Overview

• Team:
  – Members here:
    • Bree Mickolajak, Parent Partner
    • Mary Jackson, Parent Partner
    • Julie Hein, Clinical Assistant, and Parent Partner
    • Tara Talarico, RN Pediatric Manager
    • Tammy Carlson, RN Care Coordinator
    • Moira Betros, RN Care Coordinator
    • Shar Valentine, MD, Pediatrician
    • Gordy Harvieux, MD, Pediatrician
Overview

• Team
  – Addition Team Members:
    • Jennifer Armstrong
    • Jamison Armstrong
    • Brenda Rhode, social worker
Overview

- Essentia Health Pediatrics
  - Location: Duluth: on the Beautiful Shores of Lake Superior
Overview

• Essentia Health Pediatrics:
  – 9 Pediatricians.
  – 3 Pediatric Nurse Practitioners.
  – 12 Pediatric Sub-Specialties.
  – 3 Pediatric In-Reach Sub-Specialties.
Mission of Our Project

• Essentia Health Pediatrics is committed to helping our patients make a smooth transition from pediatric to adult health care.
Transition Policy

• Prior Transition Policy
  – Not followed or well agreed upon.
  – Specifically, the age of transition.
• Reviewed multiple transition policies.
• Drafted new policy.
• Drafted policy was critiqued and rewritten by our young adult and our parent partners.
Our Transition Policy

• “Between ages 12-14, we will begin working with youth and their families to prepare them to take responsibility for their own health care decision making. To support our teens in becoming more independent and engaged in their own health care, we will spend some time with them during the visit without parent/guardian present.”
Our Transition Policy

• “In addition, we encourage the use of My Health to provide internet access to the young person’s medical record, including access to office notes, letters, lab results and the ability to message with us. Beginning at age 12, to allow parental access to each adolescent’s medical record, the young person is required (by state law) to sign a proxy consent form. This proxy signature needs to be renewed yearly.”
Our Transition Policy

• “At 18, youth legally become adults. While many young adults choose to continue to involve their families in health care decisions, we can only discuss personal health information with the young adult’s consent. If the young adults have conditions that prevent them from independently making health care decisions, we encourage caregivers to consider options for supported decision making."
Our Transition Policy

• “We will collaborate with young adults and families to determine the best time to transfer from a pediatric to adult provider, ideally between the ages of 18-20. We will assist with this process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the patient’s unique needs.”
Our Transition Policy

• Ratified at our Pediatric Section (Duluth) Meeting in December 2018.

• Approved January 2019 for use system-wide through all of Essentia Health!!!:
  – East (Duluth)
  – Central (Brainerd)
  – West (Fargo)

• We also drafted a Transition Policy for use in Family Practice.
Got Transition

What is Health Care Transition?

Health care transition is the process of changing from a pediatric to an adult model of health care. The goals of health care transition are to improve the ability of youth and young adults to manage their own health care and effectively use health services, and to ensure an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care.

What are the Six Core Elements™?

The Six Core Elements of Health Care Transition™ 2.0 define the basic components of health care transition support. These components include establishing a policy, tracking progress, administering transition readiness assessments, planning for adult care, transferring, and integrating into an adult practice.

There are three sets of customizable tools available for different practice settings.

Aligned with the AAP/AAFP/ACP Clinical Report on Transition, the Six Core Elements are intended for use in primary and specialty settings. Originally developed in 2009, this updated version incorporates the results of several transition learning collaboratives, an examination of transition innovations in the US and abroad, and reviews by over 50 pediatric and adult health care professionals and youth and family experts.

Recommended Health Care Transition Timeline

Essentia Health

Here with you
Tools Developed: Transition Readiness Assessment Tool

- Derived from the many prototypes in Got Transition
- Converted into an Epic Smart Phrase
- How to administer the Readiness Assessment Tool
  - Face to Face with the Pediatrician?
    - Very time consuming.
  - Online as a My Health electronic questionnaire?
    - Yet to be built into EPIC
  - Handed out at Registration.
    - Met with the head of Patient Registration
    - Now handed out to all adolescents 16+ years old
    - Transition Policy Printed on the back.
Transition Readiness Assessment Tool

@NAME@
@DOB@
@TODAYDATE@

Transition and Self-Care Importance and Confidence:
On a scale of 0-10, please indicate the number that describes how you feel right now.

How important is it to you to manage your own healthcare? ***

How confident do you feel about your ability to manage your own healthcare? ***

Knowledge of Health and Using Healthcare:
For the following questions, answer using the options below:
1. Yes, I know this.
2. I need to learn this.
3. Someone needs to do this for me (designate who).

We discussed the following issues related to Transition:

My Health:
I know my medical needs (diagnoses).
I can explain my medical needs to others.
I know my symptoms, including ones for which I quickly need to be seen.
I know what I can do in case I have a medical emergency.
I know my own medicines, what they are for, and when to take them.
I know my allergies to medicines and the medicines I should not take.
I can explain to others customs and beliefs that affect my healthcare decisions and medical treatment.

Using Health Care:
I know I can find my doctor's phone number.
I can make my own doctor's appointments.
Before a visit, I think about questions to ask.
I have a way to get to my doctor's office.
I know I need to show up 15 minutes before the visit to check in.
I know where to go to get medical care when the doctor's office is closed.
I have a file at home for my medical information.
I know how to fill out medical forms.
I know how to get referrals to other providers.
I know where my pharmacy is and how to refill my medicines.
I know where to get blood work or x-rays done if my doctor orders them.
I carry important health information with me every day (insurance card, allergies, medications, emergency contact information, medical summary). I understand how healthcare privacy changes at 18 when legally an adult. I have a plan so I can keep my health insurance after 18 or older. I know how to use My Health and I have my own account.

I know that I need to transition to an adult provider between age 18-20. I know how to select an adult provider (male/female, location of clinic, Provider online videos, recommendations, etc.)

Of the above items which you marked "I need to learn this", which items would you like to work on first?

1.

2.

3.
Tools Developed:
Transition Plan of Care

• Goal Setting worksheet.
  – Goals.
  – Issues or Concerns.
  – Actions – Person Responsible.
  – Target Date.
  – Date Completed.
  – Initial Date of Plan.
  – Date Completed.

• First attempt done at a transition appointment with Jamison and Dr. Valentine.
Plan of Care
@NAME@
@DOB@

Instructions: This is a written document developed jointly with the young adult to establish priorities and a course of action that integrates health and personal goals. Information from the Readiness Assessment Tool can be used to guide the development of health goals. It should be dynamic and updated regularly.

What matters most to you as a young adult?

How can learning more about your health condition and how to use healthcare support your goals?

Prioritized goals:
1.

2.

Issues or Concerns:
1.

2.
<table>
<thead>
<tr>
<th>Actions</th>
<th>Person Responsible</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td>2.</td>
<td>2.</td>
</tr>
</tbody>
</table>

**Target Date:**

1.

2.

**Date Completed:**

1.

2.

**Initial date of plan:**

**Last updated:**
Tools Developed: Transition Flow Sheet

- Developed in conjunction with our IM-PEDS colleagues.
- Welcome and Orientation.
- Discussion of the Process.
- Need for Referring Physician to:
  - Communicate
  - Send Letter
  - Do Warm Handoff
  - Schedule a Shared Visit
  - Send most recent note, etc
- Adult Care Model.
- Medical Summary and Emergency Care Plan.
Welcome and Orientation:
1. IM Dept or Peds on behalf of IM: Discussed with young adult before the first visit to welcome and answer questions.
2. Transfer package received from pediatric provider.
   Routed note from the farewell visit.
   Last psych evaluation
   Transfer letter
   Final transition readiness assessment/Pediatrician narrative of patient’s transition skills.
   Plan of care, including transition goals and pending actions
   Guardianship or health proxy documents, if needed
   Establish release for parents as proxy or allowed the release of information
3. Orientation material with young adult/Internal Medicine welcome letter.
4. Practice policy on transition discussed/shared with young adult.

Adult Model of Care:
1. Clarified adult approach to care, including shared decision-making, privacy and consent, access to information, adherence to care, and preferred methods of communication.
2. If needed not previously addressed, discussed legal options for supported decision-making.

Medical Summary and Emergency Care Plan:
1. Updated and shared medical summary and emergency care plan.

Transfer Completion:
1. Communicated with pediatric provider confirming transfer of care and arranging for consultation, if needed.
2. Elicited feedback from young adult about transition and experience with care.
Problems

• Too many forms.
• What are the names of the forms?
• What does each form do?
• We couldn’t remember.
• There were too many steps.
• We didn’t want to do it: no time, too much to do.
• If we can’t remember the steps and think it’s too much, we can’t sell it to other pediatricians.
Solution
The Process

• Hand out Readiness Assessment Tool at patient registration.
• Families complete the form while waiting.
Solution
The Process

- Readiness Assessment Tool reviewed with pediatrician in the exam room.
- Goals set – things to work on.
- Goals listed in the Goals section of the Problem List for the Counseling for Transition Diagnosis.
Current Health Issues

High
- ADHD (attention deficit hyperactivity disorder), combined type
- GAD (generalized anxiety disorder)
- Autism spectrum disorder with accompanying intellectual impairment, requiring substantial support (level 2)

Medium
- Constipation
- Drusen of left optic disc

Unprioritized
- Compulsive skin picking
- Sleeping difficulty
- Counseling for transition from pediatric to adult care provider
- Disruptive mood dysregulation disorder (HCC)
- Static encephalopathy
- Fetal alcohol syndrome
- Rule out Bipolar 2 disorder (HCC)
- Aggressive behavior
- Suicidal ideation

Low
- Other speech disturbance (784.59)
- Problems with communication (including speech)
- Muscle weakness (generalized)
- Abnormal coordination
- Balance problem
- Abnormality of gait

My Goals

Transition Goals
Added: 2/21/19
- add health goals to school transition plan: know diagnoses and medication, set up her own medication box. Unsure about date of HS graduation.
- OB discussed that will have sedated first gyn exam around age 21 with IUD placement
- Would like to transition to Dr. Katie Munck IM/Peds
- Adopted parents, [redacted] to do guardianship paperwork
- Will need to transfer to adult group home around age 21
Solution
The Process

• The Transition Plan of Care:
  – Basically streamlined and incorporated into the preceding process.
Solution
The Process

• Transition Flow Sheet
• Used as the Standard of Care
• Emphasis of good communication between referring and accepting physician.
• No longer literally used as a checklist.
Transition Counseling Data

• Clarity Report (EPIC computer analysis) tracking the use of the code for Counseling for Transition from Pediatrics to Adult Care.
  – 1. All pediatricians and their patients.
  – 2. Dr. Valentine’s and Dr. Harvieux’s Care Coordination Patients
## Transition Counseling
### All Patients and Providers

**December 2017: Total 382**
- GJH: 121
- SRV: 99
- NMB: 71
- LLD: 27
- SSM: 22
- ACS: 15
- NJD: 12
- JSK: 11
- MS: 2
- CC: 2

**February 2019: Total 494**
- GJH: 152
- SRV: 143
- NMB: 86
- LLD: 23
- SSM: 22
- ACS: 23
- NJD: 14
- JSK: 14
- MS: 2
- CC: 2
- SD: 2
- BWM: 4
- KMM: 7
Transition Counseling
All Patients and Providers

- GJH 21% increase
- SRV 31% increase
- Total 23% increase - all providers

We discovered that the numbers were difficult to analyze as they were fluid:
- Patients aged out and transitioned out of our practices.
- We are working with IS to track the diagnostic code in older young adults and track where they end up.
Transition Counseling
All Patients and Providers

• Spread:
  – The message got out to our section.
  – Our colleagues increased their rates of Transition Counseling:
    • JSK 12%
    • NMB 18%
    • ACS 35%
Transition Counseling
SRV and GJH CCP

December 2017 Total: 3
• SRV  2
• GJH  1

Jan/Feb 2019 Total: 7
• SRV  2
• GJH  5

• Through End of Grant Period:
  – All 12 of our Adolescent CCPs are scheduled to be seen and receive Transition Counseling!!
Post Transition Survey

• During the course of our project we began working with Clinical Nurse Specialist Laura Kitch, RN
• Laura contacted the research coordinator from UMD Med School.
• 2 Medical Students are applying for research scholarships for summer 2019 to work with our team:
  – Develop a transition survey.
  – Survey our former patients who have transitioned into adult care.
  – Analyze the data.
Sustainability and Spread

• Regular meetings with section to
  – Discuss transition;
  – Discuss counseling rates;
  – Review their concerns.

• We have discussed meeting with the pediatric
  groups from Essentia Health Central and West
  to educate them regarding transition.

• Webinar.