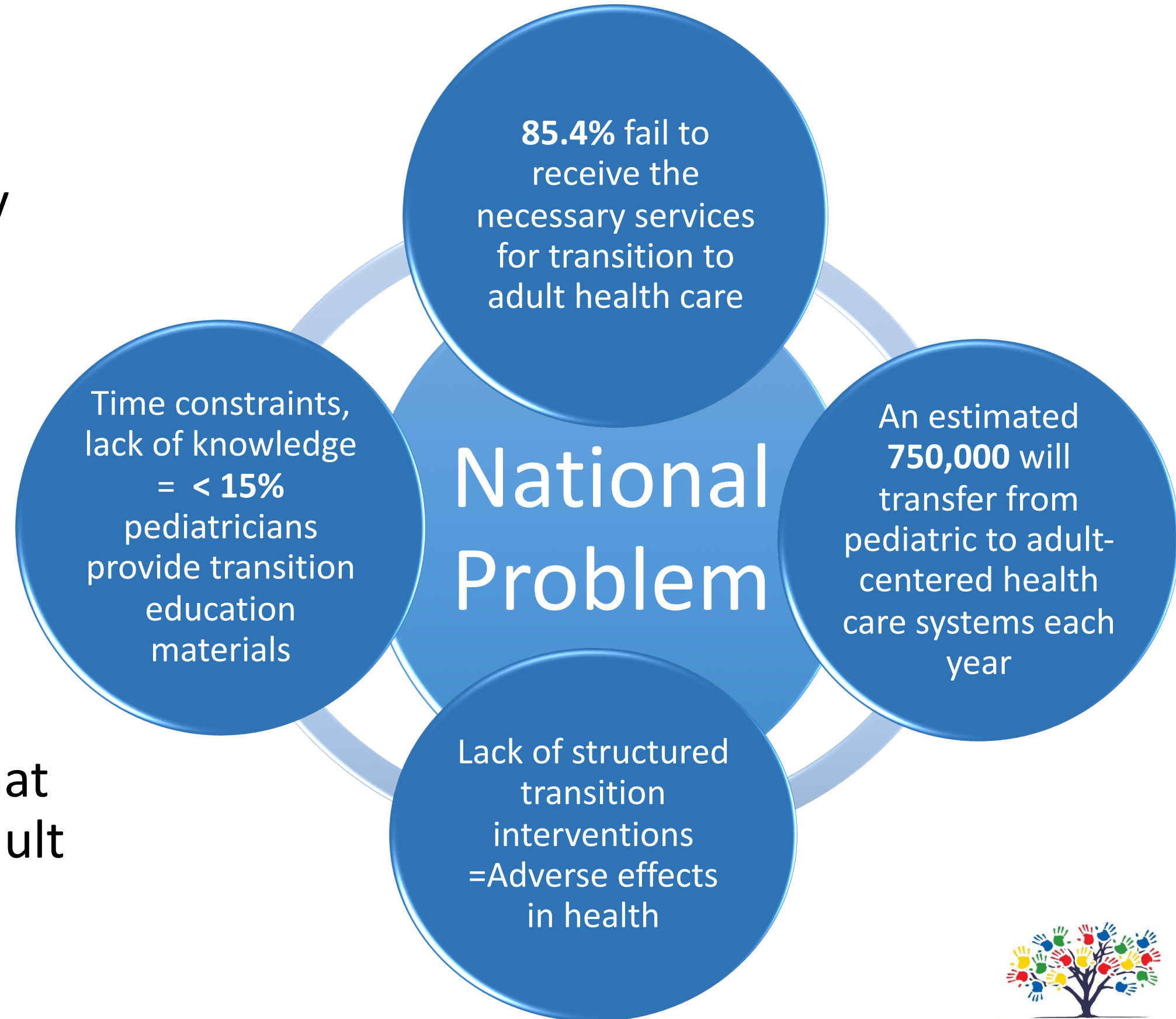
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Barriers for the Pediatrician/Office staff

- Lack of communication, coordination, guidelines between pediatric and adult offices

- Lack of time and reimbursements

- Lack of patient knowledge and engagement-young adults with lack of knowledge of their medical history and disease treatment

- Young adults' dependency on parents or guardians

- Young adults' lack of self-advocacy, decision making skills and self-help skills

- Concerns regarding loss of strong relationship with previous clinician

- Pediatricians lack of confidence in adult care for patients with disabilities

- Parents reluctance to relinquish responsibility

- Parents unaware of changes in healthcare privacy

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Local Problem:

- Growing adolescent patient cohort that had reached an age of maturity

- No logistical approach to transition patients to an adult medical home

- No process in place to include transition preparation efforts

- No systematic method of assessing transition readiness or planning for the transfer of care

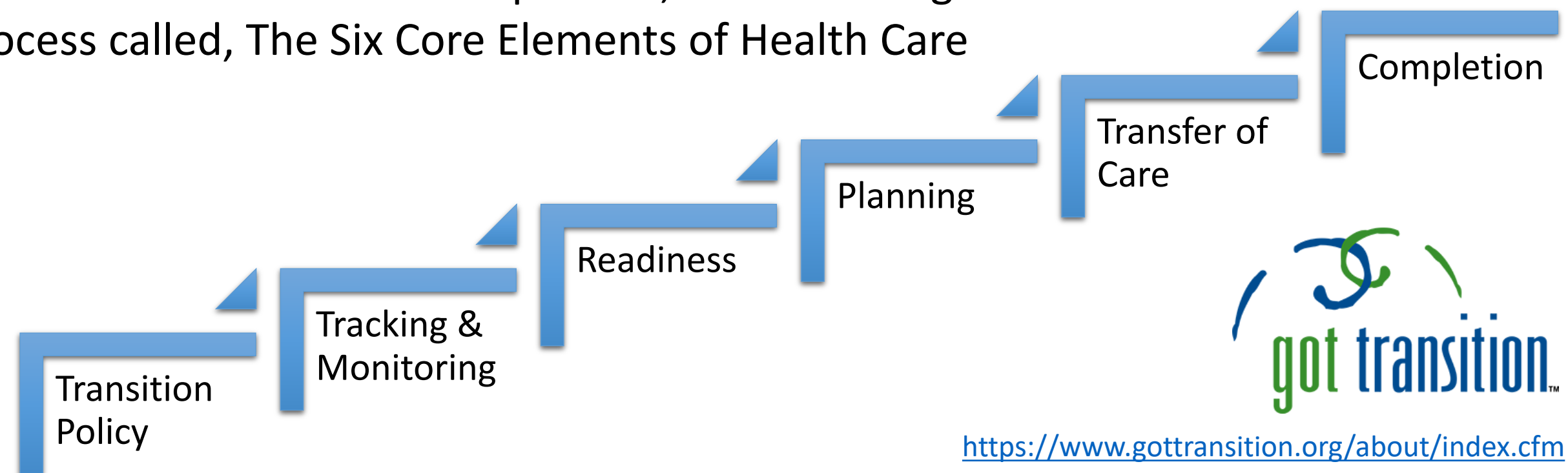- 600 patients over 21 years of age that have not been transitioned to an adult medical home

National Problem

85.4% fail to receive the necessary services for transition to adult health care

Time constraints, lack of knowledge = **< 15%** pediatricians provide transition education materials

An estimated **750,000** will transfer from pediatric to adult-centered health care systems each year

Lack of structured transition interventions =Adverse effects in health

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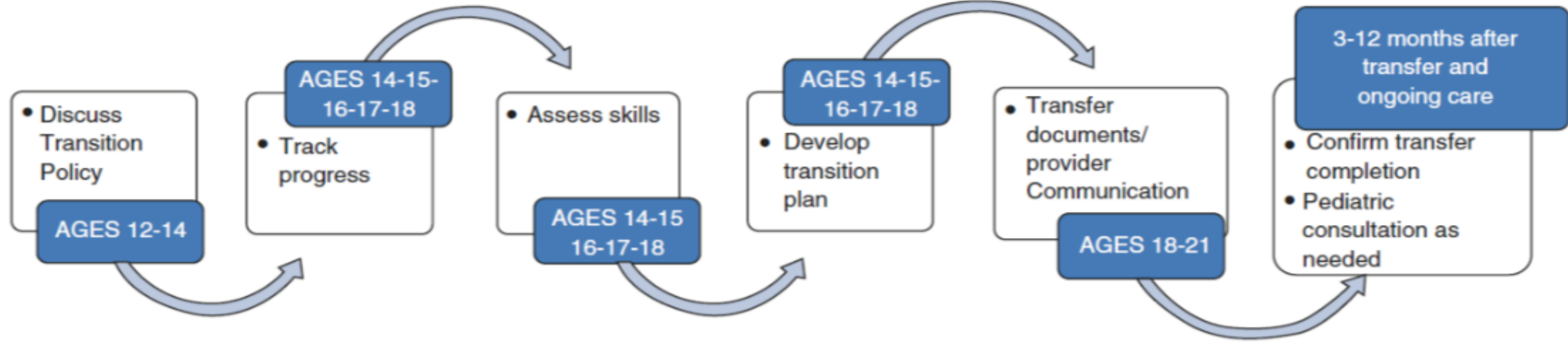
National Problem (continued)

- Institute of Medicine (IOM) Report state of health of young adults (2015):
  - "unhealthy" given the risky behaviors that peak in this age group
  - onset of mental health disorders, self-harm, substance abuse, STD's

- Poor transition planning = potential risk for care fragmentation, treatment noncompliance, ↑ morbidity & mortality

- Lack of structured HCT interventions are associated with adverse effects in terms of medical complications, limitations in health & well-being, problems with treatment & medication adherence, discontinuity of care, patient dissatisfaction, higher emergency depart & hospital use, & higher costs of care"

- In 2010, CDC issued Healthy People 2020 included a goal to increase the proportion of adolescents & young adults with special health care needs to receive discussions regarding health care transition from the health care provider, aiming to reach 45.3% by the year 2020

- Lack of time, resources, physician training, barriers to care coordination, and lack of validated measures are among the cited barriers to assess transition readiness among pediatric transition programs

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Idealized Pediatric System Health Care Transition Activities

- Clinic-wide transition model

- Enables a successful, seamless transition from pediatric to adult care

- Flexible for various patient populations

- Framework that offers a specific timeline encompassing 6 practice-based steps

- Age-based algorithmic protocol

- Defines the essential components of the health care transition process, & set the stage for the current HCT quality improvement process called, The Six Core Elements of Health Care Transition

Transition Policy

Tracking & Monitoring

Readiness

Planning

Transfer of Care

Completion

got transition™

Discuss Transition Policy AGES 12-14	Track progress AGES 14-15-16-17-18	Assess skills AGES 14-15 16-17-18	Develop transition plan AGES 14-15-16-17-18	Transfer documents/ provider Communication AGES 18-21	3-12 months after transfer and ongoing care • Confirm transfer completion • Pediatric consultation as needed

1	2	3	4	5	6
Transition Policy	Tracking and Monitoring	Transition Readiness/ Self Care Assessment	Transition Planning	Transfer of Care/Initial Adult Provider Visit	Transition Completion/ ongoing care/ Consumer Feedback

CENTER FOR HEALTH CARE TRANSITION IMPROVEMENT

got transition?

Sample Transition Readiness Assessment for Youth
Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what you already know about your health and how to use health care and the areas that you need to learn more about. If you need help completing this form, please ask your parent/caregiver.

Date:

Name: Date of Birth:

Transition Importance and Confidence
On a scale of 0 to 10, please circle the number that best describes how you feel right now.

How important is it to you to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health
Please check the box that applies to you right now.

	Yes, I know this	I need to learn	Someone needs to do this… Who?
I know my medical needs.	☐	☐	☐
I can explain my medical needs to others.	☐	☐	☐
I know my symptoms including ones that I quickly need to see a doctor for.	☐	☐	☐
I know what to do in case I have a medical emergency.	☐	☐	☐
I know my own medicines, what they are for, and when I need to take them.	☐	☐	☐
I know my allergies to medicines and medicines I should not take.	☐	☐	☐
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	☐	☐	☐
I understand how health care privacy changes at age 18 when legally an adult.	☐	☐	☐
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	☐	☐	☐

Using Health Care

	Yes, I know this	I need to learn	Someone needs to do this… Who?
I know or I can find my doctor's phone number.	☐	☐	☐
I make my own doctor appointments.	☐	☐	☐
Before a visit, I think about questions to ask.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know to show up 15 minutes before the visit to check in.	☐	☐	☐
I know where to go to get medical care when the doctor's office is closed.	☐	☐	☐
I have a file at home for my medical information.	☐	☐	☐
I have a copy of my current plan of care.	☐	☐	☐
I know how to fill out medical forms.	☐	☐	☐
I know how to get referrals to other providers.	☐	☐	☐
I know where my pharmacy is and how to refill my medicines.	☐	☐	☐
I know where to get blood work or x-rays if my doctor orders them.	☐	☐	☐
I have a plan so I can keep my health insurance after 18 or older.	☐	☐	☐
My family and I have discussed my ability to make my own health care decisions at age 18.	☐	☐	☐

Transition Improvement Process:

IHI Model

- Specific & Measurable Aim

- Measures of Improvement that are tracked over time

- Key changes that will result in desired improvement

- Series of testing "cycles"

- Act to make the successful changes permanent/adjust the changes that need more work

