7/15/2013

Florida Medical Advisory Work Group for Health Care Transition
May 30, 2013 Videoconference, 6 – 8 PM (ET)
Meeting Summary

Videoconference Attendees:
David Wood, MD, MPH, UF-Jacksonville, JaxHATS, Committee Chair
Henry Rodriguez, MD, University of South Florida, Tampa
Danny Plasencia, MD, St. Joseph's Hospital, Tampa
Stefanie Brown, MD, Jackson Memorial Hospital, Miami
Jose Rosa-Olivares, MD, Miami Children's Hospital, Miami
Martha Kronk, Shriners Hospitals for Children, Tampa
Sherry Buchman, RN, CMS, Jacksonville
Charlotte Curtis, RN, CMS Network Bureau Chief, Tallahassee
Colleen, Lenfestey, RN, CMS, Tallahassee
Patricia Trom, RN, CMS, Tallahassee
Shawn Hamm, CMS, Tallahassee
Cynthia Campbell, MBA, CMS, Tallahassee
Janet Hess, MPH, USF, FloridaHATS Project Director, Tampa

Teleconference:
Jim Burns, MD, Sacred Heart Hospital, Pensacola
Jane Park, MPH, NAHIIC & Policy Center, UC-San Francisco
John McCormick, MD, USF Med Peds, Tampa
Vinnie Chulani, MD, Arnold Palmer Hospital, Orlando
John Curran, MD, CMS, University of South Florida, Tampa

Note: CMS Medical and Nursing Directors were invited to attend the meeting via video- or teleconference. The meeting agenda and FloridaHATS 2012-2013 Activity Report were sent to Medical Advisory Work Group members and CMS staff prior to the meeting.

Discussion

The following items were discussed with respect to FloridaHATS strategies in 2013-2014.

Education and Training

1. The AAP National Conference will be held in Orlando on October 26-29; see http://www.aapexperience.org/. While this would be a good opportunity for physician outreach regarding FloridaHATS and HCT, the conference schedule/presentations are already finalized and booth space is expensive ($2,000+ minimum). If you have a suggestion for FloridaHATS participation in the conference, please let us know.
2. Work Group members suggested that we increase our outreach efforts among nurse practitioners. To that end, If anyone knows an ARNP who has an interest in transition and might want to participate in the Medical Advisory Work Group, please contact Janet Hess.
3. A new web-based CMS care coordination training module will be piloted in January 2014. The module is based on national clinical guidelines for HCT and the Florida HCT Algorithm for Youth and Young Adults with Special Health Care Needs , and will utilize a comprehensive protocol with standardized HCT materials and instruments.

4. The Illinois Transition Care Project has introduced MOC-approved, web-based training on HCT that is available nationally. Two curricula (one for peds and one for adult-oriented care) have been approved by the American Boards of Pediatrics, Internal Medicine and Family Medicine. We're interested in hearing about personal experiences with the curriculum, so please share with us if you complete it. And please share info about the training with your colleagues!
5. Dr. Brown reported that the Med Peds Program Directors Association (MPPDA) is working on core competencies for HCT. Attached is the MPPDA's Transitional Care Entrustable Professional Activities (EPAs); the document was started by the University of Minnesota Med-Peds Program. EPAs are defined as "Professional activities that together constitute the mass of critical elements that operationally define a profession." It appears that most of the activities are generalizable to Family Medicine and Internal Medicine.

Systems and Policies

6. In order to advance the Memorandum of Agreement between CMS and the Florida Association for Community Health Centers (FACHC; umbrella organization for Florida Federally Qualified Health Centers), CMS will organize a meeting in Tallahassee to include Andy Behrman (FACHC CEO), CMS administrators and FloridaHATS representatives. It was suggested that we initially focus on working with large FQHC organizations, e.g. ones with multiple facilities.
7. Dr. Brown described a new transition program at the University of Miami that was developed in partnership with Holtz Children's Hospital and Miami Children's Hospital and is funded by a 2-year grant. View the program matrix here; others might be interested in replicating this model.
8. In 2013-2014, FloridaHATS will approach Florida children's hospitals and major health care systems about developing transition programs in each organization. Dr. Wood is currently in discussion with Wolfson Children's Hospital in Jacksonville, and Dr. Northup/PanhandleHATS members are in discussion with the Sacred Heart Health System in Pensacola.

   Work Group members suggested developing a business model to include in these discussions, demonstrating the benefits of keeping transition-age patients within the same health system, e.g., potential for enhanced Medicaid reimbursement, downstream revenue, preventable hospitalizations from intensive care coordination, etc.
9. There was also a suggestion to explore impact of Accountable Care Organizations (ACOs) on HCT, and potentially develop a business template about HCT that can be given to ACOs in Florida. At this time, members were not aware of a list of Florida organizations that might be forming ACOs.

NOTE: *Subsequent to the 5/30 Work Group meeting, Dr. Wood submitted a proposal to Dana Ferrell, Executive Director of the FACH, to establish a Health and Transition Services (HATS) program in every children's hospital in Florida. The proposal was viewed favorably; there will be follow-up discussions with FloridaHATS staff and Dr. Wood will meet with the FACH Board of Directors in October.*

Future Meetings

10. Dr. Wood will present about FloridaHATS in a face-to-face meeting with CMS Medical Directors in August. We would like both CMS Medical and Nursing Directors to participate in future Work Group meetings.
11. Given the convenience of videoconferencing, we plan to schedule at least one meeting of the full Work Group in FY 2013-2014 along with some small group planning meetings.

Graduating from pediatric to adult care
FloridaHATS
Health and Transition Services

