



The GEORGIA Pediatrician

A Publication of the Georgia Chapter of the American Academy of Pediatrics

President's Letter

Why a Special Edition on Healthcare Transitions for Pediatricians?



Terri McFadden, MD

Simply put, successful healthcare transitions are just what the doctor and our healthcare system ordered. The American Academy of Pediatrics, the American College of Physicians, the American Academy of Family Physicians all signed on to a Healthcare Transitions Clinical report in 2011 which was reaffirmed by AAP in 2016 until an updated clinical report was

released in November 2018. So why are we not doing better?

According to the American Academy of Pediatrics Clinical Report entitled *Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home* released in November of 2018, *"The vast majority of US youth are not receiving transition preparation, according to the 2016 National Survey of Children's Health, a nationally representative survey of parents. New estimates of transition preparation for youth (ages 12 through 17) with and, for the first time, without SHCN reveal that 83% of youth with SHCN and 86% of youth without special needs do not meet the national HCT performance measure."* Furthermore, this report concluded that a healthcare transition is *"a process for transition preparation, planning, tracking, and follow-through for all youth and young adults beginning in early adolescence and continuing into young adulthood."*

Even without this report, all the parameters exist to identify who needs assistance; there is a defined population – youth, as young as 12 years of age can benefit from becoming confident in understanding their healthcare needs and in building their capacity to become comfortable in understanding how to manage those needs with their physician. Secondly, there is a

need for clear goal setting – how to get from the waiting room with children's books to the waiting room with chairs that seat adults. Thirdly, the timeline, Bright Futures recommends well visit annually until the age of 21 – each adolescent visit presents an opportunity to assess a youth's readiness, and for that matter the parent and physician's readiness, to let go...and support that youth in identifying an adult oriented provider.

...youth, as young as 12 years of age can benefit from becoming confident in understanding their healthcare needs and in building their capacity to become comfortable in understanding how to manage those needs with their physician.

And finally, there is even a toolbox of evidence based tools that can be customizable by your practice to allow you to support each stage of the transition process:

- 1) **Creating a Transition Policy for your practice**
- 2) **Tracking and Monitoring**
- 3) **Assessing Transition Readiness**
- 4) **Planning for Transition**
- 5) **Transferring Care and**
- 6) **Completing the Transfer Process.**

These are known as Six Core Elements of Transitions. Think of it as a bottle of Ragu spaghetti sauce – it's in there. Now

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before you even begin there is even a tool to assess where your practice stands in supporting healthcare transitions which can help you identify incremental changes to achieve successful transitions for your young adult patients. It might be good not to bypass this step as you might be further ahead in the process than you know - or at least understand how your front office staff and practice administrator have been addressing healthcare transitions.

Now if you are still not convinced, lets considered what is achieved when we support successful healthcare transitions. Controlling costs begins by noting that youth who successfully transition to adult oriented care are less likely to use the ER to manage their care, are

...we want to ensure that our patients are empowered to take on the responsibility of directing their own health care as they leave us. Proper transition completes the circle of pediatric care for our patients and helps them to complete this important rite of passage.

more satisfied consumers of healthcare, have improved health status, with improved quality of care though warm hand offs between pediatric and adult oriented physicians. Such transition allows more appropriate utilization of care without increasing costs through use of urgent or emergent care, because care is managed by their adult medical home. More importantly, we want to ensure that our patients are empowered to take on the responsibility of directing their own health care as they leave us. Proper transition completes the circle of pediatric care for our patients and helps them to complete this important rite of passage.

So how can we get to work on constructing successful healthcare transitions? Let us first be sure we know what a successful healthcare transition is not - transitions are not transfers. Transitioning is a clear and intentional set of steps that incorporates planning to support the successful linkage to adult health care. Our patients deserve this important step as they journey into young adulthood.



Terri McFadden, MD, FAAP



Meet Your New Friends – The Six Core Elements



April Hartman,
MD, FAAP

Every destination needs a road map, whether it is one you draw out on a piece of paper or create in your mind. Successfully arriving at adult care from pediatric care needs a team e.g. youth, family, pediatrician, and an adult oriented physician, to create that road map. Fortunately, there are some landmarks – the Six Core Elements, to keep you focused on your destination for this journey. The elements include policy, tracking & monitoring, transition readiness, transition planning, transfer of care, and transfer completion.

These Six Core Elements are essentially an evidence-based combination of process and tools that can ensure a successful transition of all youth and young adults into adult care. Let us take each of these one by one so that you can become familiar with each and how best to utilize them in your practice.

Like any good friend, Policy, helps you achieve your goal. In the case of health care transitions, a policy helps you establish a transparent, widely distributed, youth/family informed outline of how your practice supports youth to transition to adult oriented care. This policy will need to define the practices' approach, list the ages for transition, and notes when this policy will be put into effect.

Please refer to the policy example on page 15: Summary of Six Core Elements approach for pediatric and adult practices.

