FloridaHATS

Regional Coalition Leadership Meeting

The American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians:

Supporting Health Care Transition in the Medical Home Clinical Report 2018

Presented by Janet Hess, DrPH, December 20, 2018

Adapted from presentation by Patience White, MD, MA, to Health Care Transition Research Consortium, November 5, 2018

Agenda

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State of Health Care Transition in U.S.

Updated HCT Processes and Implementation

Recommendations for HCT

Download the 2018 Clinical Report from Pediatrics:
http://pediatrics.aappublications.org/content/142/5/e20182587

State of Health Care Transition in the U.S.

HCT Performance

- NSCH 2016-2017 combined data*
  - 17% of youth with special needs (YSHCN) in U.S. received transition planning guidance from HCPs; 5.9% in FL
  - 14% of youth without special needs in U.S. received transition planning guidance from HCPs; 6.3% in FL
  - National Performance Measure based on 1) Youth had time alone with HCP during last preventive visit, 2) HCP actively worked with youth to gain self care skills or understand changes in health care at age 18, and 3) HCP discussed eventual shift to an HCP who cares for adults

*Lebrun-Harris et al, Transition planning among US youth with and without special health care needs. Pediatrics, NSCH data at http://Childhealthdata.org

Updated HCT Processes and Implementation

CR Reviews Evidence for Structured Transition Process

- Systematic review of HCT evaluation studies from 1995-2016 indicated a structured transition process resulted in statistically significant positive outcomes for YSHCN
  - **Population health**: adherence to care, self-care skills, quality of life, self-reported health
  - **Experience of care**: increased satisfaction, reduction in barriers to care
  - **Utilization:** decrease in time between last pediatric and 1st adult visit, increase in adult visits, decrease in ER and hospital admissions
  - **Cost**: hospital savings for patients with Type 1 diabetes and medically complex populations
  - **Note:** many structured HCT interventions included several elements of the 6 Core Element process

Sources: Gabriel et al., Outcome evidence for structured pediatric to adult health care transition interventions: A systematic review. Journal of Pediatrics. 2017;188:263-269.
Maeng et al., Impact of a complex care management model on cost and utilization among adolescents and young adults with special care and health needs. Pop Health Mgmt. 2017;20(6):435-441.
Burns et al., Access to a youth-specific service for young adults with Type 1 diabetes mellitus is associated with decreased hospital length of stay for diabetic ketoacidosis. Int Med J. 2018;48(4):396-402.

Reaffirmed 2011 AAP/AAFP/ACP Clinical Report on Health Care Transition*

- Targets all youth, beginning at age 12
- Algorithmic structure with:
  - Focus on planning, transfer, integration into adult care
  - Branching for YSHCN
  - Application to primary and specialty care
- Extends through transfer of care to adult medical home and adult specialists
- Discuss HCT policy, initiate and update an HCT plan, communicate with adult provider, develop a medical summary, clarify medical decision-making support, continued self care development, how to access after hours care

Age 12	Youth and family aware of transition policy
Age 14	Health care transition planning initiated
Age 16	Preparation of youth/parents for adult approach to care; discussion of preferences and timing for transfer to adult health care
Age 18	Transition to adult approach to care
Age 18-22	Transfer of care to adult medical home and specialists with transfer package

* Supporting the health care transition from adolescence to adulthood in the medical home, *Pediatrics,* 128(1):182-200. 2011

Updated HCT Process and Implementation

- **Definition**: HCT is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician
- **Transition Goals for Youth/Young Adults and Clinicians**:
  - To improve the ability of youth and young adults to manage their own health and effectively use health services
  - To have an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care

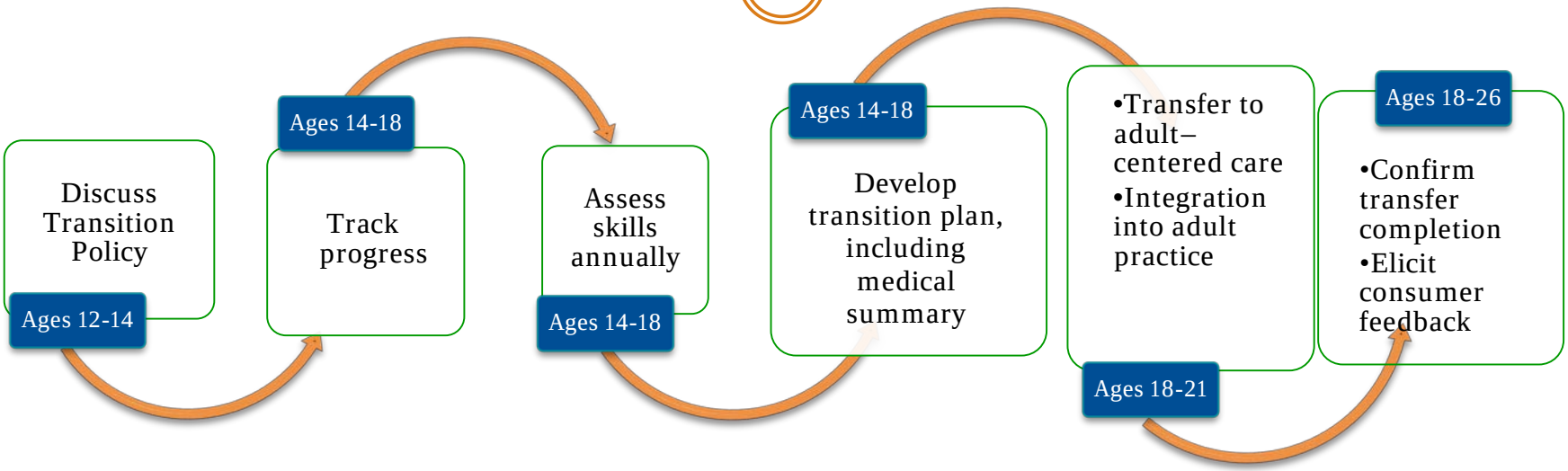
Updated HCT Process and Implementation

- Reaffirms that TRANSITION ≠ TRANSFER or PLANNING alone
- TRANSITION = planning, transfer and integration into adult care
- Provides more clarity, specificity and practical guidance on three components of transition process
  - **Planning**: Emphasis on practicing an adult model of care at age 18, on time alone with clinician, guidance on how to independently use health care and assistance with identifying a vetted adult PCP, actively engage youth in HCT and conveying positive messages about the adult clinicians and the differences in the systems of care
  - **Transfer:** Emphasis on improved communication strategies, check lists including medical summaries shared with youth/young adults and responsibility of pediatric practice until 1st adult visit
  - **Integration:** Emphasis on adult clinician's role: development of processes for adult providers to welcome young adults into their practice, responsibility with pediatric clinicians on improving adherence to care

Updated HCT Process and Implementation

- Got Transition translated the 2011 AAP/AAFP/ACP CR for clinical practice and then with extensive involvement of experts and teams developed and tested the 6 Core Element Process in many settings
  - Tested in QI learning collaboratives in DC*, MA, NH, WI, MN, CO
  - Took learnings from LCs and gained further input from transition experts including clinicians, clinic staff, youth, young adults and families
  - In 2014, released the Updated 6 Core Element process for different clinical settings (Peds, Med-Peds, Family and Internal Medicine) along with tools for customization and measurement options at www.gottransition.org

Six Core Elements Approach to Health Care Transition



1. **Transition Policy**
2. **Transition Tracking and Monitoring**
3. **Transition Readiness**
4. **Transition Planning**
5. **Transfer/ Integration into Adult-Centered Care**
6. **Transition Completion and Ongoing Care**

Six Core Elements Process

- Not a model of care but an approach
- Customized for use in busy practices with different models of care. Intensity of the intervention should be guided by medical complexity of the youth/young adults, social determinants of health, ACEs and the availability of practice resources.
- Successfully applied in many different systems/models of care: primary and subspecialty clinics, Medicaid managed care, state title V agencies, care coordination services, children's hospitals, FQHCs, SBHCs, behavioral health settings. All have incorporated the 6 Core Element Process and improved their HCT processes.
- Since the release of the updated 6 CE in 2014 to 10/2018, almost 2,000 customizable word 6CE packages have been downloaded

Updated CR Discusses

- Special Populations
  - Young adults
  - Developmental/intellectual disabilities
  - Medical complexity
  - Mental or behavioral health conditions
  - Social complexity with or without chronic conditions
- Education and Training in the Care of Youth/Young Adults with Pediatric onset conditions: e.g. resident training examples, MOC opportunities, available Med-Peds and other curriculum, new books on HCT
- Current payment opportunities (e.g. billing for readiness assessments)

Recommendations for HCT

Infrastructure Recommendations

To address gaps in infrastructure:

1. Integrate HCTs into routine preventive* primary, specialty and subspecialty, and mental/behavioral health care
2. Support QI processes within health care systems and pediatric and adult practices to:
   - Implement a structured HCT process (e.g. the Six Core Element approach) with active youth, young adult, and family engagement and feedback.
   - Work directly with their electronic health record (EHR) support team/vendor representative to integrate the Six Core Elements (transition policy, registry, readiness and self-care assessments, transition plan of care, medical summary, transition/transfer checklists, and feedback surveys) in a way that supports their own workflow and practice needs.
3. Incorporate HCT support as a recommended element in all medical home** and health home recognition and certification programs, including standards developed by the National Committee for Quality Assurance, The Joint Commission, and the Utilization Review Accreditation Commission.

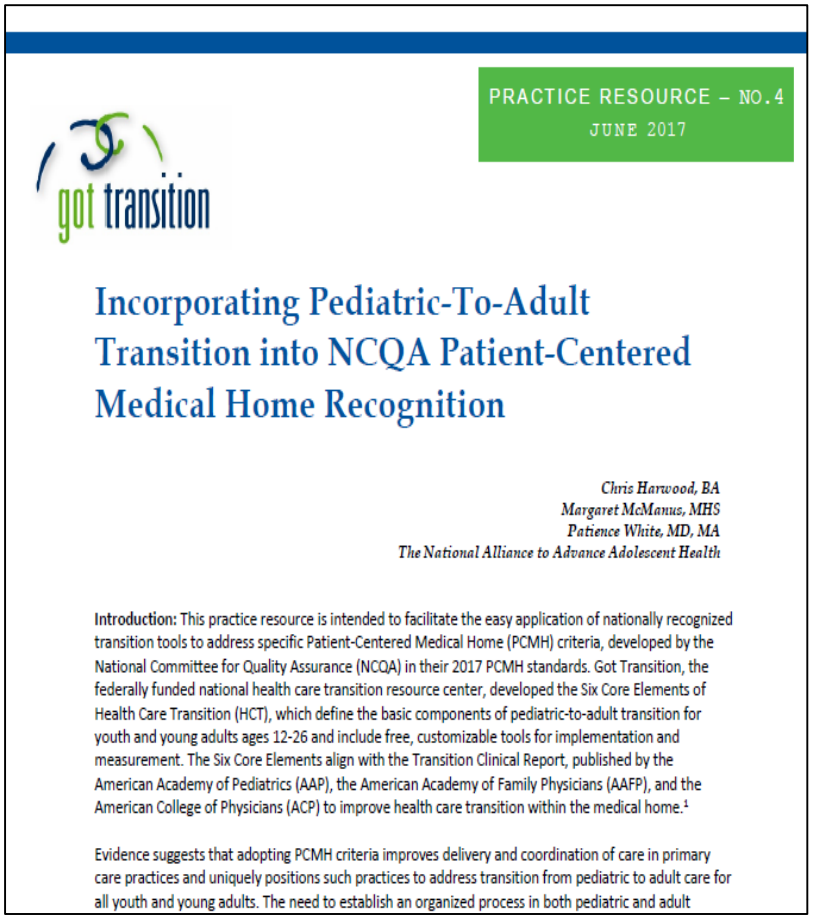
*New Got Transition and Univ. of CA Tip Sheet, "Incorporating Health Care Transition Services into Preventive Care For Adolescents and Young Adults: A Tool Kit for Clinicians"

**Incorporating Pediatric-to-Adult Transition into NCQA Patient-Centered Medical Home Recognition

Infrastructure Recommendations (cont'd)

4. Articulate specific HCT roles and responsibilities among pediatric and adult health care clinicians/ systems to facilitate the provision and coordination of recommended transition support.
5. Increase the availability and quality of care coordination support, particularly for adult practices/ systems serving young adults with chronic medical and behavioral conditions and social complexity.
6. Integrate health care transition support into other life course systems such as in education, independent living, employment, decision-making support, and power of attorney, as needed.
7. Expand the availability of pediatric consultation for adult clinicians caring for youth with pediatric-onset conditions.
8. Incorporate HCTs into the transition policies and plans of other public program systems (e.g., special education, foster care).
9. Create up-to-date listings of community resources (e.g., adult disability programs) and adult clinicians interested in caring for young adults with pediatric-onset conditions and other special populations.

Patient-Centered Medical Home Recognition



PRACTICE RESOURCE – NO.4
JUNE 2017

got transition

Incorporating Pediatric-To-Adult Transition into NCQA Patient-Centered Medical Home Recognition

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Introduction: This practice resource is intended to facilitate the easy application of nationally recognized transition tools to address specific Patient-Centered Medical Home (PCMH) criteria, developed by the National Committee for Quality Assurance (NCQA) in their 2017 PCMH standards. Got Transition, the federally funded national health care transition resource center, developed the Six Core Elements of Health Care Transition (HCT), which define the basic components of pediatric-to-adult transition for youth and young adults ages 12-26 and include free, customizable tools for implementation and measurement. The Six Core Elements align with the Transition Clinical Report, published by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) to improve health care transition within the medical home.[1]

Evidence suggests that adopting PCMH criteria improves delivery and coordination of care in primary care practices and uniquely positions such practices to address transition from pediatric to adult care for all youth and young adults. The need to establish an organized process in both pediatric and adult

- In response to popular requests for use of the Six Core Elements for PCMH certification, Got Transition completed a series of key informant interviews with clinical and administrative leaders in the health field and developed a tip sheet.
- This resource includes an easy-to-use chart displaying specific NCQA criteria and guidance with links to related Six Core Elements tools.

http://gottransition.org/resourceGet.cfm?id=444

Education and Training Recommendations

In partnership with families and youth, increase education and training opportunities for pediatric and adult health care clinicians in HCT, youth and young adult development, pediatric-onset diseases, inter-professional practice, and team-based care by adding:

1. CME opportunities (e.g., learning modules such as focusing on young adult health and pediatric onset conditions, clinical experiences, curriculum, and intra- professional training opportunities)
2. Enhanced training opportunities during residency and subspecialty training, including joint pediatric and adult training
3. HCT processes and support into education systems such as school-based health centers, college and university clinics.

Payment Recommendations

To align HCT delivery system innovations with payment incentives, public and private payors and their contracted plans should:

1. Compensate clinicians and systems of care for the provision of recommended HCT support related to planning, transfer, and integration into a new adult practice
2. Recognize and pay for CPT and Healthcare Common Procedure Coding System (HCPCS) codes important to transition to adult care*
3. Develop a CPT Category II code that can be used as a quality measure for tracking the use of transition services by pediatric and adult clinicians

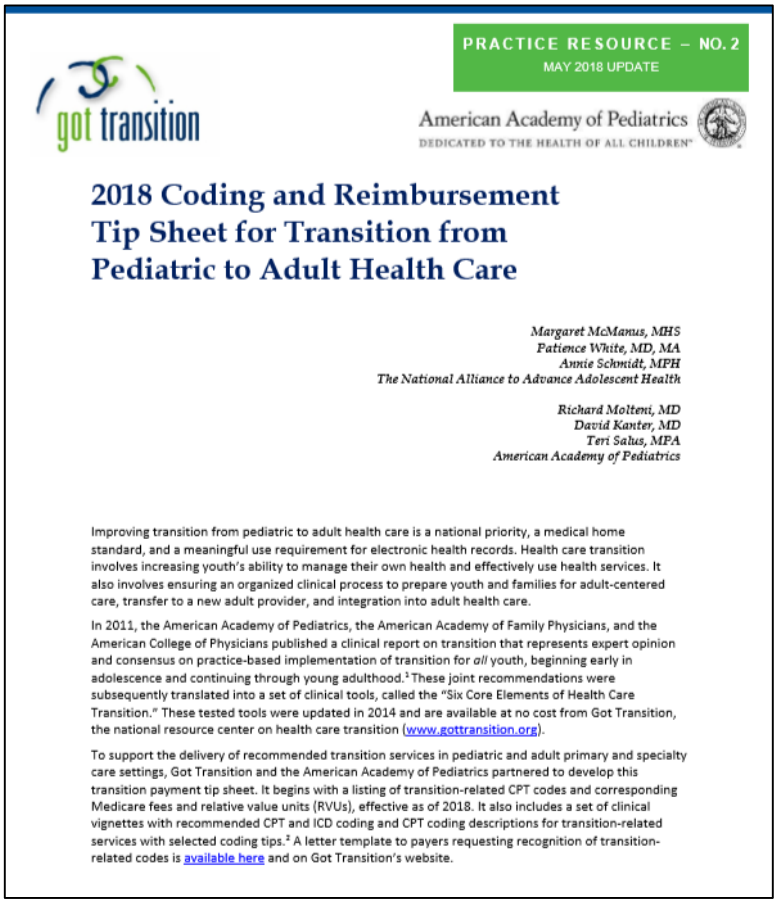
* For a complete listing see the 2018 Coding and Reimbursement Tip Sheet at www.Gottransition.org

