FloridaHATS Medical Advisory Workgroup Meeting Minutes
May 23, 2014, 8:30 AM ET

Attending:
Tampa: Martha Kronk, Joanne Angel, Janet Hess, Leandra Olson
Orlando: Vinny Chulani, Terri Doolittle, Audrie Barclay
Jacksonville: David Wood
Pensacola: Aliece Rockwell, Rex Northrup
Tallahassee: Susan Redmon, Cynthia Campbell, Shawn Hamm, Patricia Trom, Kelli Stannard
Teleconference: Jim Burns (Pensacola), Rose Marie Nealis (Gainesville), Sharon Surrency (Gainesville), Jodie Bargeron (Chicago), Diane Straub (Tampa), Jose Rosa-Olivares (Miami), Stefanie Brown (Miami), Carla Davis (Tallahassee)

1. **New CMS Care Coordination Module.** CMS is introducing a new statewide care coordination module, which functions as a proprietary electronic health record system. Key benefits are that it standardizes care coordination activities, reduces variation across individual care coordinators, and can produce customized activity reports. Seven offices have been trained to-date; remaining offices will complete training by November.

   Carla Davis from Med3000 (third party administrator) provided an overview of the module. A PPT presentation showed dashboard, navigation tools, assigned tasks, and schedule container for CMS client management.

   a. Displays all client and program info, e.g., specific network programs, enrollment date, start date, status, assessment due dates. Detailed task page includes notes/assessment/care plan; each case requires a comprehensive assessment and ongoing care plan. Care plans identify concerns, problems, diagnoses, and are reviewed on ongoing basis.

   b. The care planning section links specific concerns to a goal and an accompanying protocol set to achieve the goal. It identifies details of the goal: start, due date, series of interventions, and whether the goal is met. If the goal is not met, care coordinator indicates reason. Completed goals move to the history section.

   c. Transition activities are included in the care plan section. Standardized interventions are based on FloridaHATS algorithm for adolescents and young adults with special health care needs (see attachments). Customized reports will allow for better documentation of specific transition activities implemented with CMS clients.

   General feedback from advisory members was very positive. Dr. Northup emphasized the importance of programming the transition module so that the interventions flow smoothly and in chronological order.

2. **Health Care Transition Training for Health Care Professionals.** Overarching goal for the redesign is to update the existing training program to include current clinical guidance (Clinical Report and 6 Core Elements), evidence-based course elements, and new FloridaHATS materials**.** Dr. Hess provided an overview of the redesign (see attached PPT).

a. Hired an educational consultant for the project: Jodie Bargeron, who managed development of the Illinois MOC training in health care transition.

b. Reformatted the training to reflect best practice in adult learning: limit amount of text, target to learning objectives, use a familiar format so people can focus on course materials, imbed interactivity, allow time for reflection and integration of course material, maintain active voice, repeat important items, and avoid density.

c. Avoids duplication of what is available nationally. Comprehensive MOC Part 4 (QI) training programs for peds and adult care physicians are already offered through the Illinois Transition Project. This training offers a different but complimentary approach that is appropriate for a wide range of providers, including nurses and allied health professionals.

d. Continued accreditation through AHEC for 4 free CME/CEUs. AHEC has limited interactivity capabilities but it is cost- and time-prohibitive to secure a different provider. The 10 course modules (each lasts 15-20 minutes) will be posted on the FloridaHATS web site; users will be directed to the AHEC site to take the course for CME/CEU.

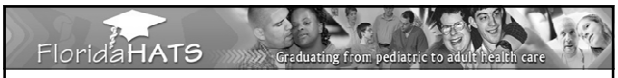
e. Ten modules cover these topics: introduction (overview of course), adolescent development, working with caregivers, assessing transition readiness, patient skill development, financial/legal considerations, insurance, working with adult medicine, care transfer, and conclusion(review of course). Each module includes these components: learning objectives, significance, evidence base, barriers, in practice, strategies and tools, discuss with patients and caregivers, key points, resources, references/citations.

Draft PPT modules were sent to members prior to the meeting for review and feedback. Dr. Wood suggested revising the slides to contain more text, and to limit the number of frameworks referenced in the presentation. Dr. Brown noted that the Health Care Transition Research Consortium currently is developing a transition curriculum for residency programs.

