Module 8: The Care Transfer

Learning Objectives

- Describe characteristics of adults' health care to students and families
- Identify care transfer activities for IHP/504/IEP
- Support students during their care transfer
- List strategies to coordinate with providers during the transfer

The Care Transfer: Differences in Care

Culture Shock

- Not knowing what to do
  - Or how
- Not knowing what is appropriate
  - Or inappropriate
- Sense others' judgment or discomfort

Childhood Care: Approach

Adulthood Care: Approach

Child Medicine: Family-Oriented

- Shared Management Model
- Decision-making and follow-up
- Caregivers are experts

Adult Medicine: Patient-Oriented

- Family not a consideration
- Physician is expert
- Make decisions and function independently

Childhood: Treatment Roles

- Caregivers' observations
- Provider: advocacy and oversight
- Condition-specific clinics

Adult: Treatment Roles

- Tests and procedures
- Patients: Oversight and advocacy
- Primary care provider refers to multiple specialists
- No role for parents

Child-Focused Practice Staff

- Multidisciplinary model
- Care coordination
- Services and supports
- Psychosocial emphasis

Adult-Oriented Practice Staff

- Roles differentiated
- Referral to social work for non-medical
- Supports less accessible

Pediatric Medicine: What Is a Transition

- Hospital discharge
- Transfer to rehabilitation facility
- From acute care to secondary care
- To adult-oriented medicine

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Adult Medicine: What Is Transition

- Hospital admission/discharge
- Nursing home admission
- Acute to secondary care

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The Care Transfer: Significance

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Policies Requiring Transfer

- Hospital policies
- Insurance reimbursement
- Professional guidelines
- Licensure limits

Emotional Response to Transfer

Expect that students and families will have feelings of grief and loss

Benefits of working with AOPs

- Experts in health of adults
- Familiar with guardianship, social services, good referral resources
  - Though usually in the context of elderly patients
- Accustomed to learning new conditions
  - Type I Diabetes

Avoid Dropping Out

From Child-Focused Care

- Transition, without transfer
- 'Transfer' to referral list
- Discharge without transition or transfer

From Adult Medicine

- Transfer without transition preparation
- Missed appointments, no follow-up
- Dissatisfied with new provider

Avoid Dropping Out

From Child-Focused Care

- Transition, without transfer
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From Adult Medicine

- Transfer without transition preparation
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Interactive Question

Have your students experienced crises-related care restrictions?

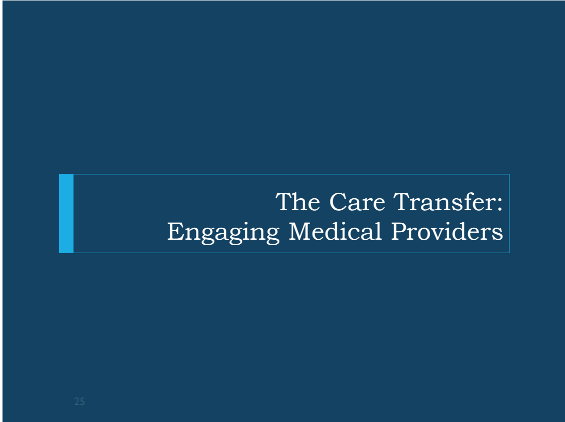
Why Educators Are Key

- More regular contact with student
- May be aware of interruptions before physicians
- Coach student & improve communication

The Transition Process: Transfer

1. Envisioning a Future
2. Basic Knowledge
3. Health Care Practices
4. Medications & Equipment
5. Doctor Visits
6. Health Care Transition
7. Transition to Adulthood
8. Health Care Systems

Reluctance to Transfer



Why Engage with Medical Providers?

- Highest risk: Dropping out
- Resources/staff you are unaware of
- Barriers/risks you are unaware of
- Impact of health on overall transition

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6 Core Elements

Transitioning Youth to Adult Health Care Providers (Pediatric, Family Medicine, and Med-Peds Providers)	Transitioning to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Med-Peds Providers)	Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, Med-Peds Providers)
1. Transition Policy	1. Transition Policy	1. Young Adult Transition and Care Policy
2. Transition Tracking and Monitoring	2. Transition Tracking and Monitoring	2. Young Adult Tracking and Monitoring
3. Transition Readiness	3. Transition Readiness .	3. Transition Readiness/Orientation to Adult Practice
4. Transition Planning	4. Transition Planning/Integration into Adult Approach to Care	4. Transition Planning/Integration into Adult Practice
5. Transfer of Care	5. Transfer to Adult Approach to Care	5. Transfer of Care/Initial Visit
6. Transfer Completion	6. Transfer Completion/Ongoing Care	6. Transfer Completion/Ongoing Care

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Tasks for Childhood Providers

- Provide/explain transition policy
- Know/understand other providers' policies
- Provide referrals for adult-oriented providers
- Coordinate care
- Prepare student for transition

Does Pediatrician Have Transition Policy?

- Practice-wide transition policy
- Prepares student for inevitable transfer
- Normalizes process

Communicate with Childhood Providers

- Encourage family to discuss health care transition
- Share their IHP/504/IEP
- Request provider-based health care transition plan

The Care Transfer: Discuss with Students and Families

Framing the Transfer

- Remind: Learned child-focused system
- Emphasize: Trust takes time
- Create realistic expectations

Caregiver Role During Transfer

- Coach?
- Cheerleader?
- Relief pitcher?

Path to Independence

PARENT-CHILD SHARED MANAGEMENT
Path to Independence

Gradual Release of Responsibility

Timing & Care Transfer

- Consider what else will occur around age 18, age 22, age 26
  - When insurance is changing
  - When they are graduating from special ed services
  - When moving to a new address

Starting College

- Students moving far away
- Students receiving on-campus care
- Accessibility of providers & pharmacies

Providers & IHP/504/IEP

- Phone contact
- Practicing activities with student
- Answering questions
- Participating in IHP/504/IEP meetings

YSHCN Transition Plan Items

- Identify new providers
  - Primary care providers, specialists, and hospitals
- Determine timing of care transfers
- Continued monitoring
- Check-ins

Transition Plan Item: Making the Referral

- Review the fields of adult medicine
  - Family, internal, med-peds
- Primary care vs. specialty care
- Hospitals
- Build confidence in their communication skills

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Student's Initial Contact

- Doctor's education and training?
- Treatment approach?
- How many young adults does provider see?
- Doctor's hospital admitting privileges?
- Insurance accepted?
- Payment methods?
- Office accessibility?
- Equipment to examine individuals with specific disability?
- Administrative policies?

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Sample Questions for Initial Visits

- May I bring a family member with me to office visits (parent, sibling, friend)?
- How many patients do you see with the same chronic health condition that I have?
- How do you involve your patients in health care decisions?
- What's the best way for me to prepare for an office visit with you?
- Do you use e-mail to answer questions from your patients?

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Interactive Question

What is one task for the care transfer that would fit into an IHP/504/IEP?

The Care Transfer: Resources

Key Points

- Care transfer akin to culture shock
- Prepare student for care transfer
  - Event itself
  - New providers
- Goal: Avoid interruptions in care

Summary of Tools

Citations

1. Clinical Report – Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home. 2011. American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Physicians. *Pediatrics*. DOI: 10.542/peds.2011-0969.

2. Six Core Elements of Health Care Transition 2.0 – Transitioning Youth to an Adult Health Care Provider. 2014. Got Transition/National Center for Health Care Transition Improvement.

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5. Parent-child shared management: The path to independence. 2010. University of Washington adolescent health transition project.