What is Multidisciplinary Care?

Multidisciplinary care is agreed upon, interdisciplinary, patient-centered, disease-focused, care delivery systems that are informed by a series of evidence-based care process models. Multidisciplinary care supports the achievement of the BIG(GER) Aim systematically across the continuum of care.

What is a Care Process Model (CPM)?

Care Process Models ensure that all care delivered by a hospital and its caregivers is medically necessary, the leading edge in medical science and the appropriate treatment intensity. Put into effect, these models will systemize treatment processes across all hospitals and practices, improving consistency as well as effectiveness. This CPM summarizes Mission Health’s approach to adolescent care.

What are the benefits of a CPM?

- Reduces variation
- Utilizes the best practice from literature and expert opinion
- Improves care delivery process
- More readily exposes errors
- Variation study informs revisions to CPMs

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Why Focus on Adolescent Care?

Adolescents make up roughly 13% of the population within the United States and estimates show the number of adolescents will reach almost 45 million by 2050. Choices made during these critical years of development affect teens’ overall wellbeing, and potentially their lifelong health. Unfortunately, adolescents historically have the lowest rates of primary care use of any group in the US. One study showed that approximately 30% of patients aged 13 through 17 with continuous insurance enrollment had no preventive care. Less than half of adolescents with behavioral health disorders received care in the year prior to the study. Further, of those who do seek care only half receive recommended counseling, health promotion, screenings, and immunizations.

Given these facts, in 2002 the World Health Organization proposed “Adolescent Friendly Health Services” throughout the world and identified five objectives of youth-centered care. The five objectives of care are: Accessible, Acceptable, Appropriate, Effective, and Equitable. Further, the American Academy of Pediatrics (AAP), American Academy of Family Physicians, and American College of Physicians professed that optimal care is achieved when each person, at every age, receives developmentally appropriate care. In response, the AAP put out a statement to help guide the delivery of care based on adolescent development, confidentiality, and transition to adult care.

This Adolescent Care Process Model (CPM) seeks to apply the principles of Adolescent Friendly Care throughout the Mission Health System in order to align with best practices for adolescent health. In an effort to be consistent with the above AAP statement, this CPM is divided by developmentally appropriate Clinical Care, Transition to Adult Care, and Confidentiality.

Inclusion and Exclusion Criteria

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<td>• Children between 11 and 21 years of age</td>
<td>• Adolescents with complex medical health histories may have needs beyond those covered in this CPM</td>
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1. Ref: Source 1
2. Ref: Source 2
3. Ref: Source 3
4. Ref: Source 4
5. Ref: Source 5
6. Ref: Source 6
7. Ref: Source 7
Standards of Developmentally Appropriate Clinical Care for Adolescent Patients

Goals:

- Create provider education tools around standards of adolescent clinical care
- Support regional clinics in designing workflows that align with evidence based adolescent care and in creating an environment friendly to adolescents
- Prepare families for what to expect during their visit for adolescent patients

Deliverables

1. Recommendation tab within the EMR for MMA practices that supports Bright Future Recommendations (Appendix A)
   a. Includes lipid screen, HIV screening, depression screening reminders

2. Standing orders within MMA practice EMR following Bright Futures recommendations as able. Can be found through “AMB Well Child 11-12 Years Subplan” and “AMB Well Child 13-17 years Subplan”


4. Create caregiver informational booklet covering what to expect at their adolescent’s visit. Available on Mission Children’s Toolbox

5. Create an Adolescent Working Group to ensure sustainability, support regional clinics, and address ongoing concerns for adolescent care

6. Provide resources for providers and adolescent patients (Appendix B)
Metrics for Success

- HEDIS quality measures
- Child Core Set/CHIP®
  - Adolescent Well Care Visits (NCQA)
  - BMI/counseling (NQF# 0024/NCQA)
  - Chlamydia screening 16-20yo (NQF 0033/NCQA)
  - Depression screen and follow-up 12-17 (NQF 0418/0418e/CMS)
  - Access to PCP (NCQA)
  - Contraceptive Care 15-20yo (NQF 2903/2904/OPA)
  - ADHD follow-up care (NQF 0208)
  - Follow-up after hospitalization for Mental illness Ages 6-20 (NQF 0576)
  - CAHPS – child version including Medicaid and children with chronic conditions
Transition of Care from Adolescence to Adulthood in the Inpatient and Ambulatory Settings

Transition of adolescents into adulthood is a key milestone in which each patient is cared for in a medical home designed to meet their evolving needs. The Maternal and Child Health Bureau (MCHB) and the National Alliance to Advance Adolescent Health have partnered to address this need to help transition patients into a model of adult health care via their Got Transition/Center. Their focus of implementation revolves around the Six Core Elements of Health Care Transition. The following integrates both the recommendations from the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians and the Got Transition initiative to create a standard of care for this unique population.

