



THE COORDINATING CENTER
INSPIRED SOLUTIONS



Adult Provider Outreach Folder Contents

Organization-Specific Resources:

- ❖ Welcome to The Coordinating Center and Transition Connection Initiative (TCI) Contact information
- ❖ Rare and Expensive Case Management (REM) Trifold
- ❖ Adult Community Services (ACS) Information Sheet
- ❖ TCI Introductory Letter for Adult Health Care Providers
- ❖ TCI's Mission Statement and Approach to Health Care Transition (HCT Policy)
- ❖ Delineation of Roles table (HCT task responsibility – Clinical Care Coordinator, Pediatric Primary Care Provider (PCP), Adult PCP, Youth/family)
- ❖ Medical Summary and Emergency Care Plan
- ❖ Youth Transition Readiness Assessment
- ❖ Parent/Caregiver Transition Readiness Assessments

State and Local Resources:

- ❖ Maryland DHMH Youth to Young Adult HCT Home Page
https://phpa.health.maryland.gov/genetics/Pages/Health_Care_Transition.aspx
- ❖ MD Office of Genetics and People with Special Health Care Needs (OGPSHCN) Special Needs Resource Locator Home Page specialneeds.dhmh.maryland.gov
- ❖ MD Transitioning Youth Home Page
<http://mdod.maryland.gov/education/Pages/transitioningyouth.aspx>
- ❖ MD Developmental Disabilities Administration Home Page
<https://dda.health.maryland.gov/Pages/home.aspx>

Got Transition Practice Resources:

- ❖ Got Transition Resources overview <http://www.gottransition.org/providers/index.cfm>
- ❖ Six Core Elements of HCT 2.0 Side-by-Side Version
<http://www.gottransition.org/resourceGet.cfm?id=206>
- ❖ Guardianship and Alternatives for Decision-Making Support
 - Handout <http://www.gottransition.org/resourceGet.cfm?id=17>
 - Webinar <https://www.youtube.com/watch?v=0xXELCIMHHE&feature=youtu.be>
- ❖ Integrating Young Adults with Intellectual and Developmental Disabilities into Your Practice: Tips for Adult Health Care Providers <http://www.gottransition.org/resourceGet.cfm?id=367>
- ❖ Communicating Effectively with Adults with Developmental Disabilities
<https://vkc.mc.vanderbilt.edu/etoolkit/general-issues/communicating-effectively/>
- ❖ Incorporating Pediatric-To-Adult Transition into NCQA Patient-Centered Medical Home Recognition
<http://www.gottransition.org/resourceGet.cfm?id=444>
- ❖ American College of Physician's (ACP) Pediatric to Adult Care Transitions Initiative
<https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/pediatric-to-adult-care-transitions-initiative>
- ❖ 2017 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care
<http://www.gottransition.org/resourceGet.cfm?id=352>



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Adult Provider Transfer Packet Contents

- ❖ Most recent transition readiness assessments
- ❖ Medical summary and emergency care plan
- ❖ Care management plan
- ❖ Plan of care for the next year
- ❖ Condition-specific fact sheet, if available
- ❖ Legal decision-making supports documentation, if needed
- ❖ Adult disability resource list
- ❖ Link to pediatric provider for information/consultation

TCI Criteria for Successful Completion of Youth to Adult Transition

- ❖ Successful transfer to Adult Primary Care Provider (PCP)
- ❖ Successful transfer to all necessary Adult Specialty Care Providers (SCP)
- ❖ Has adult health insurance
- ❖ Legal decisions about health care decision-making resolved and documented, if needed
- ❖ All adult disability supports in place



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Delineation of Roles for The Coordinating Center's Health Care Transition Approach

| Nine Core Elements of HCT | Clinical Care Coordinator (CCC) Role | Pediatric Primary Care Provider (PCP) Role | Adult Primary Care Provider (PCP) Role | Youth and Family/Caregiver Role |
|--|--|--|--|--|
| TCC HCT Mission Statement and Approach - #1 | Communicate TCC HCT mission statement and approach to youth, parent/caregiver and PCP. Letters and script provided. | Review TCC HCT policy to be sure there is no discordance with practice approach. | Review TCC HCT policy to be sure there is no discordance with practice approach. | Be aware of TCC HCT policy and ask questions if necessary. |
| Tracking and Monitoring - #2 | Document HCT in YAT tab and CMP goal progress notes in CARMA | | | |
| Transition Readiness Assessment (TRA) - #3 | Administer at age 14 – 16 and yearly through time of transfer. Identify issues, incorporate as transition goals into Care Management Plan. Share goals with pediatric PCP and with youth/family. Work with youth and family on health care self-management skills training as identified in the TRA. | Work with CCC, youth and family to improve youth's transition readiness skills. | Work with CCC, youth and family to improve young adult's self-care skills. | Take the TRA. Identify issues and set HCT goals with CCC and PCP. Work on acquisition of health care self-management skills with family, CCC and pediatric PCP. Retake the TRA yearly to identify continuing issues, document progress and set new goals. Work with adult PCP on integration into adult model of medical care. |

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|---|---|--|---|--|
| Care Management Plan - #4 | Incorporate HCT self-care skill issues identified on TRA into CM Plan goals and share with youth, family and PCP. Update as needed. | Review Care Management Plan regularly and share with youth and family. Update as needed. | Review Care Management Plan regularly and share with young adult and family. Update as needed. | Review Care Management Plan regularly, acquire HCT self-care skills and update as needed. |
| Medical Summary and Emergency Care Plan (ECP) - #5 | Check that all areas are addressed and information is current in CARMA. Print out report and share with youth, family and PCP. | Review Medical Summary and ECP, update regularly. Share with youth and family. | Review Medical Summary and ECP, update regularly. Share with young adult and family. | Review Medical Summary and ECP, provide more detail if necessary. Update regularly. Have available always. Share with health care providers. |
| Decision-Making Capacity - #6 | Address this issue with youth, family and PCP and refer to legal resources if necessary. Finalize decision-making supports by age 18 and communicate outcome to PCP. | Legal documentation provided, if needed. | Legal documentation provided, if needed. | Discuss this issue with each other and reach agreement. Finalize decision-making supports by age 18. Obtain legal documentation if necessary. Revisit issue as needed. |
| Identify Adult PCP - #7 | Assist youth and family in identification of adult PCP. Confirm availability of adult PCP. Work with pediatric PCP to complete transfer package. Later, assist in identification of adult specialty care providers and adult disability services. | Work with CCC to complete transfer package to adult PCP. Send adult PCP the complete transfer package. Offer the adult PCP consultation assistance, as needed. | Share practice information (FAQs) with youth, family and CCC. Integrate youth into adult medical model. Assist in identification of adult specialty care providers and adult disability services. | Think about what services you need from an adult PCP (location, hours, insurance, hospital referrals, etc.) Work with CCC to identify adult PCP. Ask pediatric PCP and specialists for recommendations. Later, work with CCC and PCP to identify adult subspecialists and adult disability services. |

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|---|---|--|--|--|
| First Adult PCP Appointment - #8 | Ensure that youth/family makes and attends first appointment and intends to stay with the new PCP. Document date of transfer. | Document date of transfer. | Receive transfer information from pediatric PCP. Acknowledge transfer package received. Discuss HCT, confidentiality and practice FAQs at first visit. | Schedule and keep first visit with adult PCP. Share updated Med Summary/ECP. Make sure that transfer package has been received. Discuss concerns and health goals. |
| HCT Feedback Survey - #9 | Encourage youth and families to complete the TCI survey. Review client feedback results and incorporate into ongoing HCT efforts. | | | Complete the TCI survey. Offer feedback, which will be incorporated into ongoing HCT efforts, and advocate for improvement. |

The mission of The Coordinating Center is to partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health and meaningful community life.



The HSC Health Care System