Module 9:
The Care Transfer

Learning Objectives

- Describe characteristics of adults' health care to patients and families
- Create a practice transition policy
- Identify care transfer activities for the transition plan
- Transfer care in a supportive manner

The Care Transfer: Evidence Base

The Transition Process

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

Culture Shock

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

Pediatric Care: Family-Oriented

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

Adult Medicine: Patient-Oriented

- Family not considered
- Physician is expert
- Make decisions and function independently

Pediatric Medicine: Approach

Adult Medicine: Approach

Pediatric Medicine: Treatment

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

Adult Medicine: Treatment

- Tests and procedures
- Patients: Oversight and advocacy
- PCP refers to multiple specialists

Pediatric Practice Staff

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

Adult Medicine Practice Staff

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

The Care Transfer: Significance

Policies Requiring Transfer

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

Emotional Response to Transfer

Expect that patients and their caregivers will have feelings of grief and loss

Interactive Question

Do policies limiting/restricting pediatric care affect your practice?

How have you found out about these policies?

Slide will automatically advance in 1 minute!

Common Outcomes

- Everything Stays the Same
- Mixed Transition
- Full Transition
- Dropping Out

Avoid Patient Dropping Out

From Pediatric Care

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

From Adult Medicine

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

Up Next: Video Clip!

- Interview with patient, Jeff

- First of 2 videos in this module

Patient Reluctance: Specialty Transfer

The Care Transfer: In Practice

Policies Supporting Transition

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

Your Practice's Transition Policy

- Describe transition
- Activities
- Transfer age

Deciding NOT to Transfer?

- Terminal patients
- Palliative patients
- Organ transplant

Sample Transition Policies

got transition

Sample Transition Policy

Six Core Elements of Health Care Transition 2.0

[*Pediatric Practice Name*] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult's consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.

CMHI Center for Medical Home Improvement

National Health Care Transition Center
Opening Doors to a Healthy Future

Sunshine Pediatrics
Transition of Care Policy for Youth and Young Adults
Sunshine Pediatrics models its transition policy upon the guidelines provided by the American Academy of Pediatrics' joint clinical report on transition and by Bright Futures. We believe that a smooth transition from adolescence to young adulthood includes the explicit transition from a pediatric to an adult health care model and the eventual transfer of health care to adult providers. This process requires joint planning, preparation, and implementation to begin by age 14. At age 18, most youth in our practice will transition to an adult model of care with modifications as needed for youth with intellectual disabilities. We honor the preferences of the youth and family regarding the eventual transfer of care to an adult primary care medical home, but we generally expect this to occur between 18 and 21 years of age.

Happy Valley Family Medicine
Transition of Care Policy for Youth and Young Adults
Happy Valley Family Medicine models its transition policy upon the guidelines provided by the joint clinical report on transition endorsed by the American Academy of Family Physicians and by Bright Futures. We believe that a smooth transition from adolescence to young adulthood includes the clear transition from a pediatric to an adult health care model. This process requires joint planning, preparation, and actions beginning by age 14. At age 18, all youth in our practice will transition to an adult model of care with modifications as needed for youth with intellectual disabilities. We also welcome the transition into our practice of youth and young adults with and without special health care needs and will make every effort to coordinate this transfer of care with the patient's prior medical home.

Healthy Futures Internal Medicine Associates
Transition of Care and Intake Policy for Young Adults
HFIMA welcomes all youth and young adults including those with chronic pediatric conditions and complex health care needs. We provide an adult model of care for all of our patients with modifications as needed depending on the patient's intellectual ability and guardianship status. We ask that all new young adult patients provide a portable medical summary and in the case of patients with complex chronic conditions, a current care plan. If patients do not have a portable medical summary or care plan we will work with the patient to develop them. We will also make every effort to coordinate the transfer of care with our new patient's prior medical home including pre-transfer get-acquainted consultation, direct communication with the pediatric medical home team, and assistance with the transfer of specialty care to adult specialists as needed.

Interactive Question

What would you include in your practice's transition policy?

Slide will automatically advance in 1 minute!