Figure 1 – Timeline for introducing the Six Core Elements into pediatric practices.
Transition of Care from Adolescence to Adulthood in the Inpatient and Ambulatory Settings (continued)

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<tr>
<th>Practice or provider</th>
<th>#1 Transition and/or care policy</th>
<th>#2 Tracking and monitoring</th>
<th>#3 Transition readiness and/or orientation to adult practice</th>
<th>#4 Transition planning and/or integration into adult approach to care or practice</th>
<th>#5 Transfer of care and/or initial visit</th>
<th>#6 Transition completion or ongoing care</th>
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<tr>
<td>Pediatric&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Create and discuss with youth and/or family</td>
<td>Track progress of youth and/or family transition preparation and transfer</td>
<td>Conduct transition readiness assessments</td>
<td>Develop transition plan, including needed readiness assessment skills and medical summary, prepare youth for adult approach to care, and communicate with new clinician</td>
<td>Transfer of care with information and communication including residual pediatric clinician's responsibility</td>
<td>Obtain feedback on the transition process and confirm young adult has been seen by the new clinician</td>
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<td>Adult&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Create and discuss with young adult and guardian, if needed</td>
<td>Track progress of young adult’s integration into adult care</td>
<td>Share and discuss welcome and FAQs with young adult and guardian, if needed</td>
<td>Communicate with previous clinician, ensure receipt of transfer package</td>
<td>Review transfer package, address young adult’s needs and concerns at initial visit, update self-care assessment and medical summary</td>
<td>Confirm transfer completion with previous clinician, provide ongoing care with self-care skill building and link to needed specialists</td>
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Figure 2 – Summary of Six Core Elements approach for pediatric and adult practices.<sup>10</sup>

Providers that care for youth and/or young adults throughout the life span can use both the pediatric and adult sets of core elements without the transfer process components.

Most recently, The AAP updated their Clinical Report around Adolescent Transitions. In this updated report, they continued to emphasize the importance of transitioning adolescents into adult care while now highlighting the shared responsibility of both pediatric providers as well as that of the accepting adult providers during the HCT (Health Care Transition). In this report, they highlight that > 80% of youth do not meet the national standards of HCT performance measures. Lack of structured HCT can lead to adverse effects including but not limited to treatment compliance, discontinuity of care, patient dissatisfaction, increased utilization of the Emergency Department, increased readmissions and subsequently higher costs of care.<sup>10</sup>

Goals:

- Establish a Timeline for Transitioning in the Ambulatory Setting and Inpatient Setting within the Mission Health System (see below and Appendix C)
- Provide resources to practices for Adolescent Transitioning Policy creation (Appendix D)
- Provide resources to assess readiness of patients and families for timely transitions (Appendix E)
- Outline both pediatric and adult provider checklist for seamless transitions (Appendix F)
- Define outcome metrics
- Provide a list of resources for both providers and staff (Appendix G)
Deliverables

(1) Timeline Diagram delineating age at which transition steps should take place

a. In the ambulatory setting, the “Transition Process” should be introduced to families and patients between 12 and 13 years of age. If in a Family Medicine or Med-Peds practice, the process of transitioning to an adult approach to care should be discussed. This includes but is not limited to privacy, consent, and the role of the parent/caregiver. An “individualized” transition of care should take place between 14 and 15 years of age. This plan should be updated between 16 and 17 years of age. Adult providers should be identified for future care. If the patient has Medicaid and needs assistance finding an adult practice, CCNC can help identify providers in the area who take Medicaid. Once ready for transfer, prepare records and initiate communication with accepting adult provider. Between the ages of 18 and 21 years of age, goals should be formalized and expectations as well as timing of transition should be established. Family concerns should be addressed at this time to support transition. Once the patient reaches the age of 18, pediatric providers should begin using an adult model of care to reinforce HCT regardless of location. Any patient over 21 years of age should begin transition as soon as possible. (Appendix C)

b. In the hospital setting, the Mission Children’s Transition Policy will be introduced between the ages of 16 and 18 years of age. Between the ages of 18 and 21, a plan for transition, readiness assessment, and date for transition will be established. Upon discharge, transition to adult care providers will be initiated, and the transition care plan will be outlined in the discharge summary. Once a patient turns 21, they will be prepared for transition to an adult floor for their next hospital admission. After 21 years of age, patients will be admitted to adult floors with anticipation of care by an adult care team. Collaboration with the adult provider and pediatric providers will be available as well as bridge pediatric services until fully transitioned.