Since most workgroup members were not able to review the draft slides, Dr. Hess and Ms. Bargeron will email the accompanying script (voice-over narrative for the slides), with feedback due to Dr. Hess by June 4. Final changes will reflect member feedback; the product will be completed by end of June and available on AHEC sometime in July. There was consensus that it is important to get this information into practice, have a standardized procedure, and possibly implement a requirement for physicians to review the modules.

3. **Children's Hospital Survey.** Dr. Wood presented results from a survey he conducted in fall 2013 among Florida children's hospitals (see attached report). Findings show that a fair amount of transition-related activity is occurring in the hospitals, some with a specialty focus and some with a primary care focus. This provides a lot of opportunity for CMS to partner/collaborate with children's hospitals to improve transition for children enrolled in CMS and served in these facilities.

4. **Transitioning Patients to Federally Qualified Health Centers.** Drs. Hess and Wood presented to Florida FQHC clinicians on May 1. There was interest from attendees but also discussion of barriers, such as feeling overwhelmed with highly complex patients. Next step is to identify tangible steps CMS/FloridaHATS can take to replicate the PanhandleHATS model. This may include having CMS area offices contact their local FQHCs; leverage and expand existing relationships that CMS might have with local FQHCs; identify interested FQHCs and form a learning collaborative in 2014-15.



Medical Advisory Work Group

May 23, 2014

Agenda

- Introductions
- Update from CMS Leadership
  - New Care Coordination Module
  - Medicaid Managed Care Rollout
- Redesigned "Health Care Transition Training for Professionals"
- Transitional Care and Florida Children's Hospitals
- Transitioning Patients to Federally Qualified Health Centers

HCT Training Redesign: Approach for Course Update

- Apply adult learning best practices
  - Brief, targeted to learning objectives
  - Familiar format
  - Embedded interactivity – videos, questions
  - Natural breaks, chunks
  - Active voice
  - Repetition
  - Avoid density, multiple media on single slide

Training Considerations

- Utilize content in current course
- Update with new evidence-based materials
  - 2011 Clinical Report – Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home
  - 2014 Six Core Elements 2.0
  - FLHATS materials, JaxHATS Transition Tool Kit
- MOC Part IV QI training available nationally, through Illinois project (Peds, Family Med, IM)
  - FLHATS to promote MOC among physicians
  - FL training to compliment MOC
- Explore learning tracks for selected audiences, e.g., physician, care coordination, family

(Cont'd) Training Considerations

- Limited interactivity capabilities in AHEC web platform (accrediting agency)
  - Very expensive and time-intensive to change accreditation partner
- Maintain overall course length
  - 4 free CMEs/CEUs for health professionals
- Split into shorter learning modules
  - 15-20 minutes each
  - Post modules on FLHATS web site
- Direct FLHATS web users to AHEC course

Training Course Modules

Part I:

1. Introduction
2. Adolescent Development
3. Working with Caregivers
4. Assessing Transition Readiness
5. Patient Skill Development

Part 2:

6. Financial/Legal Considerations
7. Insurance
8. Working with Adult Medicine
9. Care Transfer
10. Conclusion

Training Module Outline

- I. Learning Objectives
- II. Significance
- III. Evidence-base
- IV. Barriers
- V. In practice
- VI. Using strategies and tools
- VII. Discuss with patients and caregivers
- IIX. Key Points
- IX. Resources
- X. References/citations

CMS – FACHC Memorandum of Agreement

- MOA to facilitate smooth transition of YSHCN to FQHC adult medical homes
  - When appropriate, CMS Care Coordinators will refer CMS patients to, and communicate with, FQHC providers
  - FACHC will encourage CMS credentialing among FQHC providers
  - GME/training at FQHCs about transition

PanhandleHATS Health Care Navigation Model

- Partners
  - Escambia Community Clinics, Inc. (FQHC)
  - Children's Medical Services (Pensacola)
- Eligible Clients
  - CMS clients ages 18-21
  - Uninsured and Medicaid enrolled
  - Consent to be referred to FQHC for their Primary Care Medical Home

Referral Process

Step 1: CMS Transition client counseled on medical home options. Client consents to FQHC referral .

⇩

Step 2: Referral made to CMS social worker if client agrees or requests assistance. Client may transition without assistance. CMS social worker or nurse coordinator makes contact with ECC.

⇩

Step 3: Referral will be called to assigned ECC transition social worker.

⇩

Step 4: Assigned ECC transition social worker will make contact with patient/family

⇨

Step 5: Referred CMS client will be entered into FQHC electronic medical records system and assigned to appropriate PCMH provider support team. Client will be contacted and appointment will be scheduled.

