Taking Action with Evidence: Implementation Roadmap

National Performance Measure #12, Transition

For Assistance:
Please contact Emily Eckert at ebeckert@amchp.org
Brief Notes about Technology

Mute your line by using the mute function on your phone or by using *6 to mute/un-mute

Asking a Question
• You can type your questions into the chat box (shown right)
• Raise your hand. Using the icon at the top of your screen (example shown right)

Active Participation = 😊

For technical problems, please contact Emily Eckert at ebeckert@amchp.org
Brief Notes about Technology

Downloading Files

1. Click on the files you want to download.
2. Click on the Download File(s) button.
3. Select the file you want to download and click on "Save to My Computer".
4. Click on "Click to Download".

February 16, 2016
Brief Notes about Technology

• Today’s webinar will be recorded

• The recording will be available on the AMCHP website at [www.amchp.org](http://www.amchp.org)

• Please complete the survey to be emailed at the conclusion of the webinar
Practice Poll

• What is your favorite outdoor winter activity?
  – Skiing
  – Snowboarding
  – Ice skating
  – Sledding
  – None of the above, I like to cozy up by the fire!
Objectives

• Describe efforts to date by MCHB and partners in compiling the knowledge base of evidence pertaining to NPM #12

• Identify resources and partners from which to select existing evidence-based strategies based on state/territory’s Title V needs assessment findings of the NPM

• Evaluate potential strategies through the lens of current issues and opportunities related to the NPM

• Share feedback with MCHB and its partners on additional technical assistance needed to identify evidence based strategies and subsequently, define measures
Featuring

**Moderators:** Sarah Beth McLellan and Caroline Stampfel, AMCHP

- **Marie Mann, MD, MPH,** Senior Medical Advisor, MCHB, Division of Services for Children with Special Health Needs
- **Cynthia Minkovitz, MD, MPP,** Professor, Johns Hopkins Bloomberg School of Public Health
- **Peggy McManus, MHS,** President of The National Alliance to Advance Adolescent Health and Co-Director of Got Transition
- **Manda Hall, MD,** Title V CSHCN Director, Texas Department of State Health Services
- **Kelsey Anderson, MPH,** Program Specialist at the CSHCN Services Program, Texas Department of State Health Services
STRENGTHEN THE EVIDENCE BASE FOR MCH PROGRAMS

Cynthia Minkovitz, MD, MPP
February 10, 2016

A collaborative activity of the Women’s and Children’s Health Policy Center at Johns Hopkins University, the Health Resources and Services Administration, Welch Medical Library at Johns Hopkins University, and the Association of Maternal and Child Health Programs.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC28257, MCH Advanced Education Policy, $1.65 M. 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.
Goal

• To provide support and resources to assist State Title V Maternal and Child Health (MCH) programs in developing evidence-based or evidence-informed State Action Plans and in responding to the National Outcomes Measures, National Performance Measures, State Performance Measures and state-initiated Structural/Process Measures.
6 Objectives

1) Convene a Team of MCH Experts
2) Provide reports, including critical reviews of the evidence of effectiveness of strategies to address National and State Performance Measures
3) Provide technical assistance to State Title V MCH programs
4) Develop web-based supports and resources for State Title V programs
5) Establish an online platform for sharing best practices via a “Community of Practice”
6) Maintain and enhance an MCH digital library
Environmental Scans

- Compilations of strategies to advance performance for each of the 15 National Performance Measures (NPMs)

- Environmental Scans include:
  - **Reviews and Compilations:** identifies existing compilations for strategies that intend to improve performance for each measure; these include both scholarly reviews and compilations that have been produced by key organizations in the field
  - **Frameworks & Landmark Initiatives:** includes conceptual models underlying strategy implementation, these may or may not be explicitly highlighted in the Reviews and Compilations section; landmark initiatives include seminal programs/policies related to each NPM
  - **Data Sources:** indicates sources (e.g. PubMed), as well as criteria (search terms, publication date), and link to search strategy; also selected organizational websites
  - **Inclusion & Exclusion Criteria:** denotes types of studies, setting, populations of interest that were included in our search, and exclusion criteria
Strengthen the Evidence for MCH Programs: Environmental Scan of Strategies

National Performance Measure (NPM) #12: Transition

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Introduction

This environmental scan identifies collections of strategies to advance performance for NPM #12, Transition. The information provided in this document focuses on strategies to achieve the NPM, not on the content of care or specified health outcomes. Please note that the quality of the evidence in this compilation has not been evaluated, and that data sources describing a single strategy, rather than a collection of strategies, have been excluded.