The next element is Tracking and Monitoring. It is important for each practice to develop a system to readily identify those youth in the practice who are in the various stages of transitioning to adult oriented care and what supports are to be implemented by the practice to achieve the next step. This system can be embedded into the practice's electronic health record, a paper tracking system, or a separate database. Whichever is selected, the system must meet the needs of the youth, family, and you and your staff.

In performing tracking and monitoring, Transition Readiness can help assess how the youth and family are preparing to achieve successful transitions. Simply put, you are assessing the youth's/young adult's mastery of skills to manage their own health/health care. The results of these assessments can help direct anticipatory guidance as the youth ages and

can identify what supports and resources a youth needs to achieve a successful transition.

Our next landmark in successful healthcare transitions is Transition Planning. Now you might have considered that the policy was transition planning; however, your policy is about creating an agreement between your patient & their family and you & your staff to enable the youth to address their health care needs. Within planning, a portable medical summary that includes an emergency care plan with "special information" for their adult oriented physicians is created. This summary will also include non-medical information that the youth and family want to share and will assist the adult provider to engage the youth easily in their first visit

The Transfer of Care of element is key to achieving completion and involves the sharing of a transfer package with an adult provider to allow the young adult to engage with their new clinician. A transfer letter that outlines the youth's care until the initial adult visit, the final readiness assessment, an updated plan of care, the medical summary and emergency care plan from transition planning is created. Resources such as a condition fact sheet can also be included. The transfer letter can be sent by the pediatrician to adult clinician before or after the pediatrician has spoken to the young adult's new physician. Either way, it is most important that the youth and family are aware of when it will be delivered. Sharing a copy of the transfer letter with the family can also be a part of how a practice achieves transfer of care.

Destination arrival occurs at Transfer Completion. This establishes the beginning of care by the new adult clinician and the ending of primary care through the pediatric model of care. Here the pediatrician may serve as a consultant if needed or just communicate with adult practice to confirm the completion of transfer of care. It is also an opportunity to obtain anonymous feedback from the youth and family following that last pediatric visit. If you have found yourself exhaling after reading this overview of the Six Core Elements, it is warranted. These elements represent a complex challenge for the pediatric practice, a challenge worth facing and achieving for your young adult patient.

April Hartman, MD, FAAP

Children's Hospital of Georgia, Augusta University
Division Chief, General Pediatric and Adolescent Medicine
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Associate Professor, Medical College of Georgia



Moving from Transferring Out of Pediatric Care to Transitioning to Adult Models of Care



Jennifer Zubler, MD, FAAP

Working with your youth and families to determine their transition readiness can also help your practice staff become comfortable in supporting youth to successful transitions. The Transition Readiness Assessment tool from Got Transition® is easy to use with your patients and their parents. While using this tool does not predict how successful a youth's healthcare transition process will be, it can lead to supporting the youth in their ability to communicate about their health care needs and develop skills necessary to be a self-advocate.

The Transition Readiness Assessment tool from Got Transitions® allows you to determine how well a youth understands their health care needs and access their comfort level in being able to make health care decisions by ranking the following topics:

- Ranks importance of changing to adult provider before age 22
- Ranks confidence about ability of changing to adult provider
- Assesses self-care skills related to own health/using health services

Checking in with youth and their parents at different intervals starting at or about 14 years of age creates a safe space for youth to be open about any possible concerns they have in entering adulthood and achieving their eventual independence. The readiness tool can help you continue to provide developmentally appropriate anticipatory guidance around health care transitions. In a sense the youth is being given the opportunity to create their own vision of adulthood instead of having it evolve accidentally and without planning.

Your practice can decide if you will use these questions one at a time in your encounters with the youth and family or as a complete assessment at intervals you established. The article entitled, *Incorporating Health Care Transition Services into Preventive Care for Adolescents and Young Adults: A Toolkit for Clinicians* created by the Adolescent and Young Adult Health National Resource Center offers suggested conversation starters around health care transitions for adolescents that can be used with the Bright Futures/American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care.

My Health	<i>Please check the box that applies to you right now.</i>	<i>Yes, I know this</i>	<i>I need to learn</i>	<i>Someone needs to do this... Who?</i>
I know my medical needs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can explain my medical needs to others.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my symptoms including ones that I quickly need to see a doctor for.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what to do in case I have a medical emergency.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my own medicines, what they are for, and when I need to take them.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my allergies to medicines and medicines I should not take.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand how health care privacy changes at age 18 when legally an adult.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This resource as well as the Transition Readiness Assessment tool will allow the practice to identify what is important to the young adult and their family as well as understand how much guidance they will need to achieve a successful transition to adult care. For example, a youth that can express their health condition/needs and list the type of medications they take for their condition is on their way to building their capacity to engage in these conversations with their adult care provider. On the other hand, family members may reveal that they are not ready to step away from being a decision maker for their young adult.

Transitioning to Adult Models of Care

Continued from previous page.

Using resources like the American Academy of Pediatrics' Family Engagement around confidentiality as well as the Centers for Disease Control's handout entitled, *Teen Health Services and One-On-One Time with A Healthcare Provider: An Info brief for Parents* can help begin these conversations with parents. In general, these assessments can help guide anticipatory guidance at future visits and the expressed goals identified by the youth and family will be helpful for the youth's transfer packet for the adult health care provider.