⇧

Step 6: Once patient arrives at ECC/FQHC for appointment, client will be greeted by designated social worker and walked through check in process.

⇧

Step 7: ECC/FQHC social worker will remain with CMS transition client through visit

⇧

Step 8: All additional referrals and resources will be provided and coordinated through designated social services staff and PCMH provider support team referral specialist.

⇧

Step 9: Designated social worker will continue to be the client's contact, liaison and advocate (FQHC Case Management Model).

Model Replication

- FLHATS presented to FQHC clinicians at statewide meeting on 5/1/14
  - Interest, but acknowledgement of barriers
- CMS leadership to meet in late May to discuss
- Possible next steps
  - CMS area offices make contact with local FQHCs; leverage existing relationships
  - Identify interested centers and form learning collaborative
  - Other ideas?

CMS Health Care Transition: New Care Plan Issues, Goals, Interventions and Expected Outcomes

- **Issue:** Initiate Health Care Transition Planning Process at age 12.

  Goal: Client and caregiver will be aware of the CMS Health Care Transition Planning Process initiated at age 12.

  Intervention: Care coordinator will provide developmentally-appropriate education and transition materials to the client and caregiver.

  Intervention: Care coordinator will identify Agency for Persons with Disabilities (APD) eligibility and educational needs (Ages 12-14). Assist client and caregiver to determine eligibility.

  Intervention: Care coordinator will discuss Helpline 2-1-1 Community Resources or the appropriate directory of community resources with the client and caregiver to promote self-reliance.

  Intervention: Care coordinator will discuss and encourage self-management of health care with client and caregiver, provide mentoring, and will assist client and caregiver to develop a portable individualized Health Summary that is kept up to date.

  Intervention: Care coordinator will educate client and caregiver to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).

  Expected Outcomes: Client and caregiver will be able to verbalize understanding of Health Care Transition Planning Process and will contact care coordinator with transitions from any health care setting.

- **Issue:** Health Care Transition Planning Process: Ages 13-14

  Goal: Client and caregiver will be engaged in the Health Care Transition Planning Process when the client is age 13-14.

  Intervention: Care coordinator will assess if the client has an Individualized Education Plan (IEP) starting at age 14, will help identify health-related activities to support the IEP, and will link client and caregiver to regional representatives for assistance with IEP.

  Intervention: Care coordinator will identify Agency for Persons with Disabilities (APD) eligibility, educational needs (Ages 12-14), and will assist client and caregiver to determine eligibility if appropriate.

  Intervention: Care coordinator will discuss and encourage self-management of health care with client and caregiver, provide mentoring, and will assist client and caregiver to develop a portable individualized Health Summary that is kept up to date.

Intervention: Care coordinator will educate client and caregiver and to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).

Expected Outcome: Client and caregiver will be knowledgeable about available transition resources and will contact care coordinator with transitions from any health care setting.

- **Issue:** Health Care Transition Process: Ages 15-17

  Goal: Client and caregiver will establish a timeline for transfer to adult primary and subspecialty care.

  Intervention: Care coordinator will identify client and caregiver decision-making needs.

  Intervention: Care coordinator will discuss and encourage self-management of health care with client and caregiver, provide mentoring, and will assist client and caregiver to develop a portable individualized Health Summary that is kept up to date.

  Intervention: Care coordinator will educate client and caregiver to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).

  Intervention: Care coordinator will complete the CMS Client/Young Adult Transition Checklist with the client and caregiver.

  Intervention: Care coordinator will assist client and caregiver to complete the Transition Readiness Assessment Questionnaire (TRAQ) every 6 months beginning at age 16.

  Intervention: Care coordinator will refer client and caregiver to Florida Legal Services for legal aid, if appropriate.

  Intervention: Care coordinator will determine if the client is eligible for Division of Vocational Rehabilitation (VR) starting at age 15. If eligible, the care coordinator will obtain a referral for client.

  Intervention: Care coordinator will assist and mentor client and caregiver with major issues before the 18th birthday (advance directives, levels of guardianship, voting).

  Intervention: Care coordinator will refer client and caregiver to Florida Legal Services for legal aid, if appropriate.

  Intervention: Care coordinator will refer client and caregiver to the local Center for Independent Living for assistance if appropriate.

  Expected Outcome: Client and caregiver are completing transition activities including a timeline and planning for successful transfer to adult primary and subspecialty care.