This compilation includes the following sections:

- **Reviews and Compilations**: Identifies existing compilations of strategies that intend to improve performance for each measure
- **Frameworks and Landmark Initiatives**: Frameworks includes conceptual models underlying strategy implementation; Landmark Initiatives include seminal programs/policies related to the NPM
- **Data Sources**: Indicates sources, search criteria, links to search strategy and selected organizational websites
- **Inclusion and Exclusion Criteria**: Denotes types of studies, setting, populations of interest and exclusion criteria

Technical assistance for State Title V MCH programs related to using evidence to inform State Action Plans, selection of strategies, and development of evidence-based or evidence-informed Strategy Measures may be requested at [http://www.semoh.org/technical-assistance.html](http://www.semoh.org/technical-assistance.html)

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- Inclusion and Exclusion Criteria ..................................................... 10

Strengthen the Evidence Base for MCH Programs is a collaborative initiative of the Women's and Children's Health Policy Center at Johns Hopkins University, AMCHP, and Welch Medical Library. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U2MC28257, MCH Advanced Education Policy, $1.55M. 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.
## Reviews and Compilations: Sample Entry

<table>
<thead>
<tr>
<th>Review/Compilation</th>
<th>Summary</th>
<th>Web Link</th>
</tr>
</thead>
</table>
• Identifies tools to aid transition and transfer (Table 2):  
  - Checklists, portable medical summaries, and meeting the adult provider  
| AMCHP Innovation Station [Target: C,D,E,F] | • Texas Children’s Hospital Health Care Transition Planning  
  - Location: Texas  
  - Aims to improve transition readiness through provider use of an electronic medical record (EMR)-based health care transition (HCT) transition planning tool (TPT)  
  - Characteristics of the health care TPT  
    - Designed with input from family and Youth Advisory Boards and both pediatric and adult health care providers  
    - Addresses (directly or indirectly) five of the six core transition support indicators put forth by Got Transition  
Highlights from the Review for NPM #12

• Reviews and Compilations include:
  • 5 reviews of strategies to increase the number of adolescents who receive the necessary services to transition to adult health care
  • 4 documents produced by key organizations in the field

• Frameworks and Landmark Initiatives include:
  • 3 models relevant to health care transition
  • 2 documents describing influential programs and/or policies
  • 1 document with National Standards of Systems of Care for CYSHCN
  • 1 clinical report on practice-based implementation of transition
Examples of Strategies for NPM #12

• States
  • Support education and training for health professionals
  • Form an interagency workgroup to address transition on a statewide level
  • Facilitate the dissemination of evidence-informed transition resources for Title V recipients and health care practices

• Health Care Practices and Providers
  • Create a practice-wide transition policy
  • Develop quality improvement initiatives
  • Utilize transition checklists
Technical Assistance

- Complement ongoing HRSA investments and expertise among discretionary grantees

- *Strengthen the Evidence* team focused on TA related to evidence to inform strategies to achieve progress on state identified priorities
  - Varying levels of TA intensity
  - Recognize continuum of available evidence
  - Individual vs. groupings of states depending on needs

- Types of TA requests
  - Identifying possible strategies
  - Evaluating a selected strategy
  - Providing evidence relating to specific strategies
  - Adapting strategies for a specific population
  - Developing evidence-based or evidence-informed strategy measures

- Sample activities: In depth evidence reviews, connect states with MCH consultants, work collaboratively to provide communities of practice
Evidence-based or –Informed Strategy Measures (ESMs)

• “…the measures by which states will directly measure their impact on the NPMs.”

• Align with selected NPMs and strategies proposed to enhance performance on the NPMs


Characteristics of ESMs

• Relate to the selected strategy and are in the pathway to achieving a National Performance Measure (NPM) or a State Performance Measure (SPM)

• Link to an objective the State hopes to accomplish by tracking the measure
Selection Criteria for ESMs

• Measurable
  • Reliable and valid
  • Data available or planned over time to track progress
  • May be a percentage, rate, ratio or number, or an indicator of achievement of an activity (e.g. development of standards or guidelines)

• Meaningful
  • Related to the NPM and state priority objective
  • Incorporates stakeholder input for feedback/buy-in
  • State specific
Contact Us

• Technical Assistance Requests
  http://www.semch.org/technical-assistance.html

• Project Coordinator, Stephanie Garcia
  sgarci22@jhu.edu

THANK YOU!!!

www.semch.org
http://mchlibrary.jhmi.edu/
TAking action with evidence: Transition Implementation Roadmap

Peggy McManus, MHS
Got Transition/Center for Health Care Transition
The National Alliance to Advance Adolescent Health
Funded by Maternal and Child Health Bureau
February 10, 2016
Transition as a New National Performance Measure

• MCH Transformation 3.0 includes transition as one of its 15 national performance measures
• New Transition measure focuses on HEALTH and ALL YOUTH (though it is under CSHCN population domain)
• Past transition measure focused on YSHCN all aspects of adult life (health, work, and independence)
Significance of Health Care Transition

• Access and Equity
  – Majority of YSHCN not receiving HCT support; little know about Y without special needs
  – Disparities prevail (gender, race/ethnicity, income, condition type, and access to medical home)

• Quality
  – Pediatric and adult providers not providing recommended HCT supports
  – Consequence – problems relating to continuity of care, consumer dissatisfaction, & preventable costs

• Integration
  – Link to medical home and insurance coverage = > chance for HCT support
  – Link to adult providers = > chance for successful transfer

• Accountability
  – MCHB and state Title V agencies = public health agencies taking the lead in advancing HCT improvements
  – New resources for measuring HCT improvements at national, state, health plan, and clinical levels
Emphasis on Evidence-based Strategies

• HCT is a young field
• Systematic literature reviews reveal:
  – Limited evidence for effective HCT interventions
  – Transition interventions very heterogeneous
  – Studies mostly limited to a single condition
  – Studies primarily based in pediatric settings and seldom include adult settings
  – Measures for HCT process and outcomes variable and seldom assess impact in terms of quality, consumer experience, and costs
Building an Evidence-Informed Public Health Strategy for HCT

• 2011 AAP/AAFP/ACP Clinical Report, “Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home” represents professional consensus on timing and approach for pediatric to adult HCT
  – Start early in adolescence and continue into young adulthood
  – HCT should be a standard part of providing care for ALL youth and YA

• Clinical Report includes a series of steps:
  1. Discuss office transition policy with youth and parents
  2. Initiate a jointly developed plan with youth and parents
  3. Review and update transition plan & prepare for adult care
  4. Implement an adult care model
  5. Incorporate transition planning in care management
  6. Complete interaction

• Clinical Report recently renewed by the AAP
Six Core Elements of HCT

- Originally developed in 2012 by Got Transition
- Six Core Elements align with and operationalize the AAP/AAFP/ACP Clinical Report
- They define a process for HCT and include sample tools
- QI learning collaboratives tested Six Core Elements
- Resulted in Six Core Elements update in 2014 with 3 Six Core Element packages for:
  1) Transitioning youth to an adult provider
  2) Transitioning to an adult approach to care without changing providers
  3) Integrating young adults into adult health care
# What are the Six Core Elements?

