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Incorporating the Six Core Elements of Health Care Transition Into a Medicaid Managed Care Plan: Lessons Learned From a Pilot Project

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This pediatric-to-adult health care transition pilot project describes the process and results of incorporating the "Six Core Elements of Health Care Transition (2.0)" into a Medicaid managed care plan with a group of 35 18–23 year olds who have chronic mental health, developmental, and complex medical conditions. The pilot project demonstrated an effective approach for customizing and delivering recommended transition services. At the start of the 18-month project, the Medicaid plan was at the basic level (1) of transition implementation of the Six Core Elements with no transition policy, member transition readiness assessment results, health care transition plans of care, updated medical summaries, transfer package for the adult-focused provider, and assurance of transfer completion and consumer feedback. At the conclusion of the pilot project, the plan scored at level 3 on each core element. The primary reason for not scoring at the highest level (4) was because the transition elements have not been incorporated into services for all enrollees within the plan. Future efforts in managed care will benefit from starting the transition process much earlier (ages 12–14), expanding the role of nurse care managers and participating pediatric and adult-focused clinicians in transition, and offering payment incentives to clinicians to implement the Six Core Elements of Health Care Transition.

ALTHOUGH MOST MANAGED care plans have an organized process for hospital to home transitions, few have a systematic process in place for transition from pediatric to adult health care. This is not surprising given that professional recommendations on transition to adult care were published as recently as 2011 (American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group, 2011) and accompanying clinical quality improvement tools tested for use in pediatric and adult settings — called the Six Core Elements of Health Care Transition (2.0) — were just published in 2014 (Got Transition, 2014). Not only is this a new field of health care innovation, but most of the existing transition literature is drawn from pediatric clinical interventions with youth who have specific chronic conditions (Prior, McManus, White, & Davidson, 2014) or from consumer and provider perspectives on transition barriers (Betz, Lobo, Nehring, & Bui, 2013; Davis, Brown, Taylor, Epstein, & McPheeters, 2014; Fernandes et al., 2014; McManus, Fox, O'Connor, Chapman, & MacKinnon, 2008; Nieboer et al., 2014; Okumura et al., 2010; Peter, Forke, Ginsburg, & Schwarz, 2009).

Until now, there has been no published literature on pediatric to adult health care transition interventions within a

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managed care system. Despite this knowledge gap, evidence from hospital to home transition interventions reveals how nurse care managers in managed care plans have been effectively working with hospital discharge planners and primary care teams to improve care transitions (Diamond, 2011; Johnson & McCarthy, 2013). This has been accomplished by plans helping to identify individuals at risk for hospital readmission. It has also been achieved by greater use of plans' nurses in the areas of care coordination and self-care education for post-hospital care. Expanding the relationship between managed care and participating providers around care transitions has been shown to improve health outcomes and save money (Diamond, 2011; Johnson & McCarthy, 2013).

This article describes the results of a transition pilot project undertaken by Got Transition and a DC-based managed care plan, Health Services for Children with Special Needs (HSCSN) with funding support from the DC Department of Health. The primary question that this project was designed to address was can the Six Core Elements of Health Care Transition be incorporated into a Medicaid managed care plan. This article describes the collaborative process used to customize and integrate transition core elements within a Medicaid plan's existing care management processes. It also summarizes the changes made to the Six Core Elements and describes the pilot process used for testing the use of the new tools. Finally, it presents the results of the pilot process and the plan's performance in implementing the Six Core Elements.

Methodology

Project Design

This transