Health Transfer of Care Quality Improvement Project

Rhode Island Department of Health and Tufts Health Plan

White Paper Funding Report

Patricia Flanagan, MD, FAAP

CTC-RI Clinical Director

Elizabeth Lange, MD, FAAP

Co-Chair PCMH Kids

Susanne Campbell, RN, MS, PCMH CCE

Senior Program Administrator

Suzanne Herzberg, PhD, OTR, PCMH CCE

CTC-RI Practice Facilitator

Kim Nguyen-Leite MHA, CPHQ, PCMH CCE

Program Coordinator II

Executive Summary

In April 2021, at the request of the Rhode Island Department of Health and Tufts Health Plan, the Care Transformation Collaborative of Rhode Island piloted a quality improvement initiative that focused on transitions of care from pediatric to adult practices. This project engaged seven pediatric/adult practice dyads in a twelve-month learning collaborative with the following goals:

a) Improve care coordination by creating a standardized process for the transfer from pediatric to adult care for youth with and without special needs;

b) Use a nationally recognized health care transition (HCT) approach and quality improvement methods to implement improvements in both pediatric and adult care;

c) Strengthen engagement with youth and the collaboration between pediatric and adult primary care sites;

d) Measure HCT improvements and consumer experience;

e) Encourage sustainable, patient-centered processes by having practices apply as partners within the same systems of care.

The key components of the quality improvement initiative included:

Leadership: provided through the formation of a core planning team (including technical assistance provided by the National Alliance to Advance Adolescent Health) to oversee planning and implementation;

Assessment and Evaluation: each practice completed pre- and post-program surveys of their transition activities, using the Six Core Elements of Health Care Transition Survey Tool and obtained feedback from youth on their satisfaction with the transition process through a modified Got Transitions Youth Survey Tool;

Practice Facilitation/Performance Improvement/Peer Learning: provided through customized practice and dyad facilitation support focused on selected Transfer of Care Elements and regularly scheduled peer learning sessions with the seven dyads coming together at regular intervals to share lessons learned;

Financial Assistance: included practice infrastructure and incentive payments for meeting program expectations based on funding received from the Rhode Island Department of Health Title V and Tufts Health Plan.

All seven dyads completed the HCT 12-month learning collaborative and successfully transferred 29 young adults (with 12 young adults in the process of transferring at the conclusion of the program). All practices demonstrated improvements in their post-program assessment of HCT activities. For pediatric practices, scores improved from 11.6 to 17.5. For adult practices, scores improved from 15.5 to 19.67. The youth who completed the experience surveys indicated readiness to move to a new doctor (scores ranged from 88.2% to 94%), satisfaction with pediatric providers (scores ranged from 82 to 100%), and satisfaction with their new adult providers (scores ranged from 88.2 to 94%). Our results demonstrate that an intentional, focused, and supported quality improvement approach can improve young adults' readiness to transition to adult medical care.

Contents

1. Background/Rationale 4
2. Methods and Interventions 6
3. Outcomes 9
4. Discussion 12
5. Areas of Continued Focus 14
References 16
Appendix 18

1. Background/Rationale

The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) define health care transitions as "the purposeful, planned shift from child-centered to adult-oriented providers, settings, and content of visits to provide comprehensive, age-appropriate care." The goal is to maximize lifelong functioning and potential (White & Cooley, 2018). In accordance with the report on transition produced by these associations, planning should begin early in adolescence and continue into young adulthood for those with and those without special health care needs (AAFP, 2018). Widespread adoption of recommended transition supports as a basic standard for all adolescents has been slow across the United States; data from the National Survey of Children's Health (NSCH) 2019–2020 reflects a low percentage of youth both with and without special needs who receive adequate preparation for their transition to adult care. In Rhode Island, 80% of youth with special health care needs (YSHCN) and 84% of youth without special health care needs do not receive transition preparation from their health care providers (compared with 76% and 82% respectively across the United States); Among adolescents ages 12–17, Rhode Island has a higher prevalence of youth with special needs (29%) compared to the national percentage (26%) (Child and Adolescent Health Measurement Initiative, 2019–2020).

To better understand the perspective of primary care providers, the Office of Special Healthcare Needs (OSHCN) at the Rhode Island Department of Health (RIDOH) conducted a series of pediatric and adult primary care surveys (2006–2007). The purpose of the surveys was to understand and identify current policies, practices, beliefs, and service delivery gaps related to the transition and transfer of youth with special health care needs from pediatric care to adult primary care.

The surveys demonstrated the following:

- Family members or friends typically initiate the entry of young adults into adult primary care practices.
- The majority of respondents reported higher levels of comfort with treating young adults with obesity, hypertension, and diabetes than with treating young adults with sickle cell anemia, spina bifida, cystic fibrosis, neuromuscular disease, or those who are technology dependent.
- When asked about their patients with special health care needs, 79% of respondents responded that these young adults should ideally transfer to adult primary care by age 21. Seventy-seven percent (77%) reported they never or rarely received a written transfer summary from the pediatric health care provider. Sixty-nine percent (69%) reported they never or rarely communicated with the pediatric care providers who had previously cared for their patients with special health care needs. Ninety-four percent (94%) reported that the health plans never or rarely assisted with the transfer. Forty-

seven percent (47%) reported that young adults with special health care needs always or sometimes experienced gaps in care during the transfer from pediatric to adult care.

Two recent publications call attention to the need for a greater focus on young adult health care. A *Morbidity and Mortality Weekly Report* in 2022 noted that more than half of all young adults aged 18–34 had at least one chronic condition, and a quarter had at least two chronic conditions. The most frequently noted conditions were obesity, depression, and hypertension (Watson, 2022). Additionally, a population-based study of adolescent and young adult health care utilization in Vermont examined the association between well-visits and emergency department (ED) usage and found strong correlations between a lack of preventive visits and increased ED usage. While this association was seen across all ages and for those with and without chronic conditions, the strongest association was seen in people aged 18 to 21 who had chronic health conditions (Holland et al., 2022).

Research demonstrates the importance of preparing all adolescents for successful health care transitions (HCT). Without proper HCT preparation, youth may be at risk for limited health literacy, overuse of emergency department services, high medical costs, and increased morbidity and mortality (Leung et al., 2019). Additional studies support the importance of intentionally investing in providing youth with assistance for the transition to adult care.

A review of the literature by White and Cooley (2018) finds numerous adverse results resulting from the lack of a structured transition process, including medical complications, limitations in health and well-being, difficulties in treatment and medication adherence, discontinuity of care, preventable emergency department and hospital use, and higher costs.

Gaps in care for women of childbearing age are of added concern because of the risk of unintended pregnancies. As noted by the CDC 6|18 initiative (2019), women of childbearing age, particularly adolescents aged 15–19 years and young women aged 20–24 years, are at risk for unintended pregnancy. The risks increase among racial or ethnic minorities and women with lower levels of education and income.

The Care Transformation Collaborative of Rhode Island (CTC-RI), and its pediatric division, PCMH-Kids, is a multi-payer organization that has effectively utilized a quality improvement approach to support the transformation to advanced comprehensive medical homes with primary care practices in Rhode Island. The National Alliance to Advance Adolescent Health created Got Transition, a roadmap to support the process of healthcare transition. The 2018 Health Care Transition Clinical Report from the AAP, AAFP, and ACP recommends Got Transition's Six Core Elements of Health Care Transitions, a structured process that facilitates transition preparation, transfer of care, and integration into adult care. CTC-RI, with funding from RIDOH and Tufts Health Plan and technical assistance from the National Alliance to Advance Adolescent Health, created a learning collaborative opportunity to improve care coordination between pediatric and adult primary care practices and youth and their families to:

1. Introduce and test the concept and process for intentional transfers of care;
2. Use a quality improvement approach, including practice facilitation and sharing of best practices, to design and implement a transfer process;
3. Collect feedback from providers and patients regarding their experiences;
4. Measure practice improvement of the implementation of selected transition of care core elements;
5. Inform health care systems of potential value-based payments for planning and implementing future transitions of care.

2. Methods and Interventions

Starting in June 2020 and continuing over a six-month time frame, CTC-RI successfully implemented a work plan that included the following key components: 1) leadership and planning; 2) a structured approach; 3) peer learning; 4) self-assessments and patient feedback; 5) practice facilitation and performance improvement; and 6) financial support as outlined below.

Leadership and Planning

Planning to meet the objectives for this quality improvement initiative started in April 2021. CTC-RI formed a core planning committee with key stakeholders, including PCMH Kids co-chairs, CTC-RI project management staff, practice facilitators, family representatives from the Rhode Island Parent Information Network (RIPIN), RIDOH Title V staff, and consultants from the National Alliance to Advance Adolescent Health. RIDOH provided both leadership and Title V funding to support this quality improvement initiative, as the work supports a key priority of the state's action plan, which is to ensure care coordination for CYSHCN.

Structure

CTC-RI issued a call for applications that provided pediatric and adult primary care practices with the opportunity to apply together as dyads to participate in this twelve-month program. All practices followed the recommendation to select a partner within the same system of care to allow for direct communication; seven dyads applied and were accepted into the program. Each practice also selected a core team to participate in monthly meetings, consisting of a provider champion, a nurse care manager, a practice manager, and other relevant staff. The core team requirement was structured to allow for both management and clinical staff participation. All practices signed a participative agreement that outlined program objectives and dyad responsibilities over the twelve-month period.

The program ran from May 2021 through April 2022 and utilized the structured transition process recommended by Got Transition, a federally funded national resource for health care transitions. Got Transition's structure, resources, and technical assistance were invaluable in

designing this project, which included quality improvement, practice facilitation, peer learning and infrastructure payments to offset costs associated with staff time, participation in quality improvement activities, and possible modifications to the electronic health record,.

The Got Transitions framework, which includes its Six Core Elements, provides a step-wise guide to implementing a transition program and has separate guidelines for pediatric practices, adult practices, and family practices. The one-year timeframe of the program necessitated a focus on the transfer of young adults from pediatric to adult care, rather than on the preparation for transfer that can occur at earlier ages. The program, therefore, focused on core elements four through six for pediatric practices and three through five for adult practices. Family practices focused on the same elements as adult practices.

Core Element	Pediatric Practices *Element of Focus	Adult Practices *Element of Focus
1	Transition and care policy and guide	Transition and care policy and guide
2	Tracking and monitoring	Tracking and monitoring
3	Transition readiness	Orientation to adult practice*
4	Transition planning*	Integration into adult practice*
5	Transfer of care*	Initial visits*
6	Transfer completion*	Ongoing care

Each practice set small goals and tested customized components of the elements before implementing them on a larger scale. Pediatric practices selected five young adults to transition to their adult practice partners, with at least one patient from each practice having complex medical or social needs.

Practices used a planned approach to recruiting patients, including explaining the program to patients and families and assessing their level of interest and readiness. Patients who weren't ready to make the transition did not participate in the pilot.

Practices were asked to consider the use of the following tools offered by Got Transition: a tracking log, a medical summary and emergency contact form, a young adult transition readiness assessment, and a sample plan of care. The medical summary form included information on the

patient's diagnoses and medications and a section for the pediatric provider to share non-clinical information about the young adult, such as an interest in sports or an aptitude for drawing. This information allowed the young adults to share something that they wanted the new provider to know and helped the adult providers make a connection with their new patients at the first adult visit.

Adult practices were asked to write a welcome letter to the new patients that included a section on frequently asked questions and addressed issues such as confidentiality, location and hours, and recommendations for what to bring to the first appointment. All of the tools could be customized to meet the needs of the practice, and small tests of change were carried out at each step in the process to see if further adaptations were necessary.

Dyads had the option of participating in joint telehealth calls, using a script and toolkit provided by Got Transition. The calls were designed to have three participants: the pediatric provider, the adult provider, and the young adult. The goals of the joint calls were to increase the young adult's comfort with the transition and provide an opportunity for the providers to convey important information to each other.

Peer learning

All of the dyads participated in the learning collaborative, which offered opportunities for the practices to share both success stories and barriers to smooth transitions. The peer learning sessions also included presentations by subject matter experts from the National Alliance for Adolescent Health. These presentations provided background information, discussed the structure of the program, and provided information on subjects such as increasing the likelihood of kept appointments, billing for transition services, youth engagement in the transfer process, and the importance of feedback surveys.

Self-assessments and patient feedback surveys

Each practice completed an assessment of transition activities before beginning the program and again at its completion. Practices rated their level of transition knowledge and activities across the Got Transition Six Core Elements and forwarded the assessments to CTC-RI via email for evaluation.

The young adults participating in the health care transition process were asked to complete an anonymous survey on their experience of moving from pediatric to adult health care. The adult practices distributed and collected the surveys and then submitted them to CTC-RI via email for aggregation and evaluation.

CTC-RI staff provided project management support for planning meetings, program design and execution, practice participative agreements, learning collaborative meetings, and support for

the collection, aggregation, and evaluation of data from the feedback surveys and the practice self-assessments.

Practice facilitation and performance improvement

Practice representatives met with practice facilitators monthly to review progress, discuss next steps, address barriers, help devise and analyze quality improvement activities, and facilitate connections with dyad partners.

Using CTC-RI's milestone document as a template, the facilitators developed separate project plans for pediatric and adult practices that listed the requirements and expectations of the program by month. The project plans also contained links to the resources on the Got Transition website and templates for quality improvement.

Facilitators began the program by meeting with each pediatric and adult practice separately to review their current processes and the requirements of the program. While there was some variation in timing, by the fourth month, most of the practices had transitioned to joint meetings with their dyad partners, which helped cement relationships and speed up the processes of problem-solving and implementation.

Financial support

Through RIDOH Title V and Tufts Health Plan funding, each practice received $5,000.00 to support their work on this project.

3. Outcomes

1. Practice Assessments before and after participation

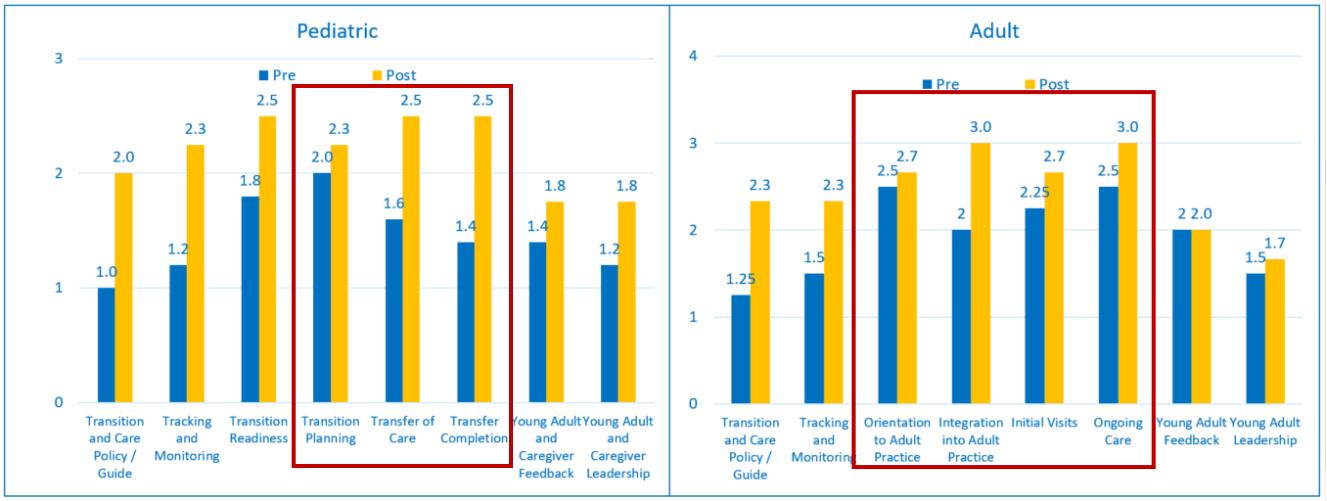
All participating pediatric and adult practices completed a pre- and post-program assessment.

The assessment, which had a maximum score of 32 points, looked at the six core elements and also considered young adult and parent or caregiver feedback and leadership. Practices used a four-point scale to rate their current knowledge and transition activities.

An evaluation of assessment scores before and after the 12-month learning collaborative showed an overall improvement in health care transition activities in both pediatric and adult practices.

Table 2: Practice Assessments – Pediatric and Adult

Elements of focus are highlighted.



All practices rated themselves an average of 2 points or more by the end of the 12 months.

2. Youth/Young Adult Surveys

All transferring young adults were asked to provide feedback on their experience moving from pediatric to adult health care.

Seventeen surveys were received from the 29 patients transferred.

Responses reflected positively on all areas of the transition process. Overall, 88.24% of the young adults felt that they had been sufficiently prepared to move to an adult provider.

Table 3: Youth/Young Adult Survey Results

DID YOUR PAST PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Explain the transition process in a way that you could understand?	100% Yes
Give you a chance to speak with them alone during visits?	100% Yes
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	100% Yes
Create and share your medical summary with you?	82.4%Yes
Help you find a new adult doctor or other health care provider to move to?	100% Yes
DID YOUR NEW ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Address any of your concerns about your move to a new practice/doctor?	88.24% Yes
Give you guidance about their approach to accepting & partnering with new young adults?	88.24% Yes
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	94.1% Yes

- **Overall, how ready did you feel to move to a new adult doctor? 88.24% "Very"; 11.76% "Somewhat"**

3. Young Adults Transferred

During the 12-month learning collaborative, 29 patients successfully transferred from pediatric to adult care. An additional 12 patients participated in the program and had appointments scheduled but had not yet seen their adult providers by the program's end.

At least five patients from all seven dyads had either successfully transferred to an adult provider or had an appointment scheduled by the end of the learning collaborative.

4. Provider and Practice Survey

All participating practices had the opportunity to complete a voluntary post-project evaluation survey.

Survey respondents were asked to provide ratings for ten different categories on a five-point Likert scale, ranging from 1 (not helpful) to 5 (extremely helpful). See Table 4 for all categories.

Respondents were also asked to provide comments about what was most valuable about the project and whether they had unmet needs. See Table 5 for comments.

Six practices completed surveys.

All categories had an average rating of 3 or above, and 8 out of 10 categories had an average rating of 4 or above, indicating that they found the program very helpful.

Table 4 – Survey Categories

On a Scale of 1 to 5, with 1 being not helpful and 5 being extremely helpful, please rate your experience/satisfaction with the following components of the project:
1. Learning collaborative meetings – Best practice sharing
2. Learning collaborative meetings – Content experts
3. PDSA cycles
4. Monthly practice facilitation meetings
5. Infrastructure payment amount and timeline
6. Incentive payment amount, timeline, and requirements to earn
7. Your practice facilitator
8. Deliverables timeline and data requirements
9. CTC project management and other administrative support
10. System of care support

Table 5 – Survey Comments

Please tell us what was most valuable about this project for your practice:
It provided the opportunity to focus on next steps to transform our transition process. Enjoyed the relationship with the adult provider team
Awareness of a problem that required policy development and new systems to implement in order to remedy.
We were able to connect with patients on a more personal level which increased the show rate of transfer patients
Hearing feedback from other practices and wealth of knowledge provided by Got Transitions Team

Please tell us what needs you have that were not met by this project:
Support, especially physical, will always be a hurdle for a small practice like mine. It will take more strategies and ongoing work to continue to improve on transitions of care.
Scheduling meetings were difficult
With this being a new project, I am not sure there would have been more to offer, but selection of shorter questionnaires for the YA to completed.

4. Discussion

This pilot included seven practice dyads, each consisting of a pediatric practice and an internal medicine or family medicine practice. We tested the feasibility of using a structured process to transfer adolescents and young adults from pediatric to adult medical care. We employed quality improvement processes, practice facilitation, and peer learning and best practice sharing, and we based our structured workflows on the National Alliance for Adolescent Health's Got Transition protocols.

We had successful engagement of all partners, with the resulting transfer of 29 young adults to adult primary care; an additional 12 were awaiting their first adult medicine appointment at the end of the program. The young adults and the providers reported positive experiences. Overall, the project succeeded in engaging youth in the process of transfer, and included the co-construction and review of medical summaries.

In reviewing our project, we believe three specific elements helped make it successful.

First, our application process required that practices apply as dyads, which led interested pediatric practices to identify and engage adult medicine partners prior to the start of the

project. Thus, conversations about transitioning youth had already begun when we kicked off the project.

Second, we supported the creation of transfer processes that included typically developing youth without complex medical conditions in addition to those with complex medical needs. Experience prior to this project had been that transition efforts mainly focused on youth with special health needs and that this often overwhelmed both the pediatric and adult providers and some families. By including relatively healthy youth, this project allowed us to create processes in a more simplified environment that could then be tailored to youth with higher levels of need. For example, one of the recommendations in Got Transition is that patients and families have a joint telehealth visit with both their pediatric and adult providers. The joint visit was very difficult to arrange in most instances, and youth and their families generally said they thought it was unnecessary. In the end, only a few joint visits involving more complex youth were completed. One very successful joint telehealth visit occurred with the nurse care managers from both dyad partners and the youth being transferred. The visit allowed the young person to meet the care manager of the practice to which he was transferring and allowed a discussion of his strengths, needs, and goals.

Third, with the technical assistance from the National Alliance, we chose to focus on the transfer itself, rather than the entire transition process, which generally begins in early adolescence, well before the actual transfer of care. Because we had a 12-month period for the project, we focused on elements 4, 5, and 6 on the pediatric side and 3, 4, 5 on the adult side. Although our workplan and milestones were framed around the transfer of at least five young adults, we found that many pediatric practices took the opportunity to address earlier steps as well. These included creating policies regarding the age at which youth age out of the practice, clear communication of policies about confidentiality and privacy, and structured elements in well-child templates through adolescence that specifically document readiness for transition discussions and skills.

One limitation of this project was that each pediatric practice transferred patients to one adult practice. Thus, youth had to be willing to enroll in that specific practice. Our hope is that now that the processes for youth engagement, communication, co-creation of a summary, and transfer are in place, these skills can be used with other practices as well.

The most difficult issue that arose was adequate payment for the work of transition. While we did not study this issue in depth, practices did not deal with coding and billing in a consistent way. At the final learning session, we asked practices to estimate the average time it took to write the summary, communicate with the adult practice, and perform the work of transferring the youth. The amount of time varied widely, mostly as a function of how complex the young person's medical conditions were. The involvement of subspecialists required outreach and coordination and increased the resources required by the primary care practices. Some pediatric practices instituted visits that specifically focused on summarizing the young person's history and goals together in preparation for transfer. At least one dyad struggled with the timing of visits, as both partners wanted to have the visit (transition from pediatric care and new patient in adult care) be an annual visit. The desire to have two annual visits left a gap during which the young person was ready for transfer but had still not been received by the adult practice. As of

October 2022, there are new ICD-10 Z codes for transition. We are exploring using these codes and advocating for adequate payment for this work.

5. Areas of Continued Focus

1. Addressing Payment and Coding Issues

The National Alliance to Advance Adolescent Health, with support from CTC-RI, completed an assessment of payment issues affecting health care transitions. These findings identify barriers to the sustainability of transition activities within pediatric and adult practices.

Low Medicaid fees and a lack of financial or system-wide incentives in Rhode Island prevent the widespread adoption of comprehensive transition activities. Recent changes made to Medicaid fee schedules could provide opportunities to increase the ability of practices to financially embrace the health transition of care work. Rhode Island Medicaid authorized an increase in Medicaid primary care payment rates so that rates are now the same as the Medicare payment rates for the same services.

The Rhode Island Early and Periodic Screening, Diagnosis and Treatment (EPSDT) schedule includes transition planning, which is defined as "equipping an adolescent and his/her family for the transfer from pediatric to adult care by age 21," but there have been no Medicaid billing codes attached to these services. Recently, there has also been positive movement with the creation of transition codes. Effective October 1, 2022, a new ICD-10 diagnosis code has been added for pediatric-to-adult transition counseling: Z71.87 (encounter for pediatric-to-adult transition counseling). There is an opportunity to continue to work with EOHHS to link the billing code to the EPSDT schedule and to advocate for commercial payment for transition services.

2. Building the Momentum for Health Transfer of Care: Providing New and Continued Learning Collaborative Opportunities

We are excited that in July 2022, two new dyads began this work, and two practices from our first cohort continued with expanded foci. One dyad, which involves pediatric and internal medicine residency training programs, has focused on resident education and involvement and seeks to transfer 35 young adults this academic year. Another practice from the first cohort is working with their system of care to embed much of this process into their system-wide EMR.

3. Building a Learning Community to Improve Care Coordination Services for Children and Youth with Special Health Care Needs (CYSHCN) in Rhode Island

CTC-RI, in partnership with RIDOH, will offer ECHO (Extension for Community Health care Outcomes) learning and quality improvement initiatives to increase the capacity of primary care teams to meet the needs of children with special health care needs. ECHO is an innovative telementoring program designed to create virtual communities of learners by bringing together health care providers and subject matter experts using video-conference technology. Health care providers engage in bi-directional learning by presenting cases, sharing clinical challenges, and learning from experts and peers. The CYSHCN ECHO program will be offered in Spring 2023 and include six one-hour sessions offered to 20 practice teams. The program will feature a brief didactic session along with case presentations, which will assist practices with providing care coordination services for CYSHCN in Rhode Island.

After the initial CYSHCN Care Coordination ECHO series is completed, CTC-RI will provide a second quality improvement learning opportunity to assist up to six practice teams with standardizing their workflows and using a quality improvement approach to improve the delivery of care coordination services. The planning team will utilize a baseline survey and implement a quality improvement plan as part of the learning collaborative.

We are grateful to RIDOH and Tufts Health Plan for funding this work and to the National Alliance to Advance Adolescent Health for their technical assistance and expertise. We thank our participating practices, patients and families. We are excited about continuing this work and the bright future of healthcare for young adults in Rhode Island.

References

AAFP. (2018, October 31). *Guidance Updated on Transition of Youth to Adult Health Care*. www.aafp.org. https://www.aafp.org/news/health-of-the-public/20181031caretransition.html

Burke R, Spoerri M, Cardosi A, Flanagan P. *Survey of Primary Care Pediatricians on the Transition and Transfer of Adolescents to Adult Care.* Clinical Pediatrics, 2008;47(4):347–354.

CDC. (2019). *The 6|18 Initiative: Accelerating Evidence into Action*. Centers for Disease Control and Prevention. https://www.cdc.gov/sixeighteen/index.html

Child and Adolescent Health Measurement Initiative. 2019–2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 11/2022. www.childhealthdata.org

Holland, J. E., Varni, S. E., Pulcini, C. D., Simon, T. D., & Harder, V. S. (2021). Assessing the Relationship Between Well-Care Visit and Emergency Department Utilization Among Adolescents and Young Adults. *Journal of Adolescent Health*, 70(1), 64–69. doi.org/10.1016/j.jadohealth.2021.08.011

Leung, S., Walgrave, M., & Mennito, S. (2019). Improving Transitions of Care for Healthy Adolescents and Young Adults. *Southern Medical Journal*, *112*(10), 501–511. https://doi.white

org/10.14423/smj.0000000000001021

Updated Clinical Report on Health Care Transitions for Youth and Young Adults. (2018, October 22). HealthyChildren.org. https://www.healthychildren.org/English/news/Pages/HealthCare-Transitions-For-Youth-and-Young-Adults.aspx

Watson, K. B. (2022). Chronic Conditions Among Adults Aged 18–34 Years — United States, 2019. *MMWR. Morbidity and Mortality Weekly Report*, *71*(964–970). https://doi.org/10.15585/mmwr.mm7130a3

White, P., & Cooley, W. (2018). Transitions Clinical Report Authoring Group; American Academy of Pediatrics; American Academy of Family Physicians; American College of Physicians. Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home. Pediatrics. 2018;142(5):e20182587. *Pediatrics*, *143*(2), e20183610. https://doi.org/10.1542/peds.2018–3610

Appendix

Core Health Transitions of Care Planning Team Members

CTC-RI/PCMH Kids	National Alliance for Adolescent Health	RIDOH
Susanne Campbell Pat Flanagan Beth Lange Pano Yeracaris Carolyn Karner Kim Nguyen-Leite	Peggy McManus Patience White Annie Schmidt	Deb Garneau Colleen Polselli
Practice Facilitators	Family Voices	
Suzanne Herzberg Sue Dettling	Tara Higgins	

Participating Practices

Center for Primary Care
Chad Nevola
East Greenwich Primary Care
East Providence Internal Medicine
Hasbro Pediatric Primary Care
Narraganset Bay Pediatrics
Pilgrim Park Physicians
Providence Community Health Center
Waterman Pediatrics

Documents

Call for Applications
Example Project Plan
Milestone Document Cohort 1 and Cohort 2
Assessments – Before Program

- Family Visiting
- Pediatric Practice

Assessments – After Program

- Family Visiting
- Pediatric Practice
- Collaborative Agreement