Payment Recommendations

4. Develop innovative payment approaches* to encourage collaboration between pediatric and adult care clinicians in the adoption of HCT processes, including the following:
   - Financial incentives for collaboration between pediatric and adult practices around HCT
   - A per-member, per-month additional payment involved in preparing youth, young adults for transfer out of pediatric care and for outreach and follow up of young adults coming into a new adult care setting
   - Performance-based incentives to encourage pediatric practices to transfer their patients at a certain age with a current medical summary, readiness assessment, and evidence of communication with the new practice and to encourage adult practices to accept a certain volume of new young adults with SHCN with pediatric consultation support
   - Payment rates for transition as well as future related research and evaluation studies should stratify for patient risk, taking into consideration not only disease complexity but also social determinants of health, adverse childhood experiences, and availability of family and community supports

* For more value-based payment suggestions, see GT's 2018 Recommendations for VBP Report at www.gottransition.org

Billing for Transition Services



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PRACTICE RESOURCE – NO. 2
MAY 2018 UPDATE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

2018 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care

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Improving transition from pediatric to adult health care is a national priority, a medical home standard, and a meaningful use requirement for electronic health records. Health care transition involves increasing youth's ability to manage their own health and effectively use health services. It also involves ensuring an organized clinical process to prepare youth and families for adult-centered care, transfer to a new adult provider, and integration into adult health care.

In 2011, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians published a clinical report on transition that represents expert opinion and consensus on practice-based implementation of transition for *all* youth, beginning early in adolescence and continuing through young adulthood.[1] These joint recommendations were subsequently translated into a set of clinical tools, called the "Six Core Elements of Health Care Transition." These tested tools were updated in 2014 and are available at no cost from Got Transition, the national resource center on health care transition (www.gottransition.org).

To support the delivery of recommended transition services in pediatric and adult primary and specialty care settings, Got Transition and the American Academy of Pediatrics partnered to develop this transition payment tip sheet. It begins with a listing of transition-related CPT codes and corresponding Medicare fees and relative value units (RVUs), effective as of 2018. It also includes a set of clinical vignettes with recommended CPT and ICD coding and CPT coding descriptions for transition-related services with selected coding tips.[2] A letter template to payers requesting recognition of transition-related codes is available here and on Got Transition's website.

- Got Transition and the American Academy of Pediatrics developed a transition payment tip sheet to support the delivery of recommended transition services in pediatric and adult primary and specialty care settings.
- The 2018 tip sheet provides a comprehensive listing of transition-related CPT codes, corresponding Medicare fees and several clinical vignettes.

https://www.gottransition.org/resourceGet.cfm?id=352

Research Recommendations

To promote a stronger evidence base for HCT, funders and researchers should consider:

1. Incorporate all 3 components of HCT—preparation, transfer, and integration into adult care—in their study design and evaluate HCT processes and outcomes.
2. Examine transition outcomes in terms of population health (e.g., adherence to care, selfcare skill development); experience of youth, young adults, and families; utilization (e.g., time between last pediatric and first adult visit, adherence to initial and follow-up adult clinician appointments, decreased emergency room use, and urgent care visits) and cost savings.
3. Develop pediatric to adult HCT measures as a part of the CMS Child and Adult Core Measure Set and the National Quality Forum measures.
4. Study the impact of HCT in terms of long-term outcomes for young adults.
5. Encourage national health surveys to include HCT questions for young adults.

Next Steps: What You Can Do

- Share the new 2018 AAP/AAFP/ACP Clinical Report widely and use it and its recommendations to support your HCT efforts
- Got Transition is requesting your help in updating the Six Core Elements of Health Care Transition. Please provide your feedback here: https://tinyurl.com/6CEsurvey