Metrics for Success

• Numbers of patients in ambulatory pediatric practices and admitted to inpatient units
  o 18-21 years old
  o > 21 years

• Survey of subspecialty patients transitioning out of the Mission Children’s Specialty clinic
Confidentiality and Communication

Learning to communicate effectively with health care providers is an essential part of the development of an adolescent’s health literacy and improves their access to health care. As physicians and other providers it is our responsibility to teach and encourage our patients to effectively communicate their concerns and needs. However, concerns about confidentiality may create barriers for communication and discourage adolescents from seeking care when needed.

Goals

- Provide overview of North Carolina law regarding adolescent confidentiality
- Establish communication guidelines around non-secure text messaging
- Clarify which parts of the record are confidential

North Carolina State Law Regarding Confidentiality

§ 90-21.5. Minor’s consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-223. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-223.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child. (1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4; 2009-570, s. 10.)

Communication guidelines:

Despite our desires as providers to be accessible to all of our patients, we must also be able to document all communications with our patients. Therefore, non-secure texting with patients and communication through social media is not recommended because it violates both Mission Health Information Security rules and HIPAA.

1. Information security rules and HIPAA require that patient information be kept secure.
2. Information given to a patient should be noted in the patient record. Phone conversations do not need to be documented verbatim, but documentation that communication with a patient occurred and the general content of the discussion should be documented every time.
3. Non-secure text messaging could be used against a physician or other provider in a medico-legal case.

EMR Confidentiality

Mission Health System limits portal access to patient or families once patients enter adolescence. It’s important to note that medical records can still be accessed through HIMS. Certain clinical notes such as psychiatry and child safety team notes remain restricted even if requested through HIMS.
References


Appendices

Appendix A. Standards of Care Guidelines

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https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_AdolVisits_BF4.pdf

Table 1 – Bright Futures Medical Screening Reference Table

Appendix A. Reference

Appendix A. Standards of Care Guidelines (continued)

**USPTF HIV Universal Screening Guideline:**

Appendix B. Provider and Patient Clinical Care Resources

- The Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD) and the Screening to Brief Intervention (S2BI)
  - Validated for primary care settings, these screeners are designed to help clinicians introduce AAP recommended, universal screening. Developed by the National Institute on Drug Abuse.

- RAAPS: Rapid Assessment for Adolescent Preventive Services
  - Standardized and validated risk assessments addressing risk behaviors in youth

- HEEADSSS: Psychosocial history should be taken based on HEADSSS method of interviewing. Includes the following domains:
  - Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, Safety

- Motivational Interviewing
  - This is a counseling style to elicit behavior change which can be used in the clinic setting
  - [https://www.youtube.com/watch?v=s3MCJZ7OGRk](https://www.youtube.com/watch?v=s3MCJZ7OGRk)

- Free CME Credit: Promoting Adolescent Health
  - Expires 9/8/2020

- Teens Increasing Preventive Services (TIPS).
  - Program implemented by UCSF Adolescent and Young Adult Division aimed to improve screening and counseling rates for risk behaviors. Includes clinician trainings and implementation of screening and charting forms
  - [http://nahic.ucsf.edu/resource_center/t-i-p-s-program/](http://nahic.ucsf.edu/resource_center/t-i-p-s-program/)

- Engaging Adolescent Videos by CCNC
  - [https://www.communitycarenc.org/population-management/pediatrics/engaging-adolescents/](https://www.communitycarenc.org/population-management/pediatrics/engaging-adolescents/)

- Crisis Text Line
  - Free, 24/7 crisis support: Text HELP to 741741
  - [https://www.crisistextline.org](https://www.crisistextline.org)

- Got Transition
  - Collaboration to improve Health Care Transition (HCT) with resources for providers and patients
  - [https://www.gottransition.org/](https://www.gottransition.org/)
Appendix C. Timeline Diagrams

Ambulatory Adolescent Transition Planning Timeline

- If Medicaid patient and need assistance finding a practice, call CCNC to find out what providers in your area take Medicaid. May need to consider transitioning medical home at 17yrs of age.
- OK to accelerate timeline if meets patient needs

12-13 yrs
Introduce “Transition Process” and expectations for future transition to adult provider