<table>
<thead>
<tr>
<th>Pediatric Practice</th>
<th>No Change in Provider</th>
<th>Adult Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  HCT Policy</td>
<td>Same</td>
<td>Same</td>
</tr>
<tr>
<td>2.  Tracking</td>
<td>Same</td>
<td>Same</td>
</tr>
<tr>
<td>3.  Transition Readiness</td>
<td>Same</td>
<td>Orientation to Adult Practice</td>
</tr>
<tr>
<td>4.  Transition Planning</td>
<td>Integration into Adult Approach</td>
<td>Integration into Adult Practice</td>
</tr>
<tr>
<td>5.  Transfer of Care</td>
<td>Adult Approach to Care</td>
<td>Initial Visit</td>
</tr>
<tr>
<td>6.  Transfer Completion</td>
<td>Ongoing Care</td>
<td>Ongoing Care</td>
</tr>
</tbody>
</table>

Free **customizable** packages are available at [www.GotTransition.org](http://www.GotTransition.org)!!

Available in English and Spanish.

Measurement tools available to assess implementation of HCT improvements and to measure consumer HCT experience.
Evidence for Six Core Elements

- DC HCT Learning Collaborative using QI methodology and the Six Core Elements resulted in development of systematic clinical transition processes in pediatric and adult practices*
- Increasing use of Six Core Elements in large integrated care systems, health plans, state Title V programs, pediatric and adult clinical sites, health professional training programs
- AMCHP’s System Standards based on Clinical Report and Six Core Elements
- See Got Transition for regular updates of transition research

* Pediatric to Adult Transition: A Quality Improvement Model for Primary Care. *Journal of Adolescent Health*. 2014
Transition Improvement and Measurement

Can address:

1) **Individual/family level**: involvement in transition QI, assessment of consumer feedback, receipt of Six Core Elements

2) **Clinical level**: implementation of Six Core Elements, provider feedback, analysis of utilization and costs, time between last pediatric and initial adult visit

3) **System level**: implementation of Six Core Elements with health plans, availability of transition training, payment for transition, retention of young adults in system
State Title V Agencies and HCT

• 32 states, including DC, selected HCT as a priority for their 5-year state Title V action plans
  – Region 1: CT, MA, RI
  – Region 2: NJ, NY (also Puerto Rico, Virgin Islands)
  – Region 3: DC, MD, VA
  – Region 4: AL, FL, GA, KY, TN
  – Region 5: IL, IN, MI, MN, WI
  – Region 6: Ark, LA, NM, OK, TX
  – Region 7: IA
  – Region 8: MT, ND, UT, WY
  – Region 9: AZ, CA, HI (also Fed. States of Micronesia, Guam, Marshall Islands)
  – Region 10: OR
States’ Transition Objectives

- Almost half of states call for increase in # or % who receive services necessary to transition to adult care
- Some states call for increase in #/% of practices with HCT policy or youth with readiness assessment and plans of care or care coordinators with HCT education
- ¾ focused on YSHCN; 1/3 on all youth
- Distinction between objectives and strategies not always clear
States’ Transition Strategies

• Almost half of states referenced Six Core Elements, Got Transition, or AMCHP’s National System Standards

• States Referencing Transition Core Elements        # States
  o Transition Policy                        6
  o Transition Registry/Tracking           6
  o Transition Readiness/Self-Care         4
  o Transition Plan of Care                6
  o Medical Summary/Emergency Plan        4
  o Transfer Checklist                     1
  o Consumer Transition Feedback          1
  o Welcome Letter/FAQs for Adult Practice 0

• 13/32 states mention adult providers in their transition strategies
Transition Population

• Transition identified under CSHCN population domain
• States can start with this important population
• In future, consider expanding to include all youth
Suggestions for Refining State Title V HCT Objectives

• New HCT questions in National Survey of Children’s Health (NSCH) and state HCT performance results will change from NS-CSHCN.