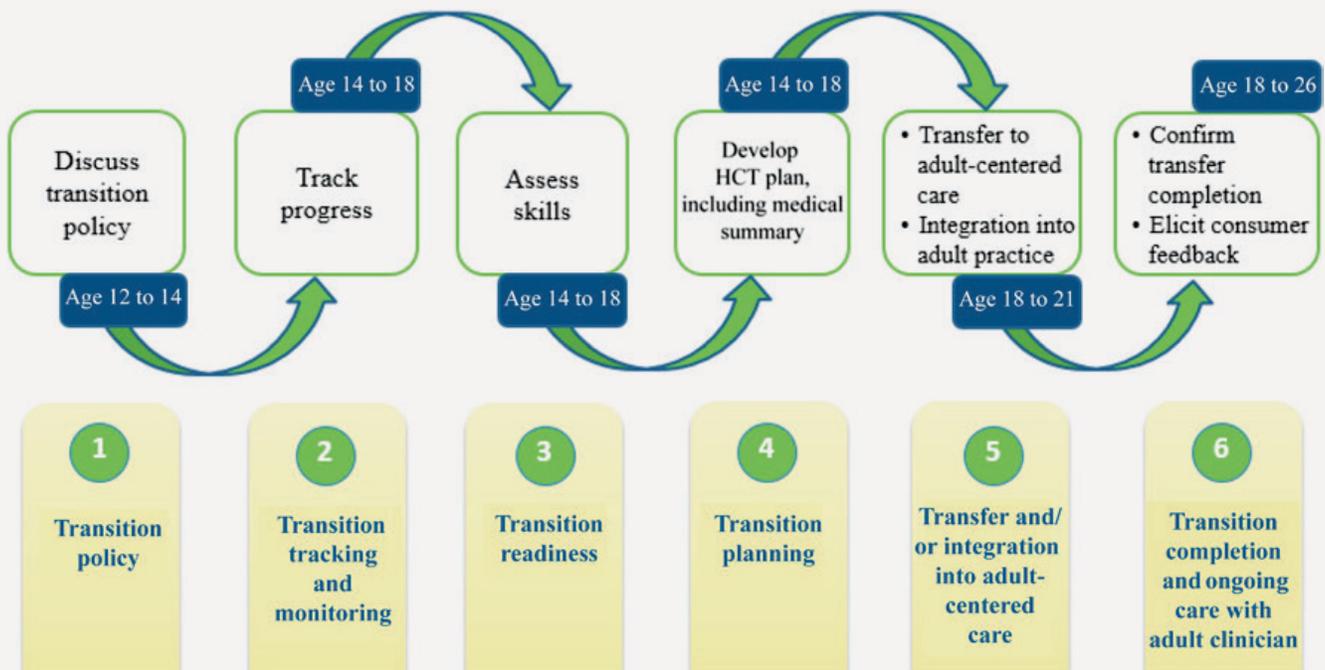
Another resource for youth is closer at hand - it is their mobile device. These devices can store a picture of their insurance card, link to medical records at places where they access care, list contact information for their pediatrician, pediatric subspecialists as well as their emergency contact person. Many youth and young adults are already using their mobile devices to record information on their pulse, sleep habits, and physical activity. An app on a mobile device can also store information on diagnosis, allergies, and medications - brand/generic names - as well as the dosage of their medications. Lastly, if a practice has a patient portal, youth can interact with their physicians by asking questions and/or uploading or downloading forms related to their health.

The above listed approaches are all a part of the process to ensure patient satisfaction and optimal health of the young adult. Further as noted in the article entitled, *Outcomes of Pediatric to Adult Health Care Transition Interventions: An Updated Systematic Review*, published in the January 2020 edition of the Journal of Pediatric Nursing, those patients who receive anticipatory guidance like that generated through intentional transition readiness assessments have higher patient satisfaction around the services they receive and higher satisfaction with care coordination.

Establishing these small acts of change can move your practice from *transferring out* young adults from pediatric care to successfully *transitioning* young adults to adult care.

Jennifer Zubler, MD, FAAP

Volunteer Pediatrician, Good Samaritan Health Center
 Consultant, Centers for Disease Control and Prevention
Learn the Signs. Act Early.



Timeline for introducing the Six Core Elements into pediatric practices.



Transitioning from Pediatric to Adult Healthcare: A Youth's Perspective



Latia Bell,
Student

My name is Latia Bell and I am a 19-year-old sickle cell patient, hemoglobin SC. For 18 years, I have been a patient at the Cancer & Blood Disorders Center at Children's Healthcare of Atlanta, Egleston campus. Before starting college at the University of Georgia in the fall of 2018, my doctors and I worked together to establish a permanent hematologist at Grady Hospital's Sickle Cell Center that I could refer to when returning home. Graduating high school in the summer of 2018, I felt very confident in making my own medical decisions. In pediatric care, my doctor would give me a written exam over my condition—a sickle cell test—every few months to challenge my knowledge about my illness and its medications and allow me to ask questions. I was taught to know my illness through and through, such as my baseline hemoglobin, which became imperative knowledge in adult care. This preparation made me feel confident in my illness academically, and as a patient. When I transitioned in the fall of 2018, I felt well prepared and confident in making my own medical decisions.

This preparation made me feel confident in my illness academically, and as a patient. When I transitioned in the fall of 2018, I felt well prepared and confident in making my own medical decisions.

Since high school graduation, I am more confident in making medical decisions and feel that the root of being able to make these decisions is based on how well a patient knows their body and their health. I cannot imagine what my experience in adult care would be like if I were not trained to know my illness and pay attention to my body and how it responds to different medications. In my experience, it is easy to be diagnosed and treated based on how most patients present—an average diagnosis. Though, when a doctor told me that my hemoglobin was 10, and that “it was good, because most patients with sickle cell have a lower hemoglobin”, I knew that there was another problem because my normal hemoglobin is usually at or above 12. This is why I urge that it is important for all patients to know their bodies, how they react, and their illnesses.

Finding an adult provider was not hard for me coming into college, as my pediatric hematologists helped me pick the right adult hematologist and transitioned me into adult care before I

went off to college. The bigger problem that I have constantly encountered is accessing healthcare with a varying medical insurance plan. I am a Medicaid recipient, but for the past few years since high school, I have struggled with getting access to see a primary doctor and other specialists because my Medicaid plan would abruptly end or not pay for certain treatments when it should. This has been the most stressful thing to deal with while away from home in college.

As of today, I feel that I am well prepared to manage my illness. I attended mandatory workshops for transitioning at my children's hospital during my sophomore, junior, and senior year of high school, and I was taught about the

differences between pediatric doctors and adult doctors and why transitioning was important. I do not think that my pediatrician and adult provider communicated about my illness before transitioning, but my doctor studied my files before my first appointment, which was very helpful. On the other hand, I do not feel that I was adequately prepared for what to expect in emergency care. I was not prepared for the judgment that I would receive from healthcare professionals as a young African American with a chronic illness. It is as if this side to medical care was completely excluded from my training, let alone nonexistent.

There is a huge difference in the level of compassion when working with kids than with working with adults. Going into adult care, I still had a child's mindset and expected to be treated as a child—with patience and care. Instead, I was forced out of my wheelchair and told to walk while in the emergency room waiting for care. I was asked confusing questions about narcotics with the intentions of labeling me as a drug addict. Being alone, away at college, it is harder to notice this treatment when sick and in pain. These types of misconceptions have left me depressed for days. Sickle cell patients lose their lives everyday due to misdiagnoses and misconceptions and for this reason, I think that it is imperative that adolescents transitioning should be warned about the different types of treatment that they will receive,

Transitioning

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as an act of preparation. During my first year in adult care, I thought that some professionals were just mean, but I did not realize that this treatment is called healthcare discrimination and it is a common problem across the globe.

I am greatly appreciative of the sickle cell exams and mandatory transitioning workshops that I attended before transitioning. This made me confident in my level of knowledge of my illness as a whole. However, I wish that there could have been training or a course over everything to know about health insurance, and how to maintain it. This could have saved a lot of stress and confusion.

Most of all, I would like future transitioning adolescents to know that it is crucial to know your body and your illness. In pediatrics, the doctor knows everything about the patient and communicates with the parent, the ultimate decision maker. In adult care, you are the decision maker and you will be for the rest of your life. This is the biggest and most important thing that I have learned during my last two years in adult care. There have been countless times where I have called my doctor for advice or to ask him if I should be seen by a doctor, and he has told me “What do you think? I cannot make that decision for you. You know your body.”

Know your body and know how to respond to what it tells you. In addition, patients should be prepared for possible discrimination. Being aware of possible discrimination will not prevent it, but at least you will not be as shocked, and know that you can request a different provider. Finally, do not be afraid to ask for help. As a college student, I would often go to the emergency room alone. This is not very safe. Have a trusted friend accompany you in the emergency room, someone with a clear mind and understanding of your illness, as you would most likely only be focused on your pain. My transition has been smooth, but the process of learning myself and my body, and recognizing my surroundings, has been a journey.

Latia Bell

University of Georgia 2022
Psychology Major | Spanish Minor
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ARE YOU READY TO TAKE CHARGE OF YOUR HEALTH?

5 Steps to Prepare for Health Care Transition

At a time when there is a lot going on in the world and in health care, Got Transition is here to make one thing a little bit easier. Now may be a great time for young people to learn about their own health and plan for health care transition. This is the process of getting ready for health care as an adult.

This process involves gaining independent health care skills, preparing for an adult model of care, and eventually transferring to new providers. The steps and resources below can prepare youth, young adults, and families to make sure the transition to adult health care goes smoothly.

1



ONLINE QUIZ

Are you ready to transition to adult care?
Take our [online quiz](#) to find out now!

2



TRANSITION TIMELINE

Know where you are before you can plan where you're going!
Find out where you are in the transition to adult care by reviewing the [Transition Timeline](#) for age-specific milestones.

3



READINESS ASSESSMENT

Find out what you already know about your health and health care by filling out our [Transition Readiness Assessment](#). Family members: fill out this [version for Parents/Caregivers](#) and compare your answers!

4



GOAL SETTING

Setting goals is an important part of helping you reach independence in your medical care. Fill out this [helpful one-pager](#) from Children's Mercy Kansas City to set your health goals.

5



TAKE YOUR HEALTH INFO WITH YOU

A smartphone is a great place to keep important health information. Fill out the [Medical ID](#) on your smartphone, which can be accessed by anyone in the case of an emergency.

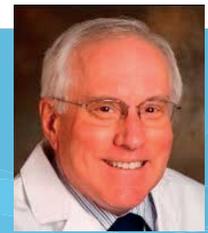


For more information, visit www.GotTransition.org

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Supporting Young Adults in Shifting from the Pediatric to the Adult Model of Care



James Eckman, MD

There is nothing like the pediatric practice, its colorful, there are toys, books, and for being brave, you get a sticker – and some places have a treasure box where you might find your very own treasure. The pediatric model of care focuses on the child as the patient within a family in a warm, open environment that seeks to understand community resources and discuss them with parents so that they can decide how best to address the child’s care needs. The relationship with a pediatrician typically develops over time and focuses on the growth and development of their patient.

The adult care environment is usually more spartan. The adult model of care has the patient as the center of care. There is shared decision making between the provider and patient with the provider serving more as a coach. The patient is their own advocate and they have responsibility for meeting their healthcare needs. There is an expectation that the patient will be actively engaged in managing their health; access care on a regular basis; and independently support their treatment.

If your young adult patient is not clear on how they experience the care they receive, consider using this graphic to discuss the differences with your patient.

Got Transition: Pediatric vs. Adult Care: gottransition.org/resourceGet.cfm?id=5

For individuals with special health care needs, there are several factors that complicate transition. Foremost is the youth’s desire to be normal, independent, and participate in all activities



PLANNING TO MOVE FROM PEDIATRIC TO ADULT CARE? HERE’S HOW THEY CAN DIFFER

Health care for youth is different than health care for adults. In adult care, you are in charge of your own care and involve your parents/caregivers if you choose. These are some of the changes that happen when you move to adult care.

Please circle any items in the Adult Approach to Care column that you have questions about. Bring this to your next doctor visit to start a conversation about any questions you may have.

Pediatric Care (Where you are now)		Adult Approach to Care (Where you will be)
Your parent/caregiver is with you for most or all of your visit.		You see the doctor alone unless you agree for others to be present.
Your parent/caregiver helps answer questions and explain your medical conditions, any medicines, and medical history.		You answer questions and explain your medical conditions, medicines, and medical history.
Your parent/caregiver is involved in making choices about your care.		You make your own choices about your care, asking your parents/caregivers as needed.
Your parent/caregiver helps make appointments and get your medicines.		You make your own appointments and get your medicines.
Your parent/caregiver helps with your care and reminds you to take your medicines.		You take control of your care and take medicines on your own.
Your parent/caregiver can see your health information, including test results.		Health information is private unless you agree to let others see it.
Your parent/caregiver knows your health insurance and pays any charges at the visit.		You keep your health insurance card with you and pay any charges at the visit.
Your parent/caregiver keeps a record of your medical history and vaccines.		You keep a record of your medical history and vaccines.
Many pediatric specialists provide both specialty and some primary care.		Adult specialists often do not provide primary care, so you need to have a primary care doctor along with a specialist.

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Shifting from the Pediatric to the Adult Model of Care

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undertaken by their peers. Many may have physical, emotional, social, and cognitive limitations that limit their ability to achieve their goals. Pediatricians need to develop and implement a transition plan with the youth, their family, and caregivers early that prepares all for a gradual shifting of responsibility to the youth so they can take full control by the legal age of maturity, 18 in most states. For youth with special health care needs, this shift in decision making may include assessment of special needs perhaps for obtaining a guardianship if necessary. Planning for support for costs associated with health care and independent living also need to be initiated long before the youth turns 18.



The adult physician faces a few challenges accepting youth into their care. The pediatrician has had a life-long relationship of trust with the patient and their families. The resources for care of the transitioning patient can also be a challenge. For youth with special health care needs, the disease may become more severe because of physiological, psychological, social, and economic factors.

The pediatrician can be extremely helpful in facilitating a smooth health care transition by providing a concise, detailed care plan that includes health maintenance, emergency plans, psychological challenges, and addresses economic factors. It should also include a social summary that highlights the youth's interests, educational goals, and long-term aspirations. This information allows the adult provider to personalize their care from the beginning, so the youth and their families develop confidence that they are interested in them as a person beyond health care.