Framing the Transfer

- Family learned pediatric system
- Emphasize: trust takes time
- Create realistic expectations

Transition Plan & Care Transfer

- Determine when pediatric care will cease
- Identify new providers
- Transfer records from pediatric to adult providers

Transition Plan Item: Making Referral

- Review the fields of adult medicine
  - Family, Internal Medicine, Med-Peds
- Primary care vs. specialty care
- Build confidence in new provider

YSHCN Transition Plan Items

- Specialty referrals
- Continued monitoring
- Check-ins

Patient'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?

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?

Avoid Patient Dropping Out

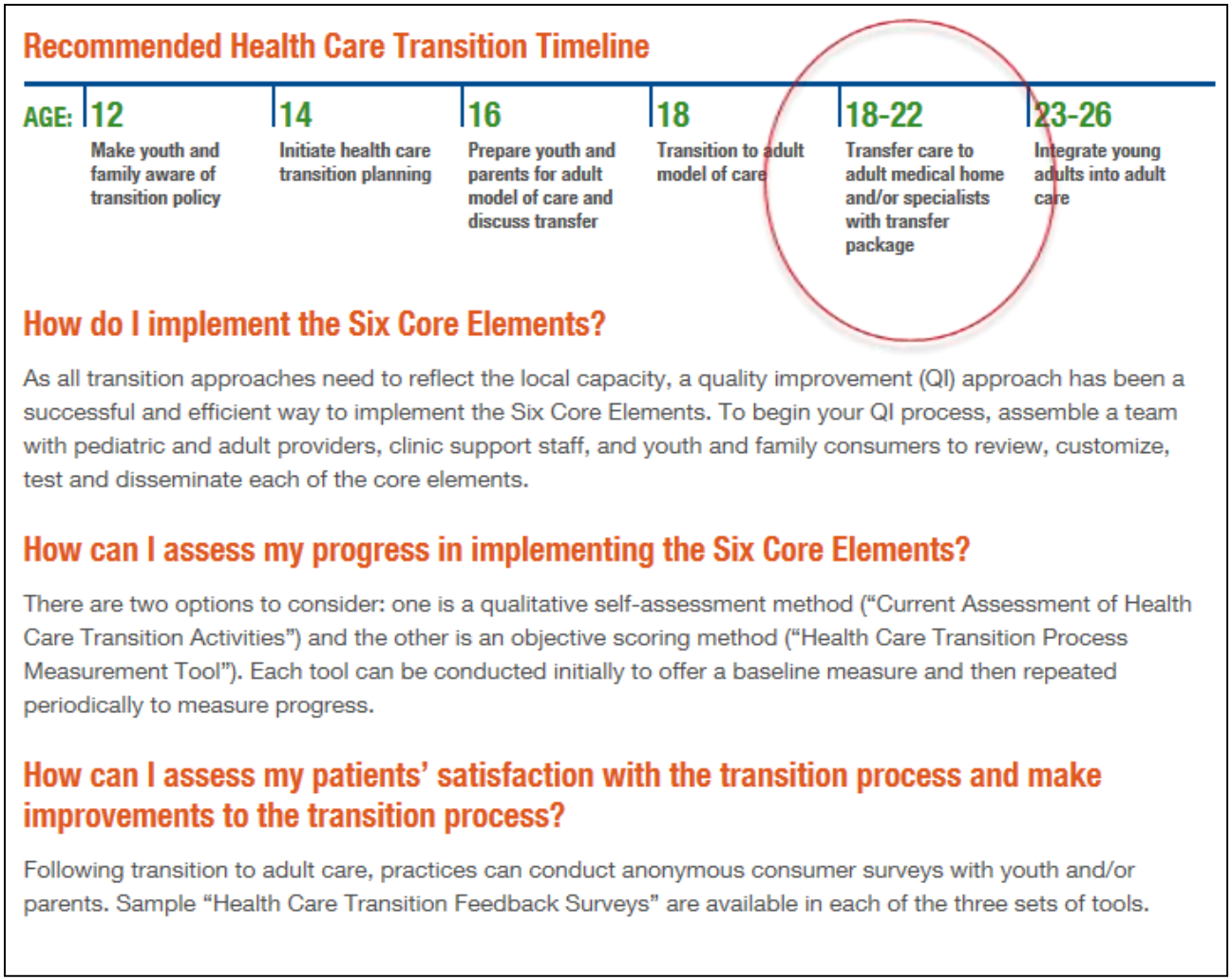
From Pediatric Care

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

From Adult Medicine

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

Resource! Six Core Elements



Recommended Health Care Transition Timeline

AGE: 12	14	16	18	18-22	23-26
Make youth and family aware of transition policy	Initiate health care transition planning	Prepare youth and parents for adult model of care and discuss transfer	Transition to adult model of care	Transfer care to adult medical home and/or specialists with transfer package	Integrate young adults into adult care

How do I implement the Six Core Elements?

As all transition approaches need to reflect the local capacity, a quality improvement (QI) approach has been a successful and efficient way to implement the Six Core Elements. To begin your QI process, assemble a team with pediatric and adult providers, clinic support staff, and youth and family consumers to review, customize, test and disseminate each of the core elements.

How can I assess my progress in implementing the Six Core Elements?

There are two options to consider: one is a qualitative self-assessment method ("Current Assessment of Health Care Transition Activities") and the other is an objective scoring method ("Health Care Transition Process Measurement Tool"). Each tool can be conducted initially to offer a baseline measure and then repeated periodically to measure progress.

How can I assess my patients' satisfaction with the transition process and make improvements to the transition process?

Following transition to adult care, practices can conduct anonymous consumer surveys with youth and/or parents. Sample "Health Care Transition Feedback Surveys" are available in each of the three sets of tools.

Up Next: Video Clip!

- Interview with patient

- Second of 2 videos in this module

Patient Experience: Preparing for New Providers

The Care Transfer: Discuss with Patients and Families