• Consider articulating a new objective:
  – Establish a state baseline on transition performance for youth with and without special needs based on the 2015-16 NSCH

• Consider a few additional objectives that link to the Clinical Report and Six Core Elements:
  – By 2020, increase the identification and availability of adult health care providers to care for YSHCN
  – By 2020, increase the number of pediatric and adult providers who are making HCT improvements consistent with the Six Core Elements
  – By 2020, expand the number of education/training opportunities for pediatric and adult health care providers on use of evidence-informed HCT recommendations (Clinical Report and Six Core Elements)
Suggestions for Refining: State Title V HCT Strategies

- Partner with AAP, AFP, ACP, AANP chapters to promote use of evidence-informed HCT services
- Identify and implement strategies to expand the availability of adult providers accepting new YA patients with special needs
- Establish baseline of Title V contracted providers (or medical home providers or health plans) regarding their current level of HCT implementation (using 6 Core Elements’ Initial Assessment of HCT Implementation) – over time assess progress
- Increase # of HCT QI initiatives involving both pediatric and adult practices and parent/young adult consumer partners using the 6 core elements
- Increase # of Title V recipients who report that they have been informed of transition policy, received a readiness assessment, a written plan of care, a medical summary, and who have received assistance identifying an adult provider – over time assess progress
- Increase the availability of HCT information and resources, including linking with Got Transition’s website
Linking HCT with Other National Performance Measures: Medical Home

• Important to align HCT with other national performance measures and strategies
• 23 of 32 states selecting HCT also selected medical home.
• Suggestions for Linked Strategies:
  – Identify adult medical home practices interested in caring for YSCHN
  – Develop written plans of care that include HCT
  – Encourage use of 6 core elements by practices seeking medical home certification
Linking HCT and Adolescent Preventive Care

• 18 of 32 states that selected HCT also selected adolescent preventive care.

• Suggestions for linked strategies (with adolescent coordinators)
  – Partner with Medicaid’s EPSDT program to educate and encourage pediatric providers to incorporate HCT readiness assessment into routine adolescent visits
  – Increase use of standardized HCT tool for transition readiness assessment
  – Partner with payers to encourage payment of readiness assessment
Linking HCT Transition and Well Care Visits for Women

• 26 of 32 states selecting HCT selected woman well visits.

• Suggestions for linked strategies:
  – Encourage adult primary and reproductive care providers to develop a young adult transition policy consistent with the 6 core elements
  – Request that these providers establish a process to welcome and orient new young adult women into their practice and provide young-adult friendly FAQs and online resources
  – Incorporate self-care assessment as part of routine preventive visits with young adult women
Linking HCT with Adequate Insurance

- 7 of 32 states selecting HCT chose adequate insurance.
- Suggestions for linked strategies:
  - Make available brief state insurance and adult disability resource summary that can be shared with pediatric and adult practices as part of transition planning
  - Partner with Medicaid to incorporate HCT contract requirements for their MCO providers consistent with the 6 core elements
  - Customize the Six Core Elements readiness assessment tool with state specific insurance question and linked enrollment resources for youth transferring out of CHIP or Medicaid
Got Transition as a Resource

- MCHB funded Got Transition as a national transition resource center
- Please visit www.GotTransition.org
- Got Transition will be offering a series of webinars for state Title V agencies – to be announced shortly
- Please contact us with Questions and TA needs
Summary

• HCT is a new field, systems not yet in place, time now to build HCT infrastructure
• Critical to emphasize AAP/AAFP/ACP Clinical Report and Six Core Elements as the evidence base for pediatric to adult HCT
• Consider refining HCT objectives and strategies with suggestions offered
• Consider linking HCT with medical home, preventive care, and insurance performance efforts
• Link with Got Transition
• Please let us know your questions and TA needs
Be sure to check out www.GotTransition.org, the federally-funded resource center on everything Health Care Transition-related!
Thank You and Questions
MMcManus@thenationalalliance.org

Like us on Facebook!
HealthCareTransition

Follow us on Twitter!
@GotTransition2
AMCHP Resource:
National Standards for Systems of Care for CYSHCN
Strengthen the Evidence Base Webinar: NPM #12, Transition

Manda Hall, MD
Title V Children with Special Health Care Needs Director

Kelsey Anderson, MPH
Program Specialist

Texas Department of State Health Services
## 2009/10 National Survey of Children with Special Health Care Needs