If in a Family Medicine or Med-Peds Practice, recommend addressing process of transitioning to adult approach to care within the practice including, but not limited to privacy, consent and roles of the parent/caregiver in the adult care model

14-15 yrs
Begin to outline “individualized” transition of care

16-17 yrs
Update “individualized” transition of care plan
Identify potential adult providers for future care

If ready for transfer, prepare records and initiate communication with accepting adult care provider

> 18 yrs
Transition any patients not already in adult care

18-21 yrs
Formalize goals, expectations and timing of transition

Address patient and family concerns

Prepare records for transfer and consider phone call or electronic communication to review patient with accepting provider

Mission Children’s Hospital Inpatient Transitioning Timeline

- Consider adult bridge services for kids > 12yrs for adult disease process or diagnosis
- Patient may need admission to adult unit with pediatric hospitalist coverage during initial transition to adult services

16-18 yrs
Introduce Mission Children’s Transition Policy

18-21 yrs
Begin to plan for transition to adult services over the next few years
Assess readiness and set date for transition
On discharge, initiate transition to adult care providers for medical home and subspecialty care
Outline Transition Care Plan in discharge summary

> 21 yrs
Offer bridge pediatric services on the adult service until fully transitioned, including but not limited to Child Life, Pediatric Pharmacy, Pediatric Respiratory Therapy and Pediatric Metabolic Support

> 21 yrs
Transition any remaining patients to the adult service in preparation for their next hospital admission
Appendix D. Sample Transition Policy for Ambulatory Practices

Sample Transition Policy
Six Core Elements of Health Care Transition 2.0

[Pediatric Practice Name] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a “pediatric” model of care where parents make most decisions to an “adult” model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult’s consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.

Appendix D. Reference

- (http://www.gottransition.org/resourceGet.cfm?id=221)

Appendix E. Transition Readiness Tools

Sample Readiness Tools:

- Readiness Tool for Youth: http://www.gottransition.org/resourceGet.cfm?id=224
- Readiness Tool for Youth (En Español): http://www.gottransition.org/resourceGet.cfm?id=224&es=1
- Readiness Tool for Parents/CareGivers: http://www.gottransition.org/resourceGet.cfm?id=225
- Readiness Tool for Parents/CareGivers (En Español): http://www.gottransition.org/resourceGet.cfm?id=225&es=1
Appendix F. Checklists for Seamless Transitions

Sample Individual Transition Flow Sheet
Six Core Elements of Healthcare Transition 2.0

Diagram 1 – Provider/Patient Tracking Tool
Appendix F. Checklists for Seamless Transition *(continued)*

**Sample Transfer of Care Checklist**  
**Six Core Elements of Health Care Transition 2.0**

<table>
<thead>
<tr>
<th>Patient Name: ____________________</th>
<th>Date of Birth: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis: _______________</td>
<td>Transition Complexity: _______________</td>
</tr>
<tr>
<td>Low, moderate, or high</td>
<td></td>
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</tbody>
</table>

- Prepared transfer package including:
  - Transfer letter, including effective date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including transition goals and pending actions
  - Updated medical summary and emergency care plan
  - Guardianship or health proxy documents, if needed
  - Condition fact sheet, if needed
  - Additional provider records, if needed

- Sent transfer package ____________
  - Date

- Communicated with adult provider about transfer ____________
  - Date

*Diagram 2 – Checklist for Handoff*
Appendix G. Resources for Transition

**Resources for Adult Providers:**

American College of Physicians Pediatric to Adult Care Initiative:


**For Patients and Families helping to Transition a Child with Special Needs:**


Family Support Network Site: [https://missionhealth.org/member-hospitals/childrens/education-outreach/family-support-network/](https://missionhealth.org/member-hospitals/childrens/education-outreach/family-support-network/)
Achieving the BIG(GER) Aim

To get every person to their desired outcome, first without harm, also without waste and always with an exceptional experience for each person, family and team member.

About Mission Health

Mission Health, based in Asheville, North Carolina, is the state’s sixth-largest health system and was recognized as one of the nation’s Top 15 Health Systems from 2012-2015 by Truven Health Analytics, formerly Thomson Reuters, becoming the only health system in North Carolina to achieve this recognition. Mission Health operates six hospitals, numerous outpatient and surgery centers, post-acute care provider CarePartners, long-term acute care provider Asheville Specialty Hospital, and the region’s only dedicated Level II trauma center. With approximately 10,700 employees and 2,000 volunteers, Mission Health is dedicated to improving the health and wellness of the people of western North Carolina. For more information, please visit mission-health.org or @MissionHealthNC.