7/15/2013

Care for Patients with Pediatric Chronic Conditions
EPA mapped to milestones

	Cannot Perform	Can Perform under direct Supervision	Can perform with indirect supervision	Can Perform Independently	Can Supervise Junior Trainees
Task (Relevant Milestones - IM Blue, Peds Red)	*Disorganized, lacks knowledge*	*Basic knowledge and organization, lacks ability to individualize*	*Solid Knowledge and organization,able to individualize plans. May be inconsistent, lacks finesse.*	*Strong fund of knowledge and organization, able to individualize plans consistently. Introduces complexity and nuance*	*Expertise.*
Planning for Transition: ICS-A1,ICS-A6, ICS-E2, ICS-F1, ICS-F2, SBP-A1, SBP-A2,SBP-A3, ICS-1, ICS-6, SBP-2, PC-3, PC-10	Waits for patient to raise issue or does not address transition at all.	Identifies need only when transition is imminent (at 18, prior to going to college, etc.). Introduces issue, but no explicit plan "You'll need to see an adult doctor".	Identifies need early (age 14 or earlier), and plans follow-up discussions. Transition plan is vague, without identified milestones/steps to transition. Plan irregularly updated.	Create a written health care transition plan by age 14 together with the young person and family. At a minimum, this plan should include what services need to be provided, who will provide them, and how they will be financed. This plan should be reviewed and updated annually and whenever there is a transfer of care. ICS-A1,ICS-A6, ICS-E2, ICS-F1, ICS-F2, SBP-A1, SBP-A2,SBP-A3, ICS-1, ICS-6, SBP-2, PC-3, PC-10	
Patient Assessment: PC-A1, PC-A3, ICS-A2, ICS-A3, ICS-A5, ICS-B2, ICS-B3,PC-4, P-2, P-5	Approaches every patient similarly, regardless of developmental stage or readiness for change.	Approaches patients according to chronologic age and a fixed set of expectations about transition. PC-A1, ICS-A2, ICS-A3	Able to identify developmental stage of patient, but may have difficulty assessing readiness for change (or vice versa) in domains of disease knowledge, treatment knowledge, self-efficacy, support systems, and financial systems. PC-A2, ICS-B2, PC-4	Identifies developmental stage (Erikson) and readiness for change (Prochanska) in domains of disease knowledge, treatment knowledge, self-efficacy, support systems, financial systems. PC-A3, ICS-A5, ICS-B3, P-2, P-5	
Primary and Preventative Care: MK-A3, MK-A5, MK-A7, MK-A8, PC-C3, PC-F3, PC-F8, PC-F9, PC-F10, P-D2, SBP-D1, P-K1,MK-1,MK-2, ICS-1,PC-6, PC-10	Does not follow guidelines when evaluating patients for primary and preventative care.	Applies the same guidelines for primary and preventative care for all adolescents and young adults. **Does not recognize** that young people with special health care needs may require more resources and services than their well peers. MK-A3, MK-A5, PC-F3, MK-1	Apply the same guidelines for primary and preventive care for all adolescents and young adults, including those with special health care needs. **Recognizes** that young people with special health care needs may require more resources and services than do other young people to optimize their health. P-D2, SBP-D1, P-K1, ICS-1, PC-10	Utilizes modified guidelines for primary and preventative care in populations whose risk factors are modified by their health conditions. (e.g. Breast Cancer screening in patient's with childhood mantle radiation) PC-C3, PC-F8, PC-F9, PC-F10, MK-2, PC-6	Understands the data and origin of current guidelines, and is able to modify recommendations appropriately based on the unique health condition of the patient, especially those with unique or orphan diseases. ICS-B2, MK-A7, MK-A8
Resource utilization: SBP-B1,SBP-B2, ICS-A1, P-K3,SBP-1, SBP-2, SBP-4, SBP-5, SBP-7, PC-9, PC-10	Does not understand adolescent health laws. Does not recognize role or importance of legal and social supports in achieving health.	Understands adolescent health laws. Recognizes importance of legal and social supports, but cannot identify which supports are most important to the specific patient based on their health condition and individual situation. SBP-B1	Understands adolescent health laws. Aware of health insurance coverage and medicare waivers, and can identify appropriate clinic, legal and social support resources to aid patient/family. But does not regularly provide anticipatory guidance around changes in services during transition.SBP-B2, ICS-A1, SBP-1, SBP-2, SBP-5, PC-9	Understands pertinent adolescent health laws. Awareness of health insurance coverage and medicare waivers so that s/he can provide anticipatory guidance around changes in coverage/benefits. Can effectively direct patient to appropriate clinic/community resources for further information and aid. SBP-4, PC-10	Understands pertinent adolescent health laws. Awareness of community resources in education, employment/finance, and recreation as they might benefit CYSHCN. Advocates for affordable, continuous health insurance coverage that covers appropriate compensation for 1) health care transition planning for all young people with SHCN, and 2) care coordination for those who have complex medical conditions.P-K3, SBP-7
Creating a Portable Health Summary: ICS-F1, ICS-F2, ICS-A1, P-A1, ICS-1 ,ICS-6,	Does not create a portable health summary for the patient.	Documents H&Ps and SOAP notes, but has difficulty editing health information into a portable health summary. Does not regularly provide a copy of this summary to the patient. ICS-F1, ICS-F2, P-A1,		Prepare and maintain an up-to-date medical summary that is portable and accessible. (AAP 2011) ICS-A1, ICS-1 ,ICS-6	
Verbal Communication (Professional): ICS-A1, ICS-C1, ICS-D2, ICS-D3, ICS-E1, SBP-A1, SBP-A2, SBP-A3, ICS-3, PC-3	Does not recognize when consultation is needed. Does not verbally communicate with other providers.	Identifies appropriate consultants, but needs prompting to provide a verbal hand-off to consultants or accepting providers. Does not clarify management plans with prior providers or consultants. SBP-A1	Provides a verbal hand-off to consultants and accepting providers. Sometimes clarifies management plans with prior providers. Inconsistently works with patients and providers throughout the transition pahse. ICS-A1, ICS-C1, ICS-D2, ICS-E1, SBP-A2, ICS-3, PC-3	Provides a verbal hand-off to consultants or accepting providers.Clarifies management plans and pending diagnostic decisions with transferring providers. Continues to problem-solve with patient and transferring/accepting provider during the transition phase. ICS-D3, SBP-A3	
Medical Knowledge (?): MK-A1, MK-A2, MK-A3, MK-A5, MK-A7, MK-A8, PC-F10, MK-1, MK-2, PC-6, PC-7	Cannot manage common complex conditions. (Examples?)	Basic understanding of common complex conditions. MK-A1, MK-A2, MK-A3, MK-A5, MK-A7,	Good understanding of common complex conditions, but may lack knowledge of more rare conditions. Doesn't regularly factor into their medical decision making how puberty, alcohol consumption and pregnancy may modify treatment approach. MK-A8, MK-1	A good understanding of common complex conditions, and a basic understanding of more rare conditions. Understands how health conditions may become complicated by puberty, alcohol consumption, and pregnancy. Utilizes appropriate resources to medically manage the patient based on their health condition and lifestyle. PC-F10, MK-2, PC-6, PC-7	Good understanding of common complex conditions and rare conditions commonly seen in practice area. Understands how life stage, lifestyle, and long term exposure to disease and treatments can impact these health conditions, and effectively utilizes resources to medically manage patients.

7/15/2013

Proposal to Establish a Health and Transition Services (HATS) Program in all Florida Children's Hospitals

Vision. Every children's hospital in Florida will provide transitional care services, ensuring that all young Floridians, including those with special health care needs, experience a smooth transition from pediatric to adult health care.