There are also adult medicine physicians who are hesitant to take on the care needs of the young adult with special health care needs that require care coordination and community supports. Patients with complex congenital heart disease, sickle cell disease, cystic fibrosis, or autism spectrum disorders present challenges for many adult oriented physicians. The pediatric specialist can provide a valuable role by continuing to provide consultations for the patient that address their special care needs, especially while the youth is integrating into the adult care system. For some, this needs to continue for some time and there are models for a medical neighborhood that may include multiple specialists collaborating in the youth's care.

Transition to adult care is often associated with decreased adherence to care plans; lack of participation in health promotion activities; and participation in risky behaviors. It is important for the pediatrician to query their transitioning patients one on one about these issues and reinforce healthy behavior.

It is also important for the pediatric provider to make sure the transfer of care is complete. This includes helping build collaboration between primary and specialty pediatric care providers and the adult providers. The pediatric provider should confirm ongoing care. They should also query the youth and their families about the experience and do continuous quality improvement in their practices based on this feedback.

James Eckman, MD

**Professor Emeritus, Department of Hematology and Oncology
Emory University School of Medicine**



Taking on Healthcare Transitions as a Quality Improvement Project for the Patient-Centered Medical Home



Jeffrey H. White, MD, FAAP

When the American Academy of Pediatrics established the medical home model of care in 1967, it was its own revolution. A revolution which started with support for a place to retain and maintain a child's health records. Subsequently a 2002 AAP statement was introduced that centered on children and youth with special healthcare needs. These needs were defined as affecting children who *"have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally."* This statement operationalized the medical home, noting that it is to be *accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.*

Then, in March 2007, the patient-centered medical home for all children and youth emerged, with emphasis on children and youth with special health care needs. A focus began to develop on the importance of a longitudinal relationship between the patient, their family and the patient's personal physician. The physician leads a team within the medical practice that focuses on building relationships and providing comprehensive care for patients.

The National Resource Center for Patient/Family-Centered Medical Home, formerly the National Center for Medical Home Implementation, notes that within the last 40 years, private organizations and national, state, and local governments have all provided evidence to support the pediatric medical home. Much of this evidence-based body of research indicates that access to a medical home ensures appropriate utilization, improved health outcomes, reduced costs for care, and improved patient and family satisfaction with the care they receive.

More and more pediatricians have braved change and begun the process of practice transformation to achieve Patient-Centered Medical Home Recognition. Although adequate reimbursement continues to lag and bureaucratic systems place burdens on quantifying this important work, patients, their families, and pediatric practices can all benefit from transitioning to a medical home. Commitment to continuous quality improvement and a patient-centered approach to care offers opportunities to essentially work smarter, not harder, and to ensure optimum health outcomes for pediatric patients.

Addressing healthcare transitions for youth (especially those with special health care needs) provides one such opportunity for quality improvement. Over the last several years the Chapter has surveyed its members and,

unfortunately, has found that active engagement in this area has not increased. The remainder of this article addresses how pediatric offices can engage in a quality improvement project to address healthcare transitions.

Engaging senior leadership is the first step in beginning any improvement process. Obtaining buy-in from both leadership and staff is critical to creating a

transition process that is functional and sustainable. Staff members from all areas of the practice - from the front desk to the physician to the referral clerk - need to be involved in offering suggestions and outlining how to proceed. Guidance from your electronic health record system provider, patient families, and a representative from an adult-oriented practice is also recommended. All participants must understand that, while they are encouraged to give suggestions and feedback, senior leadership will develop the final plan, and everyone's support is necessary to success. Staff must be willing to embrace change even if it looks different from what they initially suggested or expected.

One of the most effective ways to build support for change is to show staff why the change is important. Perhaps you have a past patient/family who struggled with the transition to adult care and is willing to share their story. A "real life" example can help your staff better understand the significant impact a successful transition process can have on patients and their families.

Healthcare Transitions as a Quality Improvement Project

Continued from previous page.

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The second step in the process is identifying your aim. The National Institute for Children’s Health Quality (NICHQ) defines an aim statement as “*a clear, explicit summary of what your team hopes to achieve over a specific amount of time including the magnitude of change you will achieve. The aim statement guides your work by establishing what success looks like.*” Hence, an aim statement identifies **who** the target of the work is, **what** the practice will be trying to achieve and **when** the work will take place.

Once a clear aim has been established, the final step is putting a system in place to evaluate the outcomes of the quality improvement work and determine whether the aim is being achieved. The Plan-Do-Study-Act (PDSA) model is a simple but effective method of assessing the outcomes of specific, incremental changes. The Agency for Healthcare Research and Quality describes the PDSA as means to “*test a change that is implemented... four steps guides the thinking process into breaking down the task into steps*

and then evaluating the outcome, improving on it, and testing again.” Evaluate every incremental change using the PDSA cycle, keeping those changes that demonstrate positive outcomes, and discarding changes that do not help you achieve your aim.

Remember, when you begin addressing healthcare transitions for youth, you need not immediately implement the effort for every adolescent or young adult in your practice. Start small. Test your new process on a small group and scale up as resources are available and your staff becomes more comfortable and efficient at implementing the new process.