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>TEXAS</th>
<th>NATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children receiving the services necessary to make the transition to</td>
<td>35.4%</td>
<td>40%</td>
</tr>
<tr>
<td>adult health care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Title V Five Year Needs Assessment

<table>
<thead>
<tr>
<th>CYSHCN OUTREACH SURVEY</th>
<th>CYSHCN PARENT FOCUS GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age of children of respondents: 12.4 years</td>
<td>Wide range of ideas about transition planning</td>
</tr>
<tr>
<td>20% felt prepared for their child to transition</td>
<td>Awareness of the term transition</td>
</tr>
<tr>
<td>40% had prepared for transition</td>
<td>Perceived need to consider transition planning</td>
</tr>
<tr>
<td>Most respondents prepared for transition by themselves</td>
<td>Unsure of where to go for assistance with transition planning</td>
</tr>
</tbody>
</table>
Who Has Helped You Prepare for Your Child’s Transition to Adulthood, by Topic

<table>
<thead>
<tr>
<th>Topic</th>
<th>Medical needs</th>
<th>Educational plans</th>
<th>Independent living</th>
<th>Financial needs</th>
<th>Social needs</th>
<th>Employment</th>
<th>Legal needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Myself</td>
<td>26.2%</td>
<td>16.5%</td>
<td>14.7%</td>
<td>12.4%</td>
<td>19.5%</td>
<td>11.4%</td>
<td>12.0%</td>
</tr>
<tr>
<td>By Myself &amp; With a Professional</td>
<td>13.1%</td>
<td>11.9%</td>
<td>7.5%</td>
<td>7.8%</td>
<td>6.2%</td>
<td>5.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>With a Professional</td>
<td>33.5%</td>
<td>41.0%</td>
<td>44.4%</td>
<td>48.6%</td>
<td>43.4%</td>
<td>46.5%</td>
<td>42.0%</td>
</tr>
<tr>
<td>N/A</td>
<td>8.6%</td>
<td>10.1%</td>
<td>15.0%</td>
<td>11.9%</td>
<td>12.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have Not Prepared</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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CYSHCN Transitioning in a Medical Home

- Unsuccessful Transition
  - With Medical Home: 39.4%
  - Without Medical Home: 78.1%

- Successful Transition
  - With Medical Home: 60.6%
  - Without Medical Home: 21.9%
• **Mission**: To promote a collaborative approach to the provision of transition services for youth in Texas with disabilities and special health care needs and their families.

• **Vision**: Successful transition outcomes for all youth in Texas with disabilities and special health care needs and their families.
TTVTW Strategic Issues

- Adult providers are not always considered stakeholders
- Opportunities for youth development and empowerment are unknown or unavailable
- Youth without medical homes are less likely to successfully transition to adulthood
- There is a lack of knowledge and utilization of best practices related to transition
- Pediatric providers lack training and/or resources to facilitate successful transitions
Engage youth and young adults with special health care needs (YYASHCN), their families, physicians and other providers in efforts to improve the transition care of YYASHCN

Educate YYASHCN, their families, physicians, and other providers about transition services

Increase statewide medical home capacity to provide integrated and coordinated care for YYASHCN
http://www.dshs.state.tx.us/cshcn/Transition-Workgroup
Focus is expanding access to medical home for individuals and families in Texas

Goal to provide opportunities to hear from practitioners that have been successful in making transformational changes to their practices

*Six Core Elements of Health Care Transition* keynote

Implementing the Elements into practice workshop
Transition and Medical Home Statewide Initiatives

- Based on best practices and recommendations:
  - “Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home” and accompanying algorithm
  - Six Core Elements of Health Care Transition
  - Standards for Systems of Care for CYSHCN
Develop, implement and evaluate a graduate-level curriculum aimed at physicians, nurses and social workers still in training to improve transition outcomes within a medical home