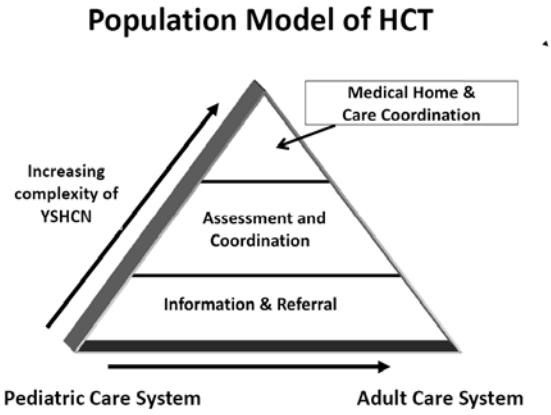
Mission. To provide a high quality system of health care that supports transition from adolescence to adulthood for all youth and young adults in Florida.

Need. Over the past 30 years, we have witnessed a significant increase in life expectancy for children and youth with special health care needs, even those with serious life threatening and debilitating chronic conditions. In Florida, there are an estimated 130,000 youth and young adults ages 14-24 with physical and mental health conditions who need support to successfully transition to adulthood.[1] After leaving pediatric services, many young people experience difficulty entering the adult system: they may have trouble finding adult providers, lose insurance and supports, become less adherent to medical regimens, and experience preventable morbidity or even premature death. In order to promote a smooth transition to adult care, most children's hospitals in the U.S. have initiated "transition programs" to better prepare youth in the pediatric system for the transition to adult care and to engage the adult system to accept these patients. These programs vary in structure but all have a core staff of one or more physicians, nurses and social workers that support families and youth - especially those with complex medical conditions - as they move out of the child-serving health care system and into the adult-serving health care system. All of the top-rated children's hospitals now have transition programs, including Boston Children's Hospital, LA Children's Hospital, CHOP, Nationwide and Cincinnati Children's Hospital, Nemours Children's Hospital, Delaware and Riley Hospital for Children, to name a few.

In Florida, the JaxHATS and the FloridaHATS programs have gained national prominence as models for providing transition care at the local level and for providing information and supports for health care transition at the state level. The purpose of this proposal is to build on that foundation to implement a comprehensive system of transitional care based in every children's hospital in the state of Florida. These Health and Transition Services (HATS) programs will help establish a system of care as described in the State Plan for Health Care Transition "Ensuring Successful Transition from Pediatric to Adult Health Care." (see www.floridahats.org/wp-content/uploads/2010/03/2009-FL-HCT-Task-Force-Report-CMS.pdf). The system of care will engage primary care providers, pediatric specialty care providers, the children's hospital, adult hospitals and adult primary care and specialty providers. The proposed model of care is portrayed in the diagram below. The basic components of this health care system are:

- Outpatient care at a dedicated health care transition clinic for youth with complex social, emotional or physical health issues
- Education and training for primary care and specialty care pediatric providers to implement health care transition preparation for youth and families
- Recruitment and training of adult primary care and specialty providers
- Care coordination by nurse and lay care coordinators

[1] In the Florida 2010 census, 2.686, 000 persons were between the ages of 14-24. An estimate 5% of the child and young adult population has physical and mental health conditions that need support during transition to adulthood.



The proposed program will ensure that youth receiving care from the children's hospital will receive the support they need during transition to achieve optimal health and well-being in adulthood. It will engage and enhance the local community's existing network of pediatric primary and specialty programs and connect them to the adult health care system.

Key steps to develop a Health and Transition Services (HATS) program:

- Establish a HATS clinic staffed by primary care provider and care coordinator(s).
- Establish an inpatient HATS consultation service.
- Train primary care and specialty pediatric and adult providers in how to educate youth about independent disease self-management and accessing the adult health care system.
- Provide care coordination for all youth and families needing support.
- Establish quality monitoring, outcomes measurement and quality improvement programs.
- Educate key stakeholders about health care transition, including youth and their families, schools, disability and social service programs, and advocacy organizations (e.g., ARC, Down Syndrome Association, Spina Bifida Association)
- Provide information and referral to all youth, families, providers and other agencies needing information about health care transition.
- Engage adult primary care providers to provide a medical home to young adults with special health care needs and engage adult specialists to provide specialty care to young adults.

The mature HATS program will provide a single source of information for youth, parents and providers via phone, internet and/or in-person consultation for the hospital's population that is "aging out." It will ensure that youth and families have access information, resources and information and referrals to support transition from pediatric care to adult care and adult life.

For more information about this proposal, please contact David Wood, MD, MPH, Children's Medical Services (CMS) Medical Consultant for Transition, david.wood@jax.ufl.edu, (904) 244-9233.