February 27, 2025
Health Transition Learning Community

Lessons from the Field: Transition Support Tools and Practices for those with Complex Medical Needs

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Tips for a successful experience in today's call

- Please mute your line.
- Presenters will take questions during and at the end of the presentation.
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Lessons from the Field: Transition Support Tools and Practices for those with Complex Medical Needs

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February 27th, 2025

Children's Wisconsin

Medical College of Wisconsin

Disclosures

I have no financial disclosures

Objectives

- Describe key elements of the Complex Care Program transition process
- Learn how the transition process has changed since the COVID-19 pandemic
- Identify how care coordination and transition supports are funded
- Identify methods used to understand the patient/family transition experience

Children with Medical Complexity (CMC) and Children's Wisconsin (CW) Complex Care Program (CCP)

- CMC
  - Subset of Children and youth with special health care needs (CYSHCN)
  - Chronic, multisystem health conditions, utilizing large number of technological supports, health care resources, and community services
  - Represent <1% of US children but account for more than 1/3 of total pediatric health care costs (Cohen et al, 2012; Murphy & Clark 2016)
- CW CCP
  - Criteria: 3+ chronic conditions involving 3+ organ systems requiring specialty care, and 10 specialty clinic visits/year OR 5 unplanned hospital days
  - ~ 730 patients in the program, 24% of which are 12 years old or older, 5% are 18 years and older

Children's Wisconsin

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Elements of Transition Process

- 6 Core Elements from Got Transition
  - Transition and Care Policy/Guide
  - Tracking and Monitoring
  - Transition Readiness
  - Transition Planning
  - Transfer of Care
  - Transition Completion

- CW Transition Policy
  - Identifying patients at 12 years old
  - No age limit identified for outpatient/inpatient care
- CCP Guide
  - Start conversations at 12, ideally discuss at every clinic visit (every 6 months)
  - Counseling for pediatric to adult transition added to problem list at age 12
  - Transition specific row added to share plan of care at age 12
  - Information based on age added to after visit summary
  - Do not receive funding from Medicaid for patients ≥ 26 years old

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  - Transition and Care Policy/Guide
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  - Transition Readiness
  - Transition Planning
  - Transfer of Care
  - Transition Completion
- Transition specific row added to share plan of care at age 12
  - Guardianship/Supported Decision Making
  - Specialty Timeline
  - Health Care System
  - Resources/benefits
    - School
    - CLTS to ADRC
    - Long term care option (IRIS, Family Care, etc)
    - SSI

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- Not currently utilizing standardized readiness assessment
- Planning
  - Discuss with specialists between 14-16 tentative transition timeline and needs
  - School plans
  - Guardianship or supported decision making

Shared Plan of Care

System/Problem	Updates and Plan	Responsible Provider	To-Do's
Cardiovascular			Next Visit:
Pulmonary			Next Visit:
ENT/Audiology			Next Visit:
FEN/GI			Next Visit:
GU/Renal			Next Visit:
Endocrine			Next Visit:
Neurology			Next Visit:
Ophthalmology			Next Visit:
Orthopedics			Next Visit:
PM&R			Next Visit:
Genetics			Next Visit:
Behavioral/ Mental Health			Next Visit:
Development/ Education			
Social			
Health Maintenance			Next Visit:
Dental			Next Visit:
Complex Care Patient and Family Goals			Next Visit:

Transition to Adult Care	Adult Institution: TBD Timeline: Will plan on reaching out to specialists. Guardianship vs Supported Decision Making: Will need guardianship. Plans after high school: TBD Home: Plans for group home at some point after he turns 18. CLTS discussing.		

14 year old

18 year old

Transition to Adult Care	• Adult Institution: Froedtert • Timeline: - Cardiology - CW indefinitely - Asthma/Allergy - CW indefinitely - Audiology: Follow until at least 18 - ENT: Unclear at this time - Dental: Transition 18 - Genetics: Follow until 21 - Heme: can follow indefinitely - Dermatology: Likely transition 2025 - PM&R: Can follow until 21 - Psychiatry: Can follow until 21 - Sleep: Transition at 18 - Orthopedics: Unclear at this time • Plans after 18: Stay in school until 21. Working with DVR on potential job opportunities. • Guardianship: Visit with guardianship clinic in October 2024. PCP filled out psychological evaluation in May 2024.		

Elements of Transition Process

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  - Transition and Care Policy/Guide
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- Connect with PCP if able
- Forward Complex Care note
- Warm handoff – QI project
- Communication throughout process
- Eventual discharge from Complex Care Program

COVID-19 and Transition

- Pre-Pandemic
  - CCP transition committee developed in 2019
  - Working on consistency between staff in guiding family, including timeline
- Pandemic
  - Delay in transfer to adult care
  - “Emergency” planning for young adult patients to be admitted to CW
- Post-Pandemic
  - Some departments with long waits (pediatric and adult)

Funding for Care Coordination and Transition

- Health Care Innovation Award 2014
  - Wisconsin Medicaid collaboration with CCP at American Family Children's Hospital and Children's Wisconsin
  - Extended ability to care for CMC
  - Develop payment model for CCP
    - https://www.forwardhealth.wi.gov/kw/pdf/20
- Codes
  - Billing based on time
  - https://www.gottransition.org/resource/?2023-coding-tip-sheet

Billing Codes

Transition Related Services		100% Medicare Payment, 2023		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Office or Other Outpatient Visit, New Patient[a]				
99202+	Straightforward medical decision making or 15-29 minutes	$72.86	$48.12	2.15/1.42
99203+	Low level of medical decision making or 30-44 minutes	$112.85	$83.03	3.33/2.45
99204+	Moderate level of medical decision making or 45-59 minutes	$167.42	$132.17	4.94/3.94
99205+	High level of medical decision making or 60-74 minutes	$220.96	$181.31	6.52/5.35
Office or Other Outpatient Visit, Established Patient[a]				
99211	Evaluation and management (E/M) that may not require the presence of a physician or other qualified health care professional (QHP)	$23.38	$8.81	0.69/0.26
99212+	Straightforward medical decision making or 10-19 minutes	$56.93	$35.58	1.68/1.05
99213+	Low level of medical decision making or 20-29 minutes	$90.83	$66.10	2.68/1.95
99214+	Moderate level of medical decision making or 30-39 minutes	$128.44	$97.60	3.79/2.88
99215+	High level of medical decision making or 40-54 minutes	$179.96	$143.35	5.31/4.23
Office or Other Outpatient Consultations, New or Established Patient[b]				
99242+	Straightforward medical decision making or at least 20 minutes	$76.25	$56.26	2.25/1.66
99243+	Low level of medical decision making or at least 30 minutes	$114.21	$88.79	3.37/2.62
99244+	Moderate level of medical decision making or at least 40 minutes	$163.35	$135.56	4.82/4.00
99245+	High level of medical decision making or at least 55 minutes	$213.17	$181.31	6.29/5.35
Prolonged Services[c]				
99358	Prolonged E/M services before and/or after direct patient contact; first hour	$92.52	$91.16	2.73/2.69
99359	Each additional 30 minutes	$43.04	$43.04	1.27/1.27
99417	Prolonged outpatient E/M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time	$31.18	$30.16	0.92/0.89

Patient and Family Transition Experience

- Complex, busy, and emotional experience for patients and families
- Importance of patient/family involvement in transition process
- 2021-2023: Dr. Beth Corbin's interviews of 10 patients who had transitioned to the adult health care system within the last 5 years
  - 10 questions regarding transition experience, including:
    - Age of transition (and if it was appropriate)
    - How they chose health care facility to transfer to
    - Positive/negative experiences and safety issues
    - Resources they gained and lost during the process, and what would be helpful transitioning
    - Advice or how to help patients/families transition in the future

Patient and Family Experience

- Themes
  - Desire for gradual transition
  - Health status impacting time of transition
  - Provider knowledge
  - Models of care – differences between pediatric and adult care
  - Preparedness – perceived and amount of guidance provided
  - Negative script provided by pediatric team regarding transition
  - Gap in resources or time between last pediatric visit and first adult visit
  - Loss of centralized support

Patient and Family Transition Experience

- Advice and wish list from interviews
  - Support groups and early ancillary service involvement (SW, psychology, medical legal support)
  - Warm handoffs between providers
  - Recommendations for providers
  - Guided-timeline and gradual transition
  - Assistance with resources and honesty about lack of resources
  - Opportunity to provide feedback on experiences and recommendations on providers to other families
  - Recognizing need for self care
  - Educating physicians that it's okay to say "I don't know"
  - Transition primary care provider first
  - Need for concrete changes in medical policies in the adult world
  - Addressing the stigma of CMC being "unfixable"

Final Thoughts

- Transitioning from pediatric to adult care is a complex process that requires ongoing guidance and monitoring from multiple providers, agencies, and other supports.
- Having a consistent place to document transition needs helps to facilitate communication with patients/families, providers and other stakeholders.
- Ongoing collaboration and advocacy needed for reimbursement of these pivotal services that have not always been covered.
- Importance of ongoing work on transition that includes patient and family experiences and feedback.

References

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Upcoming Event

Health Care Transition for I/DD ECHO

Payment for Health Care Transition Services
March 11, 2025
12:00pm-1:30pm

More information and to register:
https://www.waisman.wisc.edu/echo/health-care-transition/

Future topics and dates
- Role of Families from Different Cultures in Health Care Transition (4/8/2025)
- Mental Health Barriers and Options during the Transition to Adult Services (5/13/2025)
- Health Care Transition Services for those with Medical Complexity (6/10/2025)

Upcoming Event

Thank you to the Mount Horeb Area School District Transition team for their partnership in the Spring 2025 edition of Transition Talks Tuesdays.

- Housing Options (March 4, 6:00-7:00pm)
- Guardianship and Supported Decision Making (March 18, 6:00-7:00pm)
- Aging and Disability Resource Centers (ADRC) (April 8, 6:00-7:00pm)
- Health Care Transition (April 22, 6:00-7:00pm)
- Division of Vocational Rehabilitation (DVR) (May 6, 6:00-7:00pm)
- Transportation Options (May 20, 6:00-7:00pm)

More information and registration at
https://healthtransitionwi.org/transition-talks-tuesdays-spring-2025/

Thank you for joining today's Learning Community!

For transition resources, tools, and events, check us out at

https://healthtransitionwi.org/

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SUPPORTING YOUTH TO ADULT HEALTHCARE

Feedback

Please let us know how we are doing by answering the 3 questions in the Zoom poll!

Or reach us at healthtransitionwi@waisman.wisc.edu