• Year 1 Assessment Phase
• Year 2 Goals and Objective Phase
  • 15 modules
  • Goals, Objectives & Measures for curriculum & modules
  • 6 Core Elements addressed as cognitive objectives

• Next steps: production of a written curriculum including education strategies, content and method
Targeted Assessment n=52

Participant disciplines

- Medicine
- Nursing
- Social Work

Current Level of Professional Practice or Education

- Post-Grad Intern (10%)
- Post-Grad Resident (27%)
- 1st Yr Master (6%)
- 2nd Yr Master (19%)
- 3rd+ Yr Master (8%)
- PhD (31%)

Credited to: Barbara Jones, PhD, MSW and Kendra Koch, MA
What is your knowledge of "transition of youth with special health care needs to adult care?"

- Nothing (35%)
- Small Amt (33%)
- Moderate Amt (25%)
- Large Amt (8%)

Please tell us how you feel your graduate level education has contributed to your understanding of "adolescent to adult transition in healthcare settings thus far:

- Thorough understanding
- Adequate understanding (15%)
- Limited understanding (44%)
- No understanding (41%)
Please rank your agreement with this statement: "The knowledge that I currently have about transitioning youth with special health care needs to adult care adequately prepares me for professional practice."

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Medicine</th>
<th>Nursing</th>
<th>Social Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree (26%)</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>I disagree (50%)</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>I strongly disagree (24%)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Upcoming Transition Initiatives

Develop or expand upon a **provider tool** to support providers in preparing CYSHCN and their families for transition to adult health care within a medical home

- Based on family input, self-determination, best practices and recommendations
- Implemented within a medical home practice setting
- Evaluate, refine and implement improvements and revisions
- Create a plan for sustainability and dissemination across the state

Develop or expand upon a **family tool** to support transitioning CYSHCN and their families

- Based upon family input, self-determination, best practices and recommendations
- Address the following areas: health care, education, social skills, legal needs, financial management, independent living, employment and other needs.
- Implement the tool within the appropriate setting
- Evaluate, refine, and implement improvements and revisions
- Create a plan for sustainability and dissemination across the state
Transition
Open Enrollment Contracts

- Implement practice improvements to support the provision of transition services to adult health care for CYSHCN
- Form a Transition to Adulthood Health Care Quality Improvement Team (QI Team)
- Utilize the Six Core Elements of Health Care Transition 2.0 to identify areas of practice improvement
- Identify activities, person(s) responsible, and timelines, to attain the deliverables and improve the provision of transition services to adult health care for transition-age CYSHCN
Transition Resources

• Transition Toolkit
  • CSHCN Services Program Transition Policy
  • Resource Document
• Transition Resource Guide for Providers
• Transition Brochures
• Transition Webpages
• Gov Delivery
• Navigate Life Texas
Transition Resources

Transition Resources
Para ver esta página en español

Transition Policy
To view the CSHCN Services Program Transition Policy, please read the instructions to access the document in IBIS-Lift.

Transition Toolkit
In partnership with members of the Texas Title V Transition Workgroup, the CSHCN Services Program has developed a Transition Toolkit to assist transition-age youth with special health care needs and their families.

The Toolkit includes lists of state and local resources for youth, families and providers in the following categories: Academic/Education, Advocacy and Policy, Employment/Vocation, General Resources, Health and Safety, Health Care, Housing, Legal/Financial, Social/Recreational, Technology, and Transportation.

There is also a list of State/National Organizations and Resources which is a comprehensive directory of the links within the Toolkit.