For more than 50 years, pediatricians have been at the forefront of the medical home model of care. Our commitment to providing superior, comprehensive care for pediatric patients should not end when patients “age out” of our practice. By assisting our pediatric patients with the transition to adult care, we can work to ensure that young people begin adulthood with a plan for achieving and maintaining good health.

Jeffeory H. White, MD, FAAP

Chair, Medical Home Task Force
Founder, Whites Pediatrics
Dalton, Georgia





Updated Six Core Elements of Health Care Transition™ and Revamped Got Transition Website

Breaking News!
New Health Care Transition Resources Will be Available July 6, 2020!

Got Transition®, the federally funded national resource center on health care transition (HCT) within The National Alliance to Advance Adolescent Health, is excited to unveil updated tools, new resources, and a revamped website on July 6, 2020. These materials are intended for clinicians, youth/young adults, and parents/caregivers to assist youth and young adults (with and without special health care needs) as they move from a pediatric to an adult-centered model of health care.

After extensive review and input from clinicians, youth, young adults, and family HCT experts, Got Transition has updated the **Six Core Elements of Health Care Transition™ 3.0**, which define the basic components of HCT support and are intended for use by pediatric, family medicine, med-peds, and internal medicine practices. The three packages are aligned with the **2018 AAP/AAFP/ACP Clinical Report on Health Care Transition** and will be available on July 6 for these scenarios:

1. **Transitioning Youth to an Adult Health Care Clinician**
2. **Transitioning to an Adult Approach to Health Care Without Changing Clinicians**
3. **Integrating Young Adults into Adult Health Care**

To help practices transform their HCT processes, Got Transition has also developed new practical step-by-step Implementation Guides dedicated to each core element. Got Transition recommends a quality improvement (QI) approach to incrementally incorporate the tools as a standard part of care, and these guides offer real world examples from practices utilizing the Six Core Elements. Got Transition offers background information on how to use the Implementation Guides, as well as a Quality Improvement Primer for those unfamiliar with the QI process. Guides and information will be available on July 6 at www.GotTransition.org/six-core-elements/implementation.

Got Transition is also finalizing its revamped website, www.GotTransition.org, that will offer an interactive experience to everyone involved in this process: clinicians, youth/young adults, parent/caregivers, and researchers/policymakers. The revamped site will include new toolkits, online quizzes, one-pagers, Six Core Elements samples, and other HCT-related resources and information.

Be sure to visit www.GotTransition.org on July 6, 2020 and email info@gottransition.org for any additional HCT-related questions you may have.



Appreciation, References & Resources

This Special Edition of The Georgia Pediatrician is a collaboration between the Georgia Chapter of the American Academy of Pediatrics and the Maternal and Child Health Section, Division of Health Promotion within the Georgia Department of Public Health. The following materials were used in preparing this edition of our newsletter and can serve as resources for your practice as you strive to support successful health care transitions to adult care for your young adult patients. A special thank you to the American Academy of Pediatrics Transition ECHO team, the Got Transition® program staff within The National Alliance to Advance Adolescent Health and our local partners supporting infants, children and adolescents within Georgia's Children and Youth with Special Health Care Needs, Children's Medical Services.

Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home

Pediatrics July 2011, 128 (1) 182-200;

doi.org/10.1542/peds.2011-0969

AAP Transition ECHO

Project ECHO is a telementoring program designed to create communities of learners; this program focuses on youth and health care transitions.

www.aap.org/en-us/professional-resources/practice-transformation/echo/Pages/Transition.aspx

The AAP Transition ECHO is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U23MC26252, Awareness and Access to Care for Children and Youth with Epilepsy/cooperative agreement. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Georgia Department of Public Health Transition Resources

dph.georgia.gov/transition-resources

Got Transition®

www.gottransition.org

Transition Coding and Reimbursement Tip Sheet

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

Incorporating Transition into Epic Electronic Health Record Software: A Survey of Expert Users

eventarchive.epic.com/Webinars/KidShare/Got%20Transition%20EHR%20Report.pdf

Outcomes of Pediatric to Adult Health Care Transition Interventions: An Updated Systematic Review

Journal of Pediatric Nursing Volume 51, March-April 2020

www.sciencedirect.com/science/article/abs/pii/S088259631930555X

Mobile Apps for storing of medical histories

- 1) www.dr-hempel-network.com/digital-health-technology/top-10-mobile-apps-for-personal-medical-records
- 2) www.mymedicalapp.com

SAHM's Adolescent Medicine Resident Curriculum on Transition

[www.adolescenthealth.org/Training-and-CME/Adolescent-Medicine-Resident-Curriculum/Adolescent-Medicine-Resident-Curriculum-\(9\).aspx](http://www.adolescenthealth.org/Training-and-CME/Adolescent-Medicine-Resident-Curriculum/Adolescent-Medicine-Resident-Curriculum-(9).aspx)

