Got Transition/Center for Health Care Transition Improvement is a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health

Got Transition continues to work with several large health systems, state health departments, and other organizations to customize and implement the Six Core Elements of Health Care Transition. As part of our ongoing newsletter series, Got Transition has interviewed Dr. Kathy Rivers, Director of the Transition Connection Initiative at The Coordinating Center (Maryland), who discusses the implementation of the Six Core Elements into a statewide care coordination program for medically complex youth.

**Q: What was the impetus for developing your Transition Connection Initiative?**
A: One of the greatest needs identified by The Coordinating Center for YSHCN in Maryland's Rare and Expensive Case Management (REM) program is the lack of preparation of youth and families for the transition to adulthood and the difficulty they experience in identifying adult health care providers and services. We believe that our Clinical Care Coordinators can provide a bridge and safety net during this vulnerable period. With funding support from Maryland's Office of Genetics and People with Special Health Care Needs and technical assistance from Got Transition, The Coordinating Center developed its Transition Connection Initiative.

Q: Can you briefly describe your approach for customizing the Six Core Elements?

A: The Coordinating Center wrote a new mission statement and letter detailing our health care transition (HCT) approach. We also created a tracking mechanism using our internal electronic documentation system. Since many youths in our program have intellectual/developmental disabilities, we customized the Six Core Elements transition readiness assessment and will use it with youths and parents/caregivers at ages 14 and older. These results will be incorporated into each client's care management plan, and our Clinical Care Coordinators will work with youths and families to gain needed self-care skills. A medical summary and emergency care plan will be developed from our internal databases, and starting at age 16, the Clinical Care Coordinators will begin to discuss legal issues and decision-making capabilities to ensure that our clients and families are prepared for adult care. The Coordinating Center will assist in identifying adult primary and specialty providers and adult disability services and will work with pediatric providers to ensure that their transfer package is complete and shared with the new adult provider(s).

Q: How are you beginning to identify adult providers for receiving your medically complex young adult patients?

A: During the Transition Connection Initiative pilot, we surveyed pediatric and adult providers who care for 295 of our REM clients. They expressed an interest in continuing education on health care transition and on topics concerning the ongoing care of youth with complex childhood-onset illness and neurodevelopmental disabilities. We are also conducting outreach appointments with providers to share our transition policy, provide transition and disability resources, and identify adult provider referral options.

Q: What does success look like?

A: We want our REM participants to have a well-planned HCT approach and continuous access to high-quality medical care that meets their medical and developmental needs. Success will be measured in several ways. First, we will examine the HCT activities of The Coordinating Center at the start of this initiative and one year later, using the Six Core Elements Current Assessment of Health Care Transition Activities. Second, we will elicit consumer feedback about our HCT process using several questions from the Six Core Elements HCT Feedback Survey and additional questions that we developed. Third, we will increase the number of adult primary care providers informed and willing to accept REM participants into their practices. Health care transition is an integral part of the mission of The Coordinating Center, which 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.

For more information, please contact Dr. Kathy Rivers at KRivers@CoordinatingCenter.org.

Save the Dates: Annual Health Care Transition Events in Houston, TX

** 8th Annual Health Care Transition Research Consortium Symposium (October 25-26, 2016)
** 17th Annual Transition from Pediatric to Adult-Based Care Conference (October 27-28, 2016)

These two collaborative conferences, both held at the Baylor School of Medicine, represent the major national
and international transition meetings. The Health Care Transition Research Consortium Symposium will feature new research on consumer transition experience, quality improvement, provider and consumer education, outcomes and readiness measures, and self-management. The Transition from Pediatric to Adult-Based Care Conference has an agenda that includes a current state-of-the-art on transition, international initiatives, legal issues, payment innovations, EHR options, consumer perspectives, and adult practice strategies for accepting new young adult patients, public health transition efforts, and more. These conferences are approved for AMA PRA Category I Credits, co-provided by Baylor College of Medicine and Texas Children's Hospital Association.

**Interactive Discussion on Mental Health Transition Research (October 25, 2016)**

An interactive discussion on mental health transition research will be held at the McGovern Medical School (Houston, TX) on October 25, 2016 from 12:00 PM to 5:00 PM. The discussion will be held in collaboration with Baylor College of Medicine, the Healthcare Transition Research Consortium, and partially funded by the Hogg Foundation for Mental Health, which has awarded $10 million since 2014 to address the mental health needs of transition-aged youths and their families in the Houston area. The discussion will focus on research on transition-aged youth with mental health conditions, examine methods to increase youth voices in program development, and discuss ethical issues related to mental health transitions. To participate in this event, contact Emily Wei at (832) 822-1821 or erwei@bcm.edu.

Got Transition Partners with Young Invincibles for Millenial Health Event

Got Transition participated in a day-long summit on September 27, 2016, in partnership with Young Invincibles and the White House, that focused on health insurance coverage and health care for young adults. Young Invincibles is a non-profit organization committed to empowering young Americans with information and research on health care, insurance, economic development, and more. The morning "Millenial Outreach and Engagement Summit" featured senior White House and Administration officials, including Department of Health and Human Services Secretary Sylvia Mathews Burwell (right) and White House Chief of Staff Denis McDonough. It brought together leaders from around the country to reach young people about their health care enrollment options and help make sure they have the coverage they need as the country enters the fourth open enrollment period for the Affordable Care Act.

That afternoon, the National Coalition on Millenial Health hosted its first annual "Coverage to Care Summit." Got Transition was among several experts and coalition partners that presented as part of a broad national strategy for connecting "coverage to care" among young adults. The event also introduced the #HealthyAdulting Resource Toolkit which includes easy-to-understand information on the Affordable Care Act, what's available to young adults, how tax credits work, and what's included in preventive care.
The University of California San Diego/Rady Children's Hospital with the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) partnered with Got Transition to develop a new pediatric Maintenance of Certification (MOC) Part 4 Module on transition. The free web-based activity -- "Transitioning Youth from Pediatric to Adult-Centered Care" -- will evaluate adequacy of participant documentation of patients’ transition from pediatric to adult centered care within the Six Core Elements framework. Eligible participants include clinicians who actively evaluate pediatric patients with chronic diseases on a frequent basis to report data on 30 patient visits over a year period. This activity will provide MOC Part IV credits to participants who meet completion criteria. To learn more about completion criteria and to register for FREE, email Kim Rose (KRose@naspghan.org) by March 31, 2017 and mention "Got Transition/UC San Diego/Rady Children's Hospital."

"Health Care Transition," by Dr. John "Jack" Maypole (drmAYpole), Pediatrician and Cartoonist

The National Alliance to Advance Adolescent Health/Got Transition