- State/National Organizations & Resources (31 KB, Word)
- Academic & Education (19 KB, Word)
- Advocacy & Policy (17 KB, Word)
- Employment & Vocation (19 KB, Word)
- General Resources (16 KB, Word)
- Health & Safety (20 KB, Word)
- Health Care (19 KB, Word)
- Housing (15 KB, Word)
- Legal & Financial (16 KB, Word)
- Social & Recreational (17 KB, Word)
- Technology (16 KB, Word)
- Transportation (14 KB, Word)
ESM Development

- Logic Model
- ESM Development
  - Linking to 10 Essential Public Health Services
- Ongoing Needs Assessment
  - CSHCN Outreach Survey
  - Physician Survey
  - Focus Groups
Objective: CYSHCN and Family Transition Education

- **Strategy**: Support (Assurance)
  - **ESM 1**: Respondents who feel prepared for their child’s transition to adulthood
  - **ESM 2**: Respondents reporting they did prepare for their child’s transition to adulthood
  - **ESM 3**: Respondents reporting receiving help with their child’s transition to adulthood
Acknowledgements

**UT SSW Curriculum:**

- **Barbara L. Jones, PhD, MSW**, Assistant Dean for Health Affairs, UT Regents Professor, Co-Director, The Institute for Collaborative Health Research and Practice, The University of Texas at Austin School of Social Work

- **Kendra D. Koch, MA**, Doctoral Fellow, Institute of Collaborative Healthcare Research and Practice, The University of Texas at Austin School of Social Work

**CSHCN Services Program Staff**
Poll

• Do you think you can apply any of the strategies or resources presented to your state action plans?
  – Yes
  – No
  – Unsure
Q&A

• Mute your line by using the mute function on your phone or by using *6 to mute/un-mute

• **Raise your hand.** Using the icon at the top of your screen (example shown right)

• You can type your questions into the chat box (shown right)
AMCHP Innovation Station

- Online searchable database of cutting edge, emerging, promising, and best practices in MCH
  - New features and search functions!
- One-stop shop → Learn, Act, Share and Request Technical Assistance
AMCHP Communities of Practice

• In partnership with Johns Hopkins, AMCHP will host four Communities of Practice around the MCH Population Domains:
  – Child Health
  – Children and Youth with Special Health Needs (CYSHCN)
  – Cross-cutting / Life Course
  – Women’s / Maternal Health

• Purpose is to provide a space for peer sharing of:
  – Strategies related to the NPMs within the domain
  – Development of ESMs for strategies
  – Issues for group discussion and/or expert consultation
  – Updates on new resources and materials related to the development of ESMs
AMCHP Communities of Practice

• Who will benefit from joining:
  – State Title V staff engaged in the state action plan & developing ESMs

• Participant Involvement:
  – Participation in online discussion boards, interact with peers
  – Identify topics that require further TA
  – CoPs are participant-driven

• To learn more, visit our Communities of Practice Page:
  http://www.amchp.org/AboutTitleV/Resources/Pages/MCHPopulationCommunitiesofPractice.aspx

• To sign up, go directly to our Registration Page:
  https://www.surveymonkey.com/r/CoP_MCHPop_Reg

• Questions? Contact Caroline Stampfel at cstAMPfel@amchp.org
# Implementation Roadmap

## Webinar Schedule

<table>
<thead>
<tr>
<th>NPM #</th>
<th>Date of Webinar</th>
<th>Link to Archived Webinar</th>
</tr>
</thead>
<tbody>
<tr>
<td>#8; Physical Activity</td>
<td>10/29/2015</td>
<td><a href="http://www.amchp.org/Calendar/Webinars/Pages/ArchivedNPMWebinars.aspx">http://www.amchp.org/Calendar/Webinars/Pages/ArchivedNPMWebinars.aspx</a></td>
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<td>#4; Breastfeeding</td>
<td>12/2/2015</td>
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<tr>
<td>#10; Adolescent Well Visit</td>
<td>12/7/2015</td>
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<tr>
<td>#11; Medical Home</td>
<td>12/16/2015</td>
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<td>#13; Oral Health</td>
<td>1/7/2016</td>
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<td>#5; Safe Sleep</td>
<td>1/14/2016</td>
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<td>1/19/2016</td>
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<tr>
<td>#15; Adequate Insurance Coverage</td>
<td>2/3/2016</td>
<td>Soon to be posted!</td>
</tr>
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Webinar Evaluation

Please take a few moments to provide feedback:
Click HERE to complete the webinar evaluation.

Give us your feedback
Thank you!