Tip Sheet Links Patient-Centered Medical Home Standards with Six Core Elements

www.gottransition.org/resourceGet.cfm?id=444



References & Resources

Health Care Transition Timeline for Youth and Young Adults



Age 12-13

- Learn about your health condition, medications, and allergies.
- Ask your doctor questions about your health.
- Ask your doctor if and at what age they no longer care for young adults

Age 14-15

- Find out what you know about your health, health care, and family medical history. Both you and your parent/caregiver can take Got Transition's Transition Readiness Assessments* and discuss this together and with the doctor.
- Carry your own health insurance card.
- Learn more about your health and what to do in case of an emergency.
- Practice making a doctor's appointment and ordering prescription refills (either by phone, online, or through an app).
- Begin to see the doctor alone for part of the doctor's visit to help gain independence in managing your health and health care.

Age 16-17

- Make doctor's appointments, see the doctor alone, ask the doctor any questions you have, and refill medications.
- Ask the doctor to talk with you about your privacy rights when you turn 18.
- Work with your doctor to make a medical summary. Keep a copy for yourself.
- Before you turn 18 and become a legal adult, figure out if you will need help making health care decisions. If so, ask your Family Voices chapter for local resources.
- Talk with your parent/caregiver about the age you want to transfer to a new doctor for adult care.

Age 18-21

- You are a legal adult at age 18 and are legally responsible for your care. Parents/caregivers cannot access your medical information or be in the doctor's visit unless you agree.
- Work with your current doctor to find a new adult doctor, if needed. Make sure that the new doctor accepts your health insurance.
- Update your medical summary with your doctor. Have your doctor send this to your new adult doctor. Keep a copy for yourself.
- Call your new adult doctor to schedule the first appointment. Make sure the new office has your medical information, and learn if there are any charges at the visit.
- Learn if there are additional changes at 18 that affect you (e.g., health insurance, Social Security Income).

Age 22-25

- Continue to get care from your adult doctor, learn to manage your health and health care, and update your medical summary.
- Be sure to stay insured. If you change your health insurance, make sure your doctor takes your insurance, and learn if there are any charges at the visit.

*For a Transition Readiness Assessment for youth, visit <https://www.gottransition.org/resourceGet.cfm?id=224> and for a version for parents/caregivers, visit <https://www.gottransition.org/resourceGet.cfm?id=225>.

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Got Transition (GotTransition.org) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) (U1TMC31756). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.



References & Resources

Summary of Six Core Elements approach for pediatric and adult practices. ^a Providers that care for youth and/or young adults throughout the life span can use both the pediatric and adult sets of core elements without the transfer process components.

Practice or provider	#1 Transition and/or care policy	#2 Tracking and monitoring	#3 Transition readiness and/or orientation to adult practice	#4 Transition planning and/or integration into adult approach to care or practice	#5 Transfer of care and/or initial visit	#6 Transition completion or ongoing care
Pediatric^a	Create and discuss with youth and/or family	Track progress of youth and/or family transition preparation and transfer	Conduct transition readiness assessments	Develop transition plan, including needed readiness assessment skills and medical summary, prepare youth for adult approach to care, and communicate with new clinician	Transfer of care with information and communication including residual pediatric clinician's responsibility	Obtain feedback on the transition process and confirm young adult has been seen by the new clinician
Adult^a	Create and discuss with young adult and guardian, if needed	Track progress of young adult's integration into adult care	Share and discuss welcome and FAQs with young adult and guardian, if needed	Communicate with previous clinician, ensure receipt of transfer package	Review transfer package, address young adult's needs and concerns at initial visit, update self-care assessment and medical summary	Confirm transfer completion with previous clinician, provide ongoing care with self-care skill building and link to needed specialists

Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home Clinical Report White, Cooley Pediatrics November 2018

Creating an HCT Policy: Sample Template For Practices Transitioning Youth To Adult Health Care Clinicians:

[PRACTICE NAME] wants to help our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14 years, and their families to prepare for the change. The change is from a “pediatric” model of care where parents make most health choices to an “adult” model of care where youth make their own health choices. This means that we will spend time during the visit with the teen without the parent present. This will help youth to be more independent with their own health care.

At age 18 years, most 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 when 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 keeps him/her from making health care choices, we ask parents/caregivers to consider options for supported decision making.

We will work with youth and families about the age for moving to an adult provider and suggest that this transfer occur before the age of [INSERT AGE]. We will assist with this transfer process, including helping to identify an adult clinician, sending medical records, and work with the adult clinician about the unique needs of our patients.

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



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Looking Ahead:



● **September 24-26, 2020**
**Pediatrics on the Parkway,
Fall CME Meeting**
Cobb Galleria Centre, Atlanta

● **October 21, 2020**
**The 2020 Jim Soapes Charity Golf Classic
benefiting the Pediatric Foundation of Georgia**
Cherokee Run Golf Course

The Georgia Pediatrician is the newsletter of the Georgia Chapter/American Academy of Pediatrics

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Visit the Chapter Website for details on Chapter events. www.GAaap.org
Call (404) 881-5020 for more information.