Caregiver Role During Transfer

- Coach
- Cheerleader
- Relief pitcher

Reminder: Shared Management Model!

PARENT-CHILD SHARED MANAGEMENT
Path to Independence

Introduction: While all children are born being totally dependent on their parents for their every need, we expect them as they grow and develop to learn how to care for themselves and become independent adults. Children are expected to gradually maste the necessary skills and to be increasingly responsible for self-management of their ow needs and care. Children with developmental disabilities, chronic illness, or other disabilities may be delayed or limited in reaching this independence in daily self-management due to medical problems, physical restrictions, or cognitive limitations. Sometimes parents are hesitant or uncertain about how to encourage independence in children who have special needs.

Shared Management by parent and child is a model suggested by Dr. Gail Kieckhefer and Cristine Trahms, in which business labels are used to express the changing dynamics in the parent-child relationship as the child/youth grows and develops. Th parent's role changes over the years from the *Provider* of care to the *Manager* to the *Supervisor* and finally to the *Consultant* for the youth. The management of the child's

Develop a Termination Process

Termination Strategies

- Celebrate long-term gains and accomplishments
- Affirm new knowledge and skills
- Transition event
- Final meeting
- Certificate of acknowledgement

The Care Transfer: Resources

Key Points

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

Summary of Tools

Health Care Transition Training for Health Care Professionals
2014 Course Release

Course Toolkit

Module 9. The Care Transfer

1. National Center for Health Care Transition Improvement – Sample Transition Policy
   http://www.gottransition.org/providers/leaving-1.cfm

2. Center for Medical Home Improvement – Sample Transition Policy
   http://illinoisaap.org/wp-content/uploads/TransitionPolicyExamples.pdf

3. Path to Independence
   https://depts.washington.edu/healthtr/documents/sharedmanage.pdf

4. The Six Core Elements of Health Care Transition
   http://www.gottransition.org/6-core-elements

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.

3. Sample Transition Policy. Got transition/Center for Health Care Transition Improvement. Published January 2014. Accessed 4/5/2014. http://www.gottransition.org/providers/index.cfm.

4. Transition Policy Example. Center for Medical Home Improvement. Published 2010. Accessed 5/1/2014 http://illinoisaap.org/wp-content/uploads/TransitionPolicyExamples.pdf

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