Work Plan and Outcome Measurement Matrix

Organization:	University of Miami - Miller School of Medicine		
Project Title:	A Transitional Care Program for Adolescents with Special Health Care Needs		
Goal: To provide structure and care coordinated transition of adolescents with special health care needs to adult medical homes			
Outcome Objectives (Why) *Include Baselines	Outcome Measurement (Evidence) For each outcome objective: ∗ Explain how the outcome will be measured. *Specify indicator ∗Specify tool (if applicable) ∗Include responsible party and timeframe	Process Objectives (What)	Activities (How) ∗Include responsible party and due date

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1. Identified families of adolescent children with special health care needs (CSHCN) will be provided structured education on transitional care and support for that transition *(Baseline: State of Florida 33.8%; US 41.2%)*	1. Percentage of families and/or patients attending transition education *(Transition Liaison/Care Coordination Assistant, 5/31/2015)*	1. Conduct monthly transition education sessions for identified families at Holtz Children's Hospital (HCH) and Miami Children's Hospital (MCH) *(Begin 1/2014)*	1. Provide education for patients and families on transitional care a. Identify 25 adolescents ready for transition in CMS practices at HCH and MCH *(CMS providers 8/30/2013)* b. Identify and educate Transition Liaison from successfully transitioned patients/families. Training to include education on steps of transition, available tools, and usage of available tools. (CMS providers 12/31/2013) c. Identify and train care coordination assistant *(Project PI 12/31/2013)* d. Schedule 25 pilot adolescent patients/families for transition education sessions – Goal of training is to make families/patients aware of steps of transition, educate regarding use transition tool checklists and to increase knowledge of transition process and increase self-efficiency *(CMS care coordinators and providers begin 1/2014-6/30/2014)* e. Identify all adolescents ready for transition in CMS practices at HCH and MCH *(CMS providers 6/30/2014)* f. Schedule 100 adolescent patients/families for transition education sessions *(CMS care coordinators and providers begin 7/2014)*

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2. 125 CSHCN aging out of pediatric care will have established adult medical homes *(Baseline: Florida 41.9%; US 47.1%)*	2. # of identified and transitioned CSHCN receiving care in adult medical homes *(CMS 5/31/2015)*	2. Transition patients to adult medical home *(5/31/2015)*	2. Transition adolescents in CMS practices at HCH and MCH to adult medical homes *(5/31/2015)* a. Identify pilot adult medical homes with CMS providers *(Project PI and CMS 7/31/2013)* b. Identified pilot CMS providers in pilot medical home to complete on-line transitional care training *(Providers 11/30/2013)* c. Identify additional adult medical homes and enroll providers as CMS providers *(CMS and pediatric CMS providers 5/31/2015)* d. Adult medical homes with CMS providers to complete transitional care education via available on-line modules *(adult CMS providers 5/31/15)* e. Transition 125 CSHCN to their adult medical homes (25 in year 1 and 100 in year 2) (*CMS Providers and care coordinators 5/31/2015)*

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3. 100% of patient/families transitioned through our program will be satisfied with transition to adult medical home *(Baseline: Florida 50.2%; US 57.4%)*	3. Survey Results (Division of Pediatric Clinical Research *(DPCR) Staff 5/31/2014)*	3. Conduct patient and provider surveys biannually *(begin 5/31/2014)*	3. Adapt existing patient and provider survey and collect data using HRSA and HFSF outcomes *(DPCR 4/30/2014)*
4. 100% of adolescent CSHCN transitioned to adult medical homes will receive care coordination in partnership with CMS (*Baseline: TBD)*	4. # of adolescent CSCHN in adult medical homes receiving CMS care coordination *(CMS 5/31/2015)*	4. Enroll providers in identified adult medical homes as CMS providers *(5/31/2015)*	4. Identify all providers in adult medical homes providing service (CMS 5/31/2015)
5. Establish a network of adult primary care and subspecialty providers to provide adult medical homes and subspecialty care for CSHCN *(Baseline: TBD)*	5. # of adult providers in Miami/Dade county enrolled with CMS and/or Florida Health and Transition Services directory *(CMS 5/31/2015)*	5. Enroll adult providers in Miami/Dade County with CMS (primary care) and in Florida Health and Transition Services directory *(5/31/2015)*	5. Identify and enroll adult providers as searchable providers of care for adolescent CSHCN aging out of pediatric care *(CMS and Adult Medical Home providers 5/31/2015)* a. Enroll providers in identified adult medical homes as CMS providers b. request all primary care and subspecialty providers associated with care of identified patients to register on-line in Florida Health and Transition Services directory

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6. 100% of children will maintain and/or improve markers of disease based health outcomes and age appropriate preventive care *(Baseline: TBD)*	6. # of children who maintain and/or improve markers of disease based health outcomes and age appropriate preventive care *(DPCR and Providers 5/31/2015)*	6. Collect data for Disease based health outcomes and age appropriate preventive care *(5/31/2015)*	6. Obtain data for Disease based health outcomes and age appropriate preventive care *(PI and DCPR staff 5/31/2015)* a. Collect data HFSF clinical indicators for Diabetes and Hypertension for patients with those diseases b. Collect data regarding adult immunizations based on ACIP recommendations for patients over 18 years
7. Establish Florida Health and Transitions Services South Florida Regional Coalition *(Baseline: none)*	7. Establishment of a link to the Florida Health and Transitions South Florida Coalition on the FloridaHATS website *(Project PI 5/31/2015)*	7. Establishment of a link to the Florida Health and Transitions South Florida Coalition on the FloridaHATS website (*5/31/2015)*	7. Establish Florida Health and Transitions Services South Florida Regional Coalition a. Continue membership on medical advisory board for Florida Health and Transitions Services *(PI – 6/1/2013)* b. Using FloridaHATS published "Strategic Planning Guide for Regional Coalitions", begin planning for South Florida Regional Coalition *(PI and CMS – 5/31/2015)*

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