



## The Medical Home and the Health Care Transition of Youth – A Perfect Fit

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**H**ealth care transition (HCT), or the transfer of youth from a pediatric to an adult model of care, offers a perfect opportunity for today's primary care medical homes to fully use their transformed quality structures and processes. Patient- and family-centered teamwork, clear access, and a population approach with planned, coordinated care must blend to deliver a continuous system of care, from start to finish, for youth/young adults in this life phase. Preparation, planning, and implementation with youth and families set the stage for healthier adult years and for how young adults might value and partner with their primary care medical home towards their own health and wellness efforts across their lifespan.

What do you remember about your own transition from a pediatric to adult health care model? Did you transfer from pediatrics to adult care or shift from a pediatric focus to an adult one within a clinic? How long ago was this changeover for you, and to what extent has our health care system changed since that time? Did you have any particular special health care needs warranting careful attention?

What did you understand about the health care system? Was there a "gap" in care, particularly during your 20's and 30's? It is quite possible that children or young adults that you know are without supports to develop into independent, competent consumers of their own health care? Perhaps these same youth challenge you to offer a rationale for how and why our health care system functions as it currently does.

You are not alone if you do not have clear cut, positive answers to these questions. Advocacy groups today are concerning themselves with the lack of systematic preparation for youth to seek and develop partnership relationships within their primary care medical home. This patient/professional rapport needs to be one that supports the abilities of youth to be as responsible as possible for their own health and wellness. CMHI's (Center for Medical Home Improvement's) National Health Care Transition Center – Got Transition, funded by the HHS Maternal and Child Health Bureau, shares this concern. Got Transition is working to assure excellent health care transition implementation in primary care practices across the country. This involves using comprehensive, coordinated pathways to provide for the clear preparation, planning, and implementation of successful transfers of care. Teamwork, multiple methods of access, and planned coordinated care are necessarily family and youth-centered.

A new clinical report published in June by the American Academy of Pediatrics and endorsed by the American Academy of Family Physicians and the American College of Physicians, states that the goal of health care transition is to maximize lifelong functioning and well being for all youth, including both those who have special health care needs and those who do not – see [http://www.gottransition.org/UploadedFiles/Files/HCTClinicalReportreversion\\_27June2011.pdf](http://www.gottransition.org/UploadedFiles/Files/HCTClinicalReportreversion_27June2011.pdf). The report seeks to advance the practice-based implementation of excellent planning, preparation, implementation, and documentation of care processes for youth who are approaching or currently in transition. It lays out clear steps for HCT timing and interventions. We know that at least 500,000 youth with special health care needs are leaving their pediatric health care system and moving into the world of adult health care annually. According to the 2005-06 National Survey of Children with Special Health Care Needs, only 47% of all children with special health care needs have a medical home, and less than half (41%) of US youth with special health care needs receive the health care transition supports and services they need. Healthy and Ready to Work, a former national transition initiative, has described these youth as a group who want independence, a good doctor, and the skills to know how to use the health care system under varying conditions. They describe families navigating alone amidst a confusing and conflicting array of resources and regulations. All youth and their families benefit from caring partnerships with professionals and clear health care transition supports with focused anticipatory guidance. Youth living with chronic conditions and or disabilities bring a complex lifetime history including multiple medical interventions and varying system navigation experiences. Facilitated access, comprehension of a complex history, and orientation to the world of adult health care is critical to the future health and success of youth.

Health care transition (HCT) is a *cross cutting concern*. Current patient- and family-centered medical home initiatives speak to all that it takes to achieve quality standards of primary care. Health care transition presents a perfect challenge, or test if you will, of performance to meet these medical home standards. Are the needed care processes in place and do they systematically kick into gear for youth in transition? If so, the investment and gains of many years of pediatric primary and specialty care services will be held and not lost.

The potential for all knowledge and lessons learned to be carried forward to inform adult care will be maintained, and the accumulated expertise across the family, youth, and multiple health care teams maximized. Effective care transfers occur when pediatric and adult medical home clinicians and their health care teams prepare for effective patient and family communication and collaboration while continuously monitoring results. The use of supporting structures and processes ensure that youth who are not at risk will not be “lost to follow up”, an all too common occurrence. This careful follow up is particularly critical for youth living with chronic health conditions and disabilities. An effective medical home must be supported to hold consulting conversations designed to facilitate critical transfers of information. HIT systems are also used to supplement communication of transfer information. Tools for health care transitions are designed, integrated, and used to guide ideal preparation and transfer experiences and are ready for easy use in busy primary and specialty practices. These activities are well aligned with IHI’s Triple Aim of better care, health, and costs.

Since 1993 CMHI has been focused on building and supporting strong primary care practices. CMHI defines the medical home as a community-based, primary care setting which provides and coordinates high quality, planned, and family-centered health promotion, acute illness care, and chronic condition management ([www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org)). In spite of the current momentum promoting the medical or health care home, pediatricians and adult providers worry that finding an adult medical home for youth with chronic conditions will prove difficult. Currently our nation is focused on the systems improvement potential of the primary care medical home. This emphasis creates a perfect opportunity to lift the priority status of effective health care transition of youth - aligning it with current standards of the patient- and family-centered medical home.

Help is on the way. The National Health Care Transition Center – Got Transition is working with health care teams in three city regions (Denver, Boston, and Washington, DC) tapping into their strengths and development around teamwork, access to patient and family friendly services, relational care that is population focused, and coordinated care that is planned and proactive. Got Transition has created the *Six Core Elements of Health Care Transition* (see Figure 1 on page 5) in order to support team dyads from pediatric and adult medical homes to prepare, plan, and implement the recommendations of the AAP’s HCT Clinical Report. CMHI’s Got Transition uses a Breakthrough Series Model for quality improvement. Medical home teams measure their current practice using the Health Care Transition Index (Pediatric and Adult versions modeled after CMHI’s validated Medical Home Index).

They work to prepare, plan, and implement the transfer of care from a pediatric to an adult model of care using multiple tests of change (PDSA - plan, do, study, act). PDSA cycles allow for real time application and refinement of tools to better fit with the individual practice’s flow of care. As with all of CMHI’s initiatives, these teams include youth and families at the table helping to design and drive practice improvements in the best direction. The “changes” or tools are designed to help each team carry out the *Six Core Elements of Health Care Transition* which include pediatric and adult health care model point and counterpoint action steps.

<b>SIX CORE ELEMENTS OF HEALTH CARE TRANSITION</b>		
<b>Pediatric Health Care Setting</b>	<b>Adult Health Care Setting</b>	<b>Core Element Descriptions</b>
1) Transition Policy	1) Young Adult Privacy and Consent Policy	A HCT Policy – declared to help all patients, families and staff understand HCT and guide their preparation and interactions
2) Transitioning Youth Registry - Registry	2) Young Adult Patient Registry	A HCT Registry - to identify all age appropriate youth for transition preparation, and initiate HCT preparation, planning, implementation and monitoring
3) Transition Preparation - Readiness Assessment	3) Transition Preparation - Continued Assessment of Readiness	A HCT Readiness Assessment – to serve as a checklist for preparing youth, helping them to gain needed knowledge, skills and behaviors with the right planning interventions
4) Transition Planning - Action plan, portable medical summary & emergency plan	4) Transition Planning -Action plan, portable medical summary & emergency plan	HCT Action Plan, Medical Summary, and Emergency Plan (as needed) – to ensure solid planning, establishing core critical information to share across patients, families and each health care team
5) Transition and Transfer of Care - HCT summary & transfer of care checklist	5) Transition and Transfer of Care - Continue health care goals, care planning, & monitoring	HCT Transfer – draws from #4 above to consolidate a HCT “Package of Care” to accompany youth at transfer and support the uptake or shift into an adult model of health care
6) Transition Completion - Strategies	6) Transition Completion - Strategies	HCT “Completion” – includes strategies among youth, family, pediatric and adult medicine for communication and consultation, with assurances and acknowledgement of measured success.

**Figure 1. The Six Core Elements of Health Care Transition, ©CMHI, 2011  
Got Transition? The National Health Care Transition Center; funded by the USMCHB**

According to Winston Churchill, “He who fails to plan is planning to fail.” Got Transition is planning to succeed in supporting youth, families, and medical home practices to promote effective health care transitions. These activities are occurring in real time. Information about Got Transition’s HCT Learning Collaboratives can be found at [www.gottransition.org](http://www.gottransition.org); examples of Got Transition measures and tools will be made available at this same website in late Fall, 2011.

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