

TABLE OF CONTENTS

SECTION	PAGE
I. Policy	2
II. Authority	2
III. Supportive Data	2
IV. Signature Block with Effective Date	3
V. Definitions	3
VI. Protocols	4
A. Outcomes	4
B. Personnel	4
C. Competencies	4
D. Areas of Responsibility	4
VII. Procedures	5
VIII. Distribution List	6
IX. History Notes	6
X. Appendices	6

I. Policy


- A. Beginning at age 12, all adolescents and young adults with special health care needs enrolled in CMS and their families will receive the education and services needed to make transition to all aspects of adult life, including adult health care, work, and independence.
- B. Transition of care (e.g., pediatric to adult) is proactively planned, coordinated and documented in the care coordination module when indicated or when appropriate.
- C. The Children's Medical Services (CMS) medical record is standardized statewide to ensure consistency and to allow quality review staff to evaluate compliance with scanning and indexing procedures. Compliance will be documented by all CMS staff by adhering to the procedures as described in this policy.
- D. All care coordination staff will complete the Health Care Transition Training for Health Care Professional upon hire and annually.

II. Authority


Children's Medical Services operates under the authority of several State and Federal statutes. Chapter 391, Florida Statute (F.S.), entitled the Children's Medical Services Act and the Title V of the Social Security Act provides the primary legislative base for the program.

III. Supportive Data


CMS Care Coordination Operational Plan, CMS Documentation of Client Medical Records 145-101, CMS Area Office Oversight 145-021, Continuing Education 145-019

IV. Signature Block with Effective Date:*Signature on file*

Melissa Vergeson
Director, Children's Medical Services
Managed Care Plan Administration

Date

Kelli Stannard, RN, BSN
Director, Children's Medical Services
Managed Care Plan Operations

Date

Cheryl Young
Director, Office of Children's Medical Services
Managed Care Plan

Date**V. Definitions**

- A. **Business Objects** – Electronic system that is part of the CMS third party administrator that houses reports used by CMS Plan.
- B. **Care Coordination** – A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.
- C. **Care Coordination Module (CCM)** – The electronic documentation system for CMS Plan.
- D. **Care Plan** – Contains identified concerns, goals, interventions and established timeframes for anticipated completion. The care plan is a live, working document until the client is closed from CMS. It describes services to be provided for the client such as those related to diagnostic, therapeutic, or educational services. Care plans will be updated at least every 6 months.

- E. **Transition** – A dynamic, lifelong process that seeks to meet the health care needs for young adults with special health care needs. This process seeks to meet their individual needs as they move from childhood to adulthood. The goal is to maximize lifelong functioning and potential through provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood. It is patient-centered, and its cornerstones are flexibility, responsiveness, continuity, comprehensiveness, and coordination.

VI. Protocols

- A. **Outcomes:** Beginning at age 12, all adolescents and young adults with special health care needs enrolled in CMS and their families will receive the education and services needed to make transitions to all aspects of adult life, including adult health care, work, and independence.
- B. **Personnel:** CMS Area Office Staff
- C. **Competencies:** All personnel involved in CMS care coordination services and direct client services in the CMS clinics and all CMS administrative staff should have, at a minimum:
1. Knowledge of Chapters 391, F.S.
 2. Knowledge of CMS requirements for Health Care Transition (HCT).
 3. Knowledge of community/regional/federally funded adult health care services for primary and specialty care.
 4. Knowledge of legal and local and state financial services available.
 5. Knowledge of HCT educational resources to included CMS Plan materials, FloridaHATS and Got Transition websites.
 6. Good communication skills; rapport with CMS Plan enrollees and families, providers, and community agencies.
- D. **Areas of Responsibility:** Director, Office of Children's Medical Services Plan & Specialty Programs, Director, Children's Medical Services Plan Administration, and Director, Children's Medical Services Plan Operations.

VII. Procedures

- A. CMS Care Coordinators will assist clients who are adolescents and young adults, and their families identify their knowledge deficits about health care transition and provide educational information and resources to assist them in identifying and maintaining needed health care services as the clients prepare to leave pediatric health care and move to adult health care services.
 - 1. Adolescents and young adults, and their families will participate in the development and periodic review of their care coordination and transition plans.
 - 2. Adolescents and young adults, and their families will receive transition education and services that are developmentally appropriate.
- B. Documentation of health care transition planning and services is required to be present in the CCM for clients age 12 and older.
 - 1. Appropriate documentation in CCM addresses health care transition concerns identified by the family in the assessment within 30 days of enrollment and annually within 30 days before or 30 days after the redetermination date.
 - 2. Appropriate documentation in CCM addresses health care transition in the care plan within 45 days of enrollment and annually within 30 days before or 30 days after the redetermination date.
 - 3. Appropriate health care transition information and activities not addressed in the assessment or care plan are documented in the CCM in "Notes" section. The note type is "Care Coordination" and the note title is "Transition."
 - 4. Appropriate health care transition information and activities will be completed by utilizing the CMS Quality Improvement Process, by record reviews, and by review of performance measure reports available in the Business Objects application.
- C. Each CMS Area Office will designate one or more supervisors, care coordinators, and Family Support Workers (if applicable) to service as the CMS Transition Liaison(s).
 - 1. Transition Liaisons will participate in the CMS Transition Liaison conference calls and disperse transition resources and information to Area Office and contracted staff.
 - 2. Transition Liaisons will serve as the Health Care Transition Subject Matter Experts (SME) in their offices and identify local resources.

D. Health Care Transition Staff education and Resources:

1. Upon hire and annually, all care coordination supervisors and staff will complete Health Care Transition Training for Health Care Professionals. The training is accredited by the Florida Medical Association and Florida Board of Nursing, provides CMS/CE credit, and is valuable and appropriate for all staff. The training is approved for CE's for other allied health professionals including nutritionist, dieticians, and respiratory therapist.
 - a. The training is available for CMS/CEU credit at: www.aheceducation.com.
 - b. The training is available without credit at www.FloridaHATS.org.
 - c. The training is available without credit in the Department of Health Learning Management System (TRAIN).
2. FloridaHATS: HCT web-based resources are available for physicians, care coordinators, adolescents, young adults, and their families at: www.FloridaHATS.org.
3. Health Services and Directory for Young Adults: When adult providers or programs that service young adults are identified by staff, the provider information should be submitted by CMS staff within 30 days of identification on the FloridaHATS website at www.FloridaHATS.org. Related service directories are also available.

VIII. Distribution List: CMS Central Office Staff, CMS Care Coordinators, Supervisors, Nursing Directors, Regional Nursing Directors, and Family Support Workers.

IX. History: Health Care Transition IOP 145-204-11, Created 11/2014

X. Appendices: None