- **Issue:** Health Care Transition Process: Ages 18-21

  Goal: Client and caregiver will transition to an adult health care provider.

  Intervention: Care coordinator will discuss and encourage self-management of health care with client and caregiver and provide mentoring and will assist client and caregiver to update the portable individualized Health Summary.

  Intervention: Care coordinator will educate client and caregiver to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).

  Intervention: Care coordinator will identify the client's/caregiver's insurance coverage and discuss SSI/private and public insurance options and will link the client and caregiver to local contacts.

  Intervention: Care coordinator will assist the client and caregiver to find adult providers: Call physician's offices to discuss if they will accept the client and caregiver. Utilize the CMS Provider Relations Liaison (PRL) for assistance. Verify client/caregiver has contact information for adult provider.

  Intervention: Care coordinator will assist the pediatric primary care provider and specialty providers in preparing the Transfer of Care Package which includes at a minimum: Transfer letter from pediatric PCP, Transition Checklist, portable individualized Healthy Summary, Transition Readiness Assessment Questionnaire, and Emergency/Disaster Plan.

  Intervention: Care coordinator will assist client and caregiver to complete the Transition Readiness Assessment Questionnaire (TRAQ) every 6 months beginning at age 16.

  Intervention: Care coordinator will assist the client and caregiver with transition to adult primary care and specialty providers and will initiate follow-up interaction to monitor successful transfer of care.

  Intervention: Care coordinator will assess the client and caregiver to determine if they are receiving the services necessary to make a successful transition to adult life before closing the client and caregiver to CMS.

  Expected outcome: The client and caregiver will experience successful transition to an adult primary care and specialty care providers before closing to CMS.

Graduating from pediatric to adult care
FloridaHATS
Health and Transition Services

5a

Incorporate transition planning in chronic care management. Coordinate with CMS Nurse if patient is enrolled in CMS.

Health Care Transition Preparation for Youth and Young Adults with Special Health Care Needs in Florida

Age Ranges

Is patient 12-14 years? — No → Is patient 15-17 years? — No → Is patient 18-21 years?

Yes (12-14) → Step1

Yes (15-17) → Step 2

Yes (18-21) → Step 3

Action Steps for Specific Age Ranges

Step1

Provide age-appropriate counseling and transition materials to youth and family.
Identify APD eligibility and education needs.
See local 2-1-1 Helpline for other social services.

Step 2

Ensure Step 1.
Assess transition readiness (TRAQ or other tool).
Explore post-high school options; identify decision-making needs.
Establish timeline for transfer to adult primary and subspecialty care.

Step 3

Ensure Steps 1 and 2.
Identify insurance coverage, adult service and employment needs.
Transfer to adult primary and subspecialty care.

Determination of Services Needed

Is patient eligible for MedWaiver program? — No → Does patient have IEP? — No

Yes → See handout on Medicaid Waiver programs.
For patients with I/DD, APD does intake; send all patient documents to APD.
Patient is put on waiting list for APD's Home and Community-Based Medicaid Waiver.
Patient may come off waiting list if urgent/ emergent.

Yes → Help identify health-related activities to support patient's education plan.
Contact Project 10 regional rep for assistance with transition IEP, starting at 14 years.
Refer to Project 10 Resource Directory for local services/ programs.

Is patient eligible for VR? — No → Needs help with decision-making? — No

Yes → Starting at age 15, send referral with patient information.
VR sends information to correct geographic area for placement with VR counselor.
Patient must be looking for work to receive services.
Patient may be put on waiting list (handout)

Yes → Assist with age of majority issues before patient's 18th birthday (advance directive, levels of guardianship, voting, other legal needs).
Refer youth/family to Florida Legal Services for legal aid.
Refer patient to local Center for Independent Living for additional guidance. (handout)

Insurance patient will have as adult?

Yes → Discuss SSI/private and public insurance options with youth/family.
Provide 411 Insurance Guide (or handout) and local contact information.
Help find providers for patients; see Young Adult Health Services Directory.
Call physician offices to see whether they will accept patient.

Care Coordination Support

5b

Have age appropriate transition issues been addressed?

No → 5c Initiate follow-up interaction.

Yes → 6 Transition component of interaction complete.