- Identify an Opportunity & Plan the test of change

Act

Plan

Study

Do

- Track progress using quantitative & qualitative methods; study results of work

- Do the work to make the change
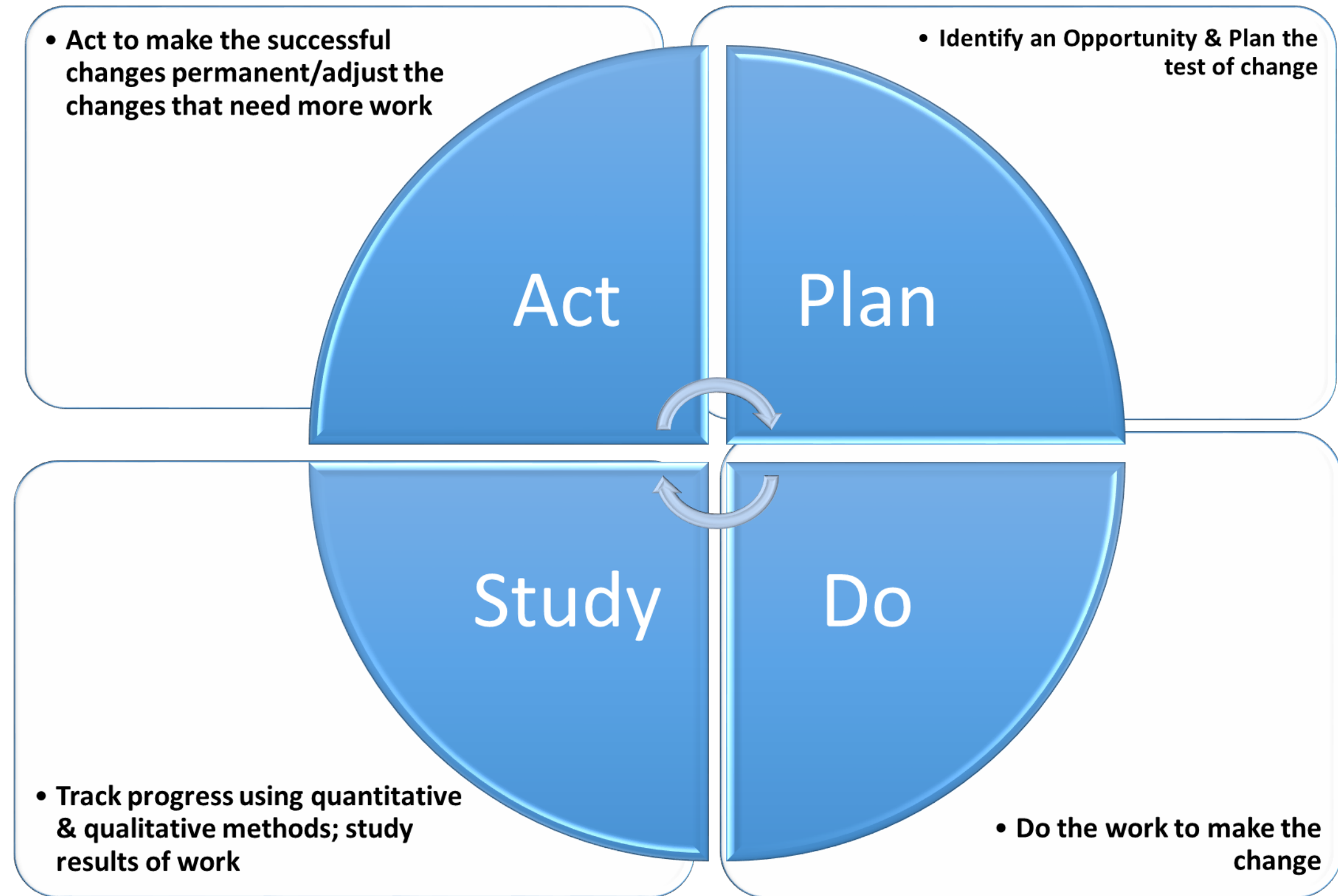
Framework to improve structural outcomes and encourage regular measurements for tests of change

Plan for Improvement

1. Getting Started:

• Implement QI strategies

• Focused on adolescents not receiving transition preparation that they should

• Identified challenges with the number of adolescents that are not receiving transition readiness screening.

➤*Problem Statement*:

- ▪ Missing formalized practice-wide approach to the transition patients to the adult care system

- ▪ Needed a systematic method of assessing transition readiness & planning for the transfer of care

THE ROAD TO INDEPENDENCE
A Journey to
Adulthood!

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2. Assemble the Team

• **Transition Task Force:** stakeholders: physician, project manager, office manager, nurse manager, pediatrician, billing & coding manager, referral care coordinator & IT specialist

• Met regularly (Weekly/biweekly): Focused on identified key issues

•Guided the project's development

➤*Aim Statement:*

- Standardize the HCT process to patients ≥ 14 years of age by February 2019

- 30% of well-child visit electronic health records for adolescents that are 14 years of age and older will have a transition readiness assessment screening tool documented in their preventive visit.

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Collaboration

Team Member	Role
Physician Team leader	- Establishes and strengthens links between pediatric and adult health systems - Advises on routine adolescent/young adult health needs - Assists with medical condition co-management as needed during the period of transfer - Assesses patients' home care needs - Counsels families around advanced directives and shared decision-making
Advanced Practice Clinician	- Assess unmet medical needs during transition phases & at the time of transfer - With the physician, may provide medical condition co-management as needed during the period of transfer
Nursing	- Assesses patients' readiness to transition to adult care - Ensure proper tracking of transition planning by documenting transition efforts in EHR. - Educates patients around disease self-management ad self-care - Assists patients with knowledge deficits (I.e. provide teaching moments with patients that need additional guidance with health care self-management. Such as demonstrating how to use inhaler properly, how to take medications, etc.).
Referral Department	- Provider/Patient/family advisor on transition related resources - Provides referrals to adult PCP's, Specialist, community mental health services, and other community resources. - Assists families with guardianship applications - Provides resources for advanced directives and shared decision-making - Maintains resource directories - Establishes and strengthens links between pediatric and adult healthcare systems
Front Desk Staff	- First point of contact that provides patient & caregivers transition planning information - Responsible for providing the necessary forms/resources for transition preparedness - Assist patients & caregivers navigate the transition readiness screening tool
Management	- Manages the day-to-day business affairs of the team - Technology Consultants: works with the team to develop EHR-based care plans, questionnaires, and tracking tools - Serves as a consultant around strategies to share health information electronically
Transition Champions	- Advocate for the transition team's activities at clinic level committee - Perform process improvement initiatives to optimize transition planning - Update patient/caregiver handouts - Stay current and keep team informed on latest transition guidelines and standards of care

3. Examine Current Approach:

- Process Map: Revise previous process to align with new interventions

4. Intervention:

➢ Development of Transition Program: "The Road to Independence"
  ➢ Focused on adapting purposeful & useful templates from *Got Transition:*
  ➢ Creation of innovative, transition strategies, tools, & resources for patients, caregivers & staff
    ➢ Adolescent Transition Companion Workbook
    ➢ Patient/Caregiver Handouts
    ➢ Staff Training
    ➢ Incorporate Transition Planning in EHR
    ➢ Practice Policy (Starting at 14 years old)

https://midd.me/ugzV

Plan for Improvement

Adolescent Transition Planning (ATP) Tool

- Structured Transition to Adulthood Readiness (STAR) Screening Tool Screening tool: assess adolescent transition preparation

- Guides interaction between clinicians, patients & families in transition planning

- Assess & intervene on self-management skills before the transfer to adult care

- Evaluate transition understanding, confidence, & level of importance

- Self-report measure

- Adapted 23 core questions from Transition Readiness Assessment for Youth/Young Adults: 6 Core Elements of Health Care Transition 2.0 (Got Transition, 2014).

- Integrated with QR Codes

- Clinicians asked to complete the STAR during well visit & documented in EHR (ATP Care Plan)

OFFICIAL Adolescent Transition Readiness Assessment.pdf

Question #1: "I understand my healthcare needs"

Are you ready to transition to adult health care?

https://gottransition.org/youthfamilies/HCTquiz.cfm

Adolescent Transition Readiness Assessment

Health	Things I need to know or do	Will someone else have to do this for me?	I will finish by (date)	Scan this Code with a Smart Phone to Learn More!
1. I understand my healthcare needs. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
2. I explain my medical needs to others. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
3. I know my symptoms including ones that I quickly need to see a doctor for. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
4. I know what to do in case I have a medical emergency. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
5. I know my own medicines, what they are for, and when I need to take them. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
6. I know my allergies to medicines and medicines I should not take. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
7. I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary). ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
8. I understand how healthcare privacy changes at age 18 when legally an adult. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
9. I can explain to others how my customs and beliefs affect my health care decisions and medical treatment. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		

How important is it to you to prepare for/transfer to an adult clinician before age 18?

☐ 0 (NOT Important)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (Very Important)

How confident do you feel about your ability to prepare for/transfer to an adult clinician before age 18?

☐ 0 (NOT Important)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (Very Important)

⭐ **Scan here to learn about our Transition Policy!**

Adapted from "Six Core Elements of Health Transition 2.0," Sample Transition Readiness Assessment for Youth by Got Transition/Center for Health Care Transition Improvement, 2014, The National Alliance to Advance Adolescent Health. Retrieved from https://www.GotTransition.org. Copyright 2014 by Got Transition.

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https://midd.me/oGCJ

Question #5: I know my own medicines, what they are for, and when I need to take them

https://qrs.ly/6j7p6g9

https://midd.me/oGCJ

Question #7:

I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary)

https://qrs.ly/5s7p6l5

Adolescent Transition Readiness Assessment

Health	Things I need to know or do	Will someone else have to do this for me?	I will finish by (date)	Scan this Code with a Smart Phone to Learn More!
1. I understand my healthcare needs. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
2. I explain my medical needs to others. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
3. I know my symptoms including ones that I quickly need to see a doctor for. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
4. I know what to do in case I have a medical emergency. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
5. I know my own medicines, what they are for, and when I need to take them. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
6. I know my allergies to medicines and medicines I should not take. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
7. I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary). ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
8. I understand how healthcare privacy changes at age 18 when legally an adult. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
9. I can explain to others how my customs and beliefs affect my health care decisions and medical treatment. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		

How important is it to you to prepare for/transfer to an adult clinician before age 18?

| ○ 0 (Not Important) | ○1 | ○2 | ○3 | ○4 | ○5 | ○6 | ○7 | ○8 | ○9 | ○ 10 (Very Important) |

How confident do you feel about your ability to prepare for/transfer to an adult clinician before age 18?

| ○ 0 (Not Important) | ○1 | ○2 | ○3 | ○4 | ○5 | ○6 | ○7 | ○8 | ○9 | ○ 10 (Very Important) |

⭐ **Scan here to learn about our Transition Policy!**

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https://midd.me/oGCJ

Question #8:

I understand how healthcare privacy changes at age 18 when legally an adult.

https://qrs.ly/ih7p6lh

Adolescent Transition Readiness Assessment

Health	Things I need to know or do	Will someone else have to do this for me?	I will finish by (date)	Scan this Code with a Smart Phone to Learn More!
1. I understand my healthcare needs. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
2. I explain my medical needs to others. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
3. I know my symptoms including ones that I quickly need to see a doctor for. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
4. I know what to do in case I have a medical emergency. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
5. I know my own medicines, what they are for, and when I need to take them. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
6. I know my allergies to medicines and medicines I should not take. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
7. I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary). ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
8. I understand how healthcare privacy changes at age 18 when legally an adult. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
9. I can explain to others how my customs and beliefs affect my health care decisions and medical treatment. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		

How important is it to you to prepare for/transfer to an adult clinician before age 18?

| ☐ 0 (NOT Important) | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 | ☐6 | ☐7 | ☐8 | ☐9 | ☐ 10 (Very Important) |

How confident do you feel about your ability to prepare for/transfer to an adult clinician before age 18?

| ☐ 0 (NOT Important) | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 | ☐6 | ☐7 | ☐8 | ☐9 | ☐ 10 (Very Important) |

⭐ Scan here to learn about our Transition Policy!

Adapted from "Six Core Elements of Health Transition 2.0," Sample Transition Readiness Assessment for Youth by Got Transition /Center for Health Care Transition Improvement, 2014, The National Alliance to Advance Adolescent Health. Retrieved from https://www.GotTransition.org, Copyright 2014 by Got Transition.

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Question #15:

I know where to go to get medical care when the doctor's office is closed.

https://qrs.ly/rz7qmzk

Adolescent Transition Readiness Assessment

Independent Living	Things I need to know or do	Will someone else have to do this for me?	I will finish by (date)	Scan this Code with a Smart Phone to Learn More!
10. I know or I can find my doctor's phone number. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
11. I make my own doctor appointments. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
12. Before a visit, I think about questions to ask. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
13. I have a way to get to my doctor's office. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
14. I know to show up 15 minutes before the visit to check in. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
15. I know where to go to get medical care when the doctor's office is closed. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
16. I have a file at home for my medical information ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
17. I have a copy of my current plan of care. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
18. I know how to fill out medical forms. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
19. I know to get referrals to other providers. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
20. I know where my pharmacy is and how to refill my medicines. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
21. I know where to get blood work or x-rays if my doctor orders them. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
22. I have a plan so I can keep my health insurance after 18 or older. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		
23. My family and I have discussed my ability to make my own healthcare decisions at age 18. ☐ YES, I know this ☐ NO, I need to learn		☐ YES ☐ NO		

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Using EHR in Transition: Transition Tools e-ATP Care Plan

Components of Care Plan:
- Goals
- Actions
- Next Steps
- Care Coordination Notes (Internal Use)
- Team Members

- Integrates all transition planning components for consolidated and streamlined documentation of transition planning progress in the patients' EHR over time.

- Used with phrase expander sub-system.

- An EHR record that incorporates transition planning activities in the patient's health records

- Available on the medical summary, or other protocols in the EHR to track, coordinate, & print the management plan, thus providing easy access for the clinicians overseeing the adolescent.

Instructional Video

Note. The Adolescent Transition Planning (ATP) care plan video features the innovative use of the participating institution EHR system to support and document transition and transfer the adolescent and young adult patients. The narrator presents the protocol built into the EHR that tracks patient's progress toward meeting transition educational milestones and acquiring the competencies critical for successful transition.

Staff Education: Transition Toolkit
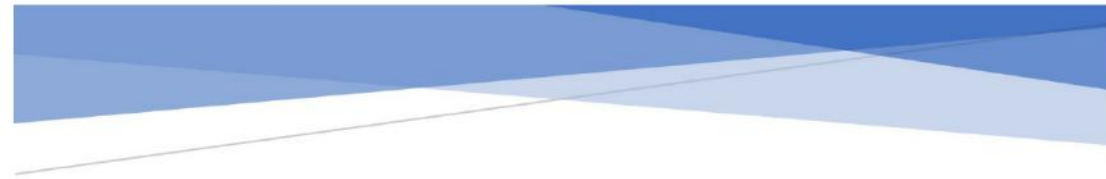
HEALTH CARE
TRANSITION SERVICES
FOR ADOLESCENTS
AND YOUNG ADULTS:

*Curriculum and Resources for Clinicians and Staff on Transition
from Pediatric to Adult-Based Health Care*

Delia Garcia, MSN, RN, CPN, FNP-C
Jennifer Gray, M.D., F.A.A.P.
Carolyn Wagner, M.D., F.A.A.P.

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https://midd.me/0EcK

Staff Tool Kit. Guidelines for clinicians to support the delivery of transition planning. Developed by the Taskforce committee & adapted from Got Transition (2014).

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Data Collection Methods

- **Data extraction from the electronic health records**
  - ATP Utilization**:** # of active adolescents that are 14 years of age & older that received STAR screening using the electronic adolescent transition care plan (ATP) during routine well-visits
  - EHR records were extracted, & data was stratified as performance data by patient age, sex, date of birth, date of service, ATP care plan use, & whether the STAR tool was documented within the ATP care plan.
  - Calculated the % of adolescents ≥ 14 years of age having the STAR screening in the electronic ATP care plan with well-visit encounters using Microsoft Excel.
  - Process was evaluated by noting the patient's age, gender, & whether the encounter contained ATP use & evaluating how clinician's ATP use changed over time after the initial intervention.

- **Written narratives of observed responses**
  - Collected & shared among the transition taskforce to share regular improvement feedback.
  - Project log was utilized to document issues that arise and annotate decisions made at the project progressed.

- **Self-report via clinician surveys & interviews**
  - Assess the clinician's experience, evaluate the clinician's perception of their access to electronic transition planning tools & make modifications based on user feedback on the transition program materials provided
  - Open & closed-ended feedback to assess the impact of the interventions & allow respondents to express their answers freely.
  - Individual interviews were conducted, in which clinicians & ancillary staff responded to open-ended questions, providing insight into the stakeholder's perspectives regarding the adolescent transition program.

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PDSA CYCLES

Plan (Cycle with Plan highlighted)

Cycle #1:
- Baseline & Formal Training Phase
- Promote STAR use with all clinicians

Cycle #2:
- ↑ Transition/STAR use knowledge
- Assistance with STAR/ATP
- Interventions to reduce barriers

Cycle #3:
- Intensive training
- Sustainability efforts
- ↑ Communication
- Competency Checklist
- Individual technical assistance
- QI Log
- Newsletter
- EHR Documentation

Do (Cycle with Do highlighted)
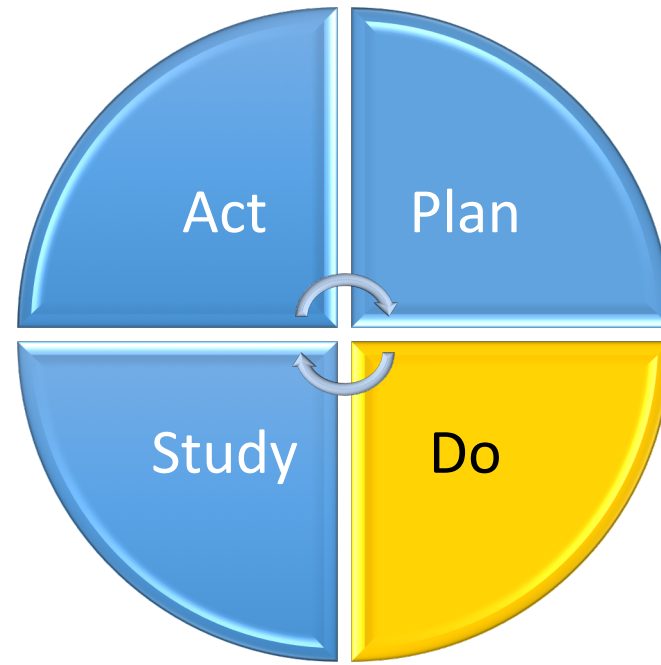
Cycle #1:
- Test the Theory: # of Encounters with STAR use (EHR Audits), Document problems & observations

Cycle #2:
- Test the Theory: # of Encounters with STAR use), Document problems & observations

Cycle #3
- Test the Theory: # of Encounters with STAR use), Document problems & observations

Study (Cycle with Study highlighted)
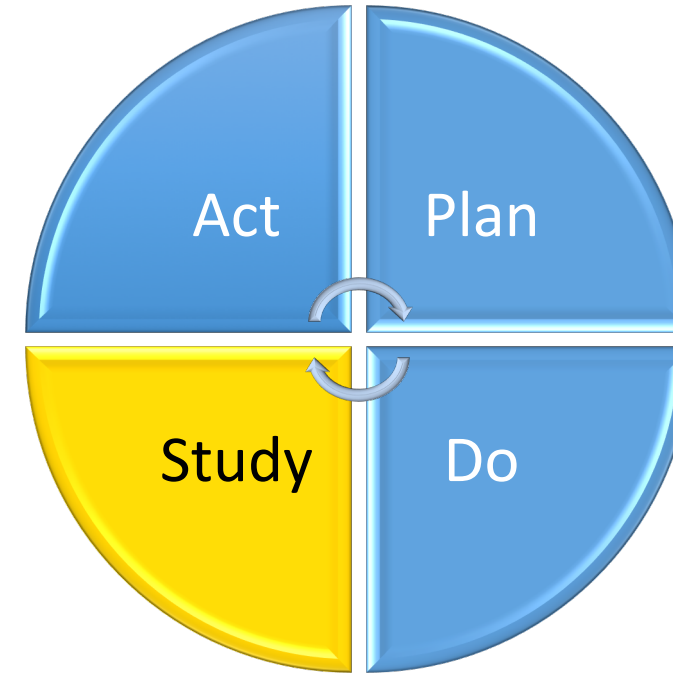
Cycle #1:
- Analyze Results: Online Questionnaire, Interviews, EHR Record reviews, observations

Cycle #2:
- Analyze Results: Interviews, EHR Record reviews, observations

Cycle #3
- Analyze Results & compare to predictions: Interviews, EHR Record reviews, observations

Act (Cycle with Act highlighted)
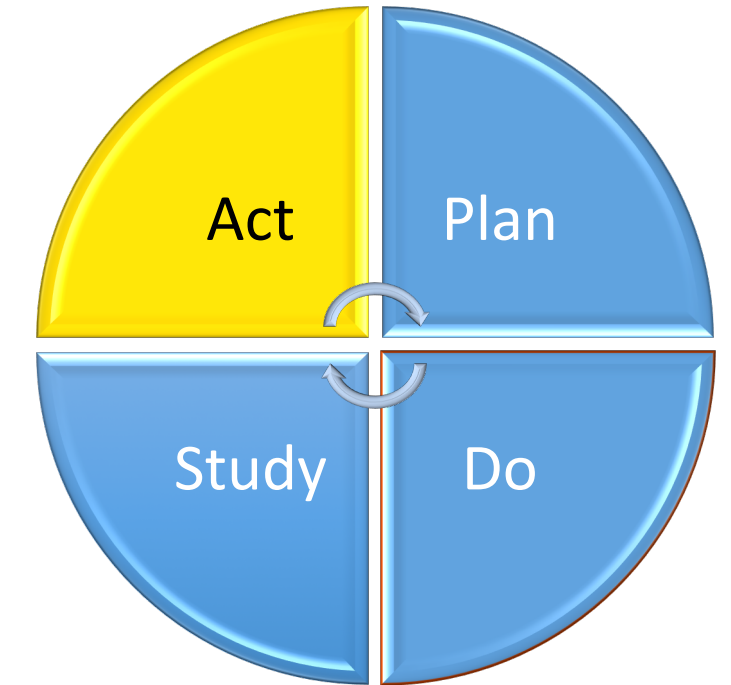
Cycle #1:
- Lessons learned
- Changed strategies
- Established Future Plans

Cycle #2:
- Make plans for next cycle
- Standardize Improvement

Cycle #3:
- Meetings with Task Force team
- Establish future plans

PDSA Cycles
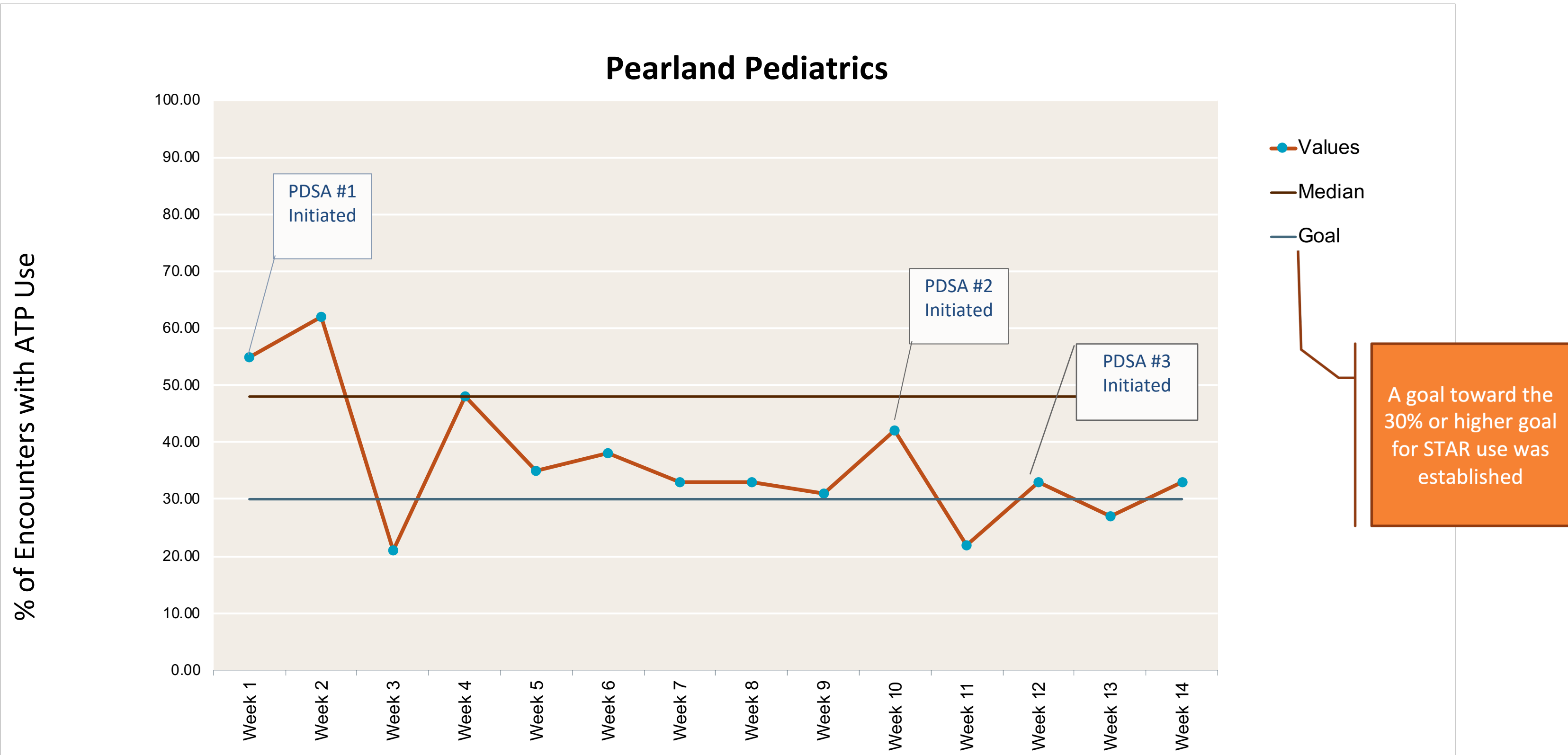
Figure 1. Structured Transition Adolescent Readiness (STAR) utilization across the clinic during plan-do-study-act (PDSA) cycles 1-3.

Road to Independence Clinician Questionnaire

Road to Independence Clinician Questionnaire

1. In reference to the Adolescent Transition Planning (ATP) Care Plan, how satisfied are you with the ease of using the electronic ATP Care Plan?
2. The time it takes to utilize the electronic Adolescent Care Plan in clinic?
3. The training you were given prior to using the electronic Adolescent Transition Planning (ATP) tool?
4. Technical assistance or trouble shooting in using the electronic Adolescent Transition Planning (ATP) tool?
5. The flow of using the Adolescent Readiness Assessment Screening form, electronic Adolescent Transition Planning (ATP) tool, and providing the educational materials to the patient related to transition planning?
6. In your opinion, how much additional time per patient has the overall Adolescent Transition Planning added to your usual patient visit?
   a. Less than 1 minute
   b. Between 1 minute and 3minutes
   c. Between 3 minutes and 5 minutes
   d. Between 5 minutes and 7 minutes
   e. Between 7 minutes and 10 minutes
   f. More than 10 minutes
   g. Other

Note. This questionnaire was used to gain an understanding of clinician's confidence, knowledge, and understanding of their role in transition preparation. The survey was adapted from the Family-Centered Care Self-Assessment Tool (Family Voices, 2008). Developed for this study based on reviewing literature (Lobstein et al. 2005, 2009: Sawicki et al, 2011; Wiemann et al., 2015).

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Evaluating Interventions

Clinician Interview Script
1. In your opinion, what are the reasons why clinicians do not always follow the guidelines for transition care?
2. In your experience, what are some reasons why so many adolescents/young adults do not receive transition planning anticipatory guidance?
3. Are there any particular aspects of the Got Transition recommendations that you may disagree with? Why?
The next few questions are about your experiences with the EHR System….
4. How often do you use the ATP during your adolescent well-visits?
5. Overall, how much has your work routine changed as a result of ATP?
6. Do you have any comments about the process of implementing transition planning in your daily work routine?
9. Do you have any recommendations for how alerts or other information tools for adolescent transition care should be designed in PCC?
10. Do you have any other final comments?

Note. This is an interview guide was designed to be conducted with clinical staff in ambulatory setting. The tool includes questions to assess the current state of electronic health records.

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Clinician Interview Questionnaire: Clinician's Perception of Transition Planning Time

In your opinion, how much additional time per patient has the overall Adolescent Transition Planning added to your usual patient visit?	Response Count
Less than 1 min	1
Between 1 min-3 minutes	1
Between 3 min-5 minutes	4
Between 5 min-7 minutes	1
Between 7 min-10 minutes	0
More than 10 min	0
Other	3

Note. This table illustrates the total count of clinician's response on their perception of the additional time transition planning has added to the well-visit. The survey was adapted from the Family-Centered Care Self-Assessment Tool (Family Voices, 2008). Developed for this study based on reviewing literature (Lobstein et al. 2005, 2009: Sawicki et al, 2011; Wiemann et al., 2015).

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ADOLESCENT TRANSITION PROGRAM

TRANSITION SKILLS/AREA KNOWLEDGE CHECKLIST

TRAINING TOPIC	Where to locate/learn more:	DATE COMPLETED	EMPLOYEE'S INITIALS
TRANSITION POLICY (Parent Handout)			
ADOLESCENT TRANSITION PLANNING TOOL (ATP)			
ADOLESCENT TRANSITION POLICY (Office Policy)			
ADOLESCENT TRANSITION COMPANION WORKBOOK			
ADOLESCENT TRANSITION EHR DOCUMENTATION			
PRIVACY CHANGES STARTING AT 18 YRS OF AGE			
ADULT REGISTRATION FORM			

The "Transition Improvement Planning Self-assessment" (TIPS) clinical checklist developed by project leader and the clinical nurse manager in the task force committee to address staff knowledge deficits and develop individual enrichment interventions to improve in transition planning efforts.

Disseminating Communication

Front page image of the participating institution's transition newsletter. A full digital version can be accessed here:

https://simplebooklet.com/pearlandpediatricsherald

Limitations

- ↓ participation rates of some clinicians

- Single location & small sample size limit the generalizability of the findings.

- Less than average total # of well-visits that met criteria during holiday break, & the limited amount of time to conduct the study interfered with the ability to collect study data.

- Clinicians may have asked STAR questions but may have not documented its use

- Running reports on Careplans

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Lessons Learned

- Time pressures & scheduling demands
  - Collaboration/communication plan for development phase is crucial
- Time Constraints to STAR use
  - EHR must have supporting functionalities
  - Staff Education
- Staff Turnover
  - Streamlined/Structured workflow
  - Properly engage new staff
- Organizational Culture
  - Adapting to change
- Generational Gaps

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Opportunities

- Identifying an Adolescent Transition champion for the office
- Utilizing technology and/or telemedicine for completion of the transition process/coordination of care
- Utilizing appropriate billing codes
- Connecting with adult primary care physicians locally who are willing to accept new young adult patients
- Becoming more knowledgeable about the resources available for our special needs population (ie, local academic centers have young adult transition clinics)
- Dedicated time to develop transition programming, develop tools & resources that can be easily embedded/modified to meet specific patient & program needs
- Incorporating inter-professional collaboration, technology, innovation & creativity.

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Program Sustainability

Table 1. Sample listing of CPT codes related to transition

Applicable Transition CPT Codes	Service Descriptions
99241-99245	Office or other outpatient consultations
99339, 99340	Care plan oversight services
99354, 99355, 99358, 99359	Prolonged services
99366-99368	Medical team conference
96160	Health and behavior risk assessment (e.g., transition readiness/ self-care assessment)
99441-99443	Telephone services
99444	Online medical evaluation
99446-99449, 99451, 99452	Interprofessional telephone/Internet/electronic health record assessment and management services
99487, 99489	Complex chronic care management services
99490, 99491	Chronic care management services
99495, 99496	Transitional care management services
98960-98962	Education and training for patient self-management services

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	Transition Related Services	100% Medicare Payment, 2019		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Care Plan Oversight Services[b]				
99339	Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	$78.20	NA	2.17/NA
99340	30 minutes or more	$109.92	NA	3.05/NA
Prolonged Services[c]				
99354[†]	Prolonged evaluation and management (E/M) or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting, with direct patient contact beyond the usual service; first hour	$132.26	$123.97	3.67/3.44
99355[†]	Each additional 30 minutes	$100.91	$93.70	2.80/2.60
99358	Prolonged E/M services before and/or after direct patient contact; first hour	$113.52	$113.52	3.15/3.15
99359	Each additional 30 minutes	$54.78	$54.78	1.52/1.52

	Transition Related Services		100% Medicare Payment, 2019		
CPT Code	Service Description		Office	Facility	RVUs (Non-Facility/Facility)*
Medical Team Conference[d]					
99366	With interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician qualified health care professional		$43.61	$42.89	1.21/1.19
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician		NA	$57.66	NA/1.60
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional		NA	$37.48	NA/1.04
Preventive Medicine Services[e]					
99384	Initial comprehensive preventive medicine E/M, new adolescent patient; ages 12 through 17 years		$138.75	$103.79	3.85/2.88
99385	Ages 18 through 39 years		$134.07	$99.47	3.72/2.76
99394	Periodic comprehensive preventive medicine reevaluation and management of an established adolescent patient; ages 12 through 17 years		$118.57	$88.66	3.29/2.46
99395	Ages 18 through 39 years		$121.09	$91.18	3.36/2.53
Health and Behavior Risk Assessment[f]					
96160	Administration of patient-focused health risk assessment instrument (e.g., transition readiness assessment) with scoring and documentation, per standardized instrument		$3.24	NA	0.09/NA

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Adolescent Transition Coding

CPT Code	Transition Related Services — Service Description	100% Medicare Payment, 2019		
		Office	Facility	RVUs (Non-Facility/Facility)*
General Behavioral Health Integration Care Management[g]				
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month	$48.65	$32.80	1.35/0.91
Care Management Services[h]				
99487	Complex chronic care management services with required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision-making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$92.98	$52.98	2.58/1.47
99489	Each additional 30 minutes	$46.49	$26.67	1.29/0.74
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline; comprehensive care plan established, implemented, revised, or monitored	$42.17	$32.44	1.17/0.90

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CPT Code	Transition Related Services	100% Medicare Payment, 2019		
	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Telephone Services[j]				
99441	Telephone E/M service provided by a physician or other qualified health professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$14.06	$12.97	0.39/0.36
99442	11-20 minutes of medical discussion	$27.39	$25.95	0.76/0.72
99443	21-30 minutes of medical discussion	$40.36	$38.92	1.12/1.08
Interprofessional Telephone/Internet/Electronic Health Record Consultations[i]				
99446	Interprofessional telephone/Internet/electronic health record assessment and management services provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	NA	$18.38	NA/0.51
99447	11-20 minutes of medical consultative discussion and review	NA	$36.40	NA/1.01
99448	21-30 minutes of medical consultative discussion and review	NA	$54.78	NA/1.52
99449	31 minutes or more of medical consultative discussion and review	NA	$73.16	NA/2.03
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	$37.48	$37.48	1.04/1.04
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes	$37.48	$37.48	1.04/1.04

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Adolescent Transition Coding

	Transition Related Services		100% Medicare Payment, 2019		
CPT Code	Service Description		Office	Facility	RVUs (Non-Facility/Facility)*
Telephone Services^j					
99441	Telephone E/M service provided by a physician or other qualified health professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion		$14.06	$12.97	0.39/0.36
99442	11-20 minutes of medical discussion		$27.39	$25.95	0.76/0.72
99443	21-30 minutes of medical discussion		$40.36	$38.92	1.12/1.08
Interprofessional Telephone/Internet/Electronic Health Record Consultationsⁱ					
99446	Interprofessional telephone/Internet/electronic health record assessment and management services provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review		NA	$18.38	NA/0.51
99447	11-20 minutes of medical consultative discussion and review		NA	$36.40	NA/1.01
99448	21-30 minutes of medical consultative discussion and review		NA	$54.78	NA/1.52
99449	31 minutes or more of medical consultative discussion and review		NA	$73.16	NA/2.03
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time		$37.48	$37.48	1.04/1.04
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes		$37.48	$37.48	1.04/1.04

CPT Code	Transition Related Services	100% Medicare Payment, 2019		
	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Education and Training for Patient Self-Management[m]				
98960[†]	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	$27.75	NA	0.77/NA
98961[†]	2-4 patients	$13.69	NA	0.38/NA
98962[†]	5-8 patients	$10.09	NA	0.28/NA

*In some cases, payers will not use the Medicare total RVUs for a service in the calculation of physician payment. Instead, they may apply their own relative value adjustments.

†These CPT codes may be used for reporting synchronous telemedicine services when appended by modifier 95, and involving electronic communication using interactive telecommunication equipment that includes, at minimum, audio and video.

NA: Certain CPT codes do not have assigned RVUs.

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Appendix A: Characteristics of Services Specific to Provider Designation

CPT Code	Physician or Other Qualified Health Professional[1]		Clinical Staff Member[2]	
	Face-to-Face[3]	Non-Face-to-Face	Face-to-Face[3]	Non-Face-to-Face
Office or Other Outpatient Services, New Patient				
99201	X			
99202	X			
99203	X			
99204	X			
99205	X			
Office or Other Outpatient Services, Established Patient				
99211	X			
99212	X			
99213	X			
99214	X			
99215	X			
Office or Other Outpatient Consultations, New or Established Patients				
99241	X			
99242	X			
99243	X			
99244	X			
99245	X			
Care Plan Oversight Services				
99339		X		
99340		X		
Prolonged Services				
99354	X			
99355	X			
99358		X		
99359		X		
Medical Team Conference				
99366	X			
99367		X		
99368		X		
Preventive Medicine Services				
99384	X			
99385	X			
99394	X			
99395	X			
Health and Behavior Risk Assessment				
96160	X	X	X	X
General Behavioral Health Integration Care Management				
99484			X	X

CPT Code	Physician or Other Qualified Health Professional[1]		Clinical Staff Member[2]	
	Face-to-Face[3]	Non-Face-to-Face	Face-to-Face[3]	Non-Face-to-Face
Care Management Services				
99487			X	X
99489			X	X
99490			X	X
99491		X		
Transitional Care Management Services				
99495	X	X	X	X
99496	X	X	X	X
Telephone Services				
99441		X		
99442		X		
99443		X		
Online Medical Evaluation				
99444		X		
Interprofessional Telephone/Internet/Electronic Health Record Consultations				
99446		X		
99447		X		
99448		X		
99449		X		
99451		X		
99452		X		
Education and Training for Patient Self-Management				
98960	X			
98961	X			
98962	X			
Miscellaneous Services				
99078	X			

[1] The American Medical Association distinguishes a qualified health care professional from a clinical staff member in terms of which providers may report services. In addition to a physician, "other qualified health care professionals" include, but are not limited to, clinical nurse specialists, nurse practitioners, physician assistants, and clinical social workers.

[2] A "clinical staff member" is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and faculty policy to perform or assist in the performance of a specified professional service, but who does not individually report the professional service. Clinical staff include, but are not limited to, medical assistants and licensed practical nurses.

[3] Physical face-to-face presence and synchronous real-time audio-visual face-to-face are considered equivalent. Note this statement from 2019 CPT regarding modifier 95: "The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction."

Address to Insurance Carrier Claims Review Department
Address to Insurance Carrier Medical Director

Dear (to be individually addressed on practice or chapter letter head):

I am writing to object to [*Carrier Name*] policy of [*select as appropriate either not covering or bundling, or inadequately paying for*] CPT codes related to transition from pediatric to adult care. Transition services are intended to be part of routine preventive, primary, and chronic care for all adolescents and young adults. Our physicians and their clinical staff are appropriately reporting CPT codes even though the services may otherwise be denied by the payer. The specific CPT codes listed below are necessary to report the additional time and work for transition services and should be paid appropriately.

These transition-related codes align with the pediatric and adult patient-centered medical home model of care[1] and the AAP/AAFP/ACP Clinical Report on Transition to Adulthood,[2] which calls for a structured transition process beginning early in adolescence and continuing through transfer to adult care. Recognizing these codes would enable physicians and their clinical staff to provide the recommended transition planning, transfer assistance, and effective integration of into adult care. Evidence shows that a structured transition to adult care improves adherence to care, consumer satisfaction, and use of adult ambulatory care services.[3] A complete list of transition codes with corresponding Medicare fees, relative value units, and clinical vignettes was published in 2019.[4]

The CPT codes related to transition that are at issue include the following: [*please select those codes that the practice is addressing (a listing of CPT codes related to transition is attached in Table 1 for the practice's reference)*].

We urge you to recognize and pay appropriately for these services related to transition from pediatric to adult care. We look forward to your response on your coverage and payment policy for these health care transition-related CPT codes. If you have any questions or need additional information, please contact [*include contact information*].

Sincerely,
X

Access additional supporting handouts/resources here:
https://simplebooklet.com/exploretransition

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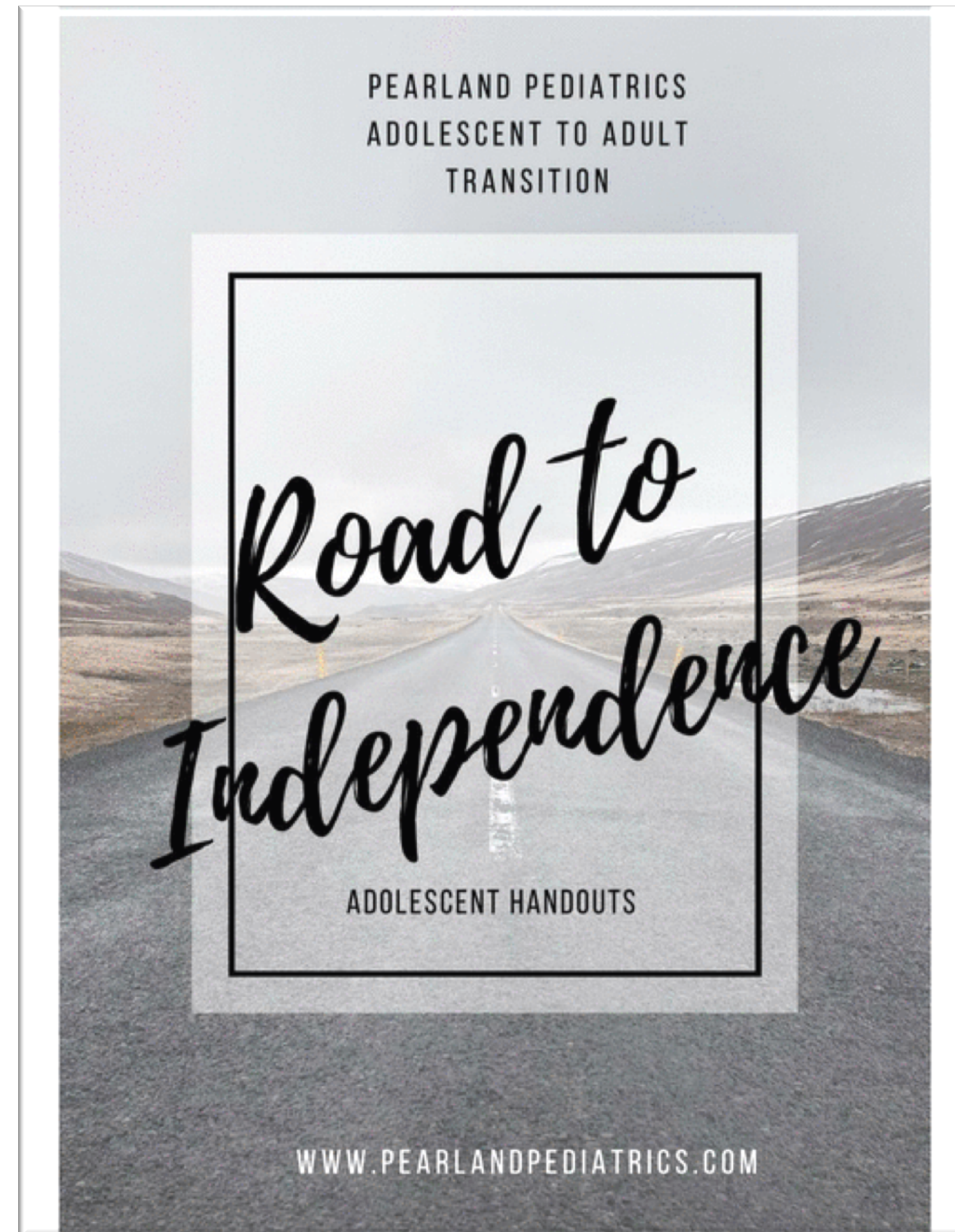
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