Glossary:

APD: Agency for Persons with Disabilities
CMS: Children's Medical Services, Department of Health
I/DD: Individuals with intellectual or developmental disabilities
IEP: Individual Educational Plan
TRAQ-5.0 Transition Readiness Questionnaire 5.0 (or use other checklists)
VR: Vocational Rehabilitation Program

*Handouts are available in English, Spanish and Haitian Creole at www.FloridaHATS.org

Florida Children's Hospital Health Care Transition Survey Response Summary

During the month of September, I surveyed the Chief Medical Officers of the 12 Children's Hospitals in Florida who are members of the Florida Association of Children's Hospitals (FACH). Only one children's hospital in Florida is not a member of FACH (Nemours Children's Hospital in Orlando) and it was not included in the survey. The survey was conducted on-line with the CMOs being asked to fill out the survey on Survey Monkey. 100% of the CMOs responded. We contacted them via email (4 rounds of emails were sent) and by phone (my research assistant did initial calls asking them to respond to the survey and I did follow up calls if they had not responded within one week).
Below is the list of the hospitals that responded to the survey.

Hospital
All Children's Hospital
Baptist Children's Hospital
CECH
Florida Hospital for Children
Golisano children's hospital of SW Florida
Holtz Children's Hospital
Joe DiMaggio Children's Hospital
Miami Children's Hospital
Sacred Heart Children's Hospital
UF Health Children's Hospital
St Joseph's Children's Hospital.
Wolfson

Responses to the question: **Does your institution have an age limit for services?**

Age Limit				
Age_limit_1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
No	3	25.00	3	25.00
Yes	9	75.00	12	100.00
Limit: 18	5	50		
Limit: 21	5	50		

Florida Children's Hospital Health Care Transition Survey Response Summary

Responses to the question: **Does your Children's Hospital have a program to support health care transition?**

HCT Program	Frequency
No	6
Yes	5

For those 5 (five) hospitals that reported they had a transition program below are the individual descriptions of the programs provided by the respondents:

1. Certain specialties are more advanced in developing transition plans, notably cardiology and pulmonology. Specific adult providers have been identified and regularly accept patients >18 with congenital heart disease and cystic fibrosis. The transition is less well developed in endocrinology (mostly type I diabetics) and hematology/oncology. We are trying to coordinate a late effects clinic for childhood survivors of cancer but is in early stages of development

2. Developing Two Programs. One associated with complex care clinic for all patients. The other program is an adult congenital heart program as part of our cardiology program

3. Most of the children are transitioned by their pediatrician. For those children seen frequently by sub-specialists, information about healthcare transition is given to patients and their families around 16 years of age, mostly to those patients with chronic illnesses (CF, sickle cell, ESRD, etc). Depending on the disease process, social worker from that sub-specialty program reaches out to the family and identifies particular issues to be resolved before patient turns 18 years of age. Then, if issues are resolved and an adult specialist is identified and willing to take over the care, transition is made gradually (CF, renal programs and sickle cell disease work quite well). For those who have either unresolved issues or there is no adult service available (endocrinology, gastroenterology, neurology, special care needs, etc), if they present to ER or require admission, nursing staff identifies them (they are flagged in EHR chart) and the adult ER staff accommodates them. Once stabilized, they go home and outpatient providers follow them.

4. The transition program is staffed by an RN Manger, Social Worker and the CMS Nurse,

5. The program is just beginning and is a patient and family education program to provide a structured transition for adolescents with special health care needs from their pediatric medical home to their adult medical home.

Florida Children's Hospital Health Care Transition Survey Response Summary

6. We are starting a program transition program with our congenital heart patients. We have plans to do the same with the rest of our patients as part of a complex care program, but this is only in the planning stage. Wolfson works closely with two institutional partners, Nemours Children's Clinic Jacksonville and University of Florida College of Medicine/Jacksonville for the management of transition services. Nemours and UF physicians provide most of the subspecialty care for patients at Wolfson. As these patients approach adulthood, they are referred to the JaxHATS transition program, staffed by UF. Additionally, Wolfson has a Center for the Medically Complex Child, also staffed by UF physicians, that provides primary care and care coordination for patients with chronic and complex medical conditions. These patients are also transitioned through JaxHATS.

For which clinical or specialty areas/programs/conditions do you provide HCT service? Please list.

1. Primary care (Pediatric to Med-Peds or Family Medicine); Hematology/Oncology - has support group and faculty to faculty transition; HIV has transition program that is not structured.
2. Asthma, cystic fibrosis, metabolic disorders, renal disease, congenital cardiac disease, diabetes, neuromuscular disorders, spina bifida, cancer, sickle cell disease, gastrointestinal disorders, etc.
3. CF, Nephrology, Sickle Cell
4. CPMR, Sickle Cell, CF
5. Cardiology and Pulmonology

What services do you provide in your HCT program? The following services were listed.

1. Counseling on HCT by specialty programs by 2 hospitals
2. In-patient consultation/education for HCT by 3 hospitals
3. Care coordination services by 3 hospitals
4. An outpatient clinic dedicated to the care of youth with complex social, emotional or physical health issues including HCT by 2 hospitals
5. Outreach education and training on HCT for primary care and specialty care pediatric providers by 3 hospitals
6. Outreach education and training on HCT for youth and families by 3 hospitals
7. Recruitment and training of adult primary care and specialty providers by 4 hospitals

Florida Children's Hospital Health Care Transition Survey Response Summary

Is the hospital leading or participating in any on-going planning process related to health care transition? Seven (7) hospitals indicated that they have on-going planning process. The 7 hospitals described their planning process in the following manner:

1. Focusing first on the establishment of medical homes for chronic and complex adult patients. Pediatric component will follow.
2. On-going coordination with JaxHATS and development/expansion of the Center for the Medically Complex Child.
3. Outpatient department for primary care, specifically addressing the transition of children with special needs
4. Specialty clinics are under the physicians employed by Nemours Children's Clinic-Pensacola. The leadership of the Children's Hospital does recognize the importance of building an HCT process but has not formally developed one yet.
5. The focus of our project is to provide structured and care coordinated transition for adolescent CSHCN identified by MCH, HCH and CMS from Pediatric Medical Homes to Adult Medical Homes. Families with adolescent CSHCN will be offered group education and preparation for transition to adult care. Program physicians and CMS staff will identify adult care provider(s) for each family. Care coordination will be provided for patients through CMS until age 21. Adult and Pediatric Providers will be offered education through available on-line transitional care modules provided by AHEC (Area Health Education Center) as well as education regarding the tools available on the FloridaHATS website. As part of this project, a network of primary care and subspecialty providers will be developed who are educated and knowledgeable about transition of care.
6. We have a small steering committee forming with Nursing, physician, Case Management and Social Work (initially). We are looking at forming a program that begins at age 14 driven by case management for medically complex children. This is limited due to availability of adult physicians willing to assume care for patients who are on Medicaid.

We asked them who the physician leaders were of their HCT planning projects or services. Below are the responses of 8 hospitals that responded to this question.

1. Director of the medical home project, Director of Primary Care Clinic.
2. Dr. Arwa Saidi, Dr. Schuler.
3. Dr. Constantine Mavroudis-Adult Congenital Heart; Dr. Stacy McConkeyand Dr. Ben Guedes-all other patients.
4. Dr. David, Wood
5. Hospitalists.
6. Rosha McCoy, MD Alex Constantinescu, MD.
7. Stefanie Brown, Nidhip Patel, Lawrence Friedman, Stephanie White, Audrey Ofir, Judy Schaecter.
8. William Blanchard-Cardiology, Okan Elidimir-Pulmonology, CF Clinic Director

Florida Children's Hospital Health Care Transition Survey Response Summary

We asked those hospitals that DID NOT have a transition program if they would be interested in stating one (n=6). All hospitals indicated they would be interested in starting one.

We asked if the Children's hospitals had had any discussions with adult hospitals or physicians about establishing a referral program for children from the children's hospital to the adult system. Nine (9) hospitals indicated that they had had some discussions with their adult system but that these were in very preliminary stages and no formal programs existed linking the children's hospital patients to the adult health care system.

We asked what aspects of a Health Care Transition system would be attractive to or be perceived as providing benefit to the adult care system and then offered them the following options (number of hospitals agreeing with that option are in parentheses:

- As a cost saving program (3 hospitals)
- As a revenue generating program (3 hospitals)
- As a quality of care program (3 hospitals)
- As volume builder (1 hospital)

Conclusion

The results of this survey demonstrate that there is a significant opportunity for CMS to partner with the Florida Children's hospitals to further the practice and policy agenda in health care transition. Some hospitals are starting transition programs, but they are just getting started. Those who haven't started transition programs want to. Virtually all children followed by CMS are patients of the children's hospitals, especially those most in need of support during health care transition, those with complex conditions. By partnering with FACH, CMS can substantially enhance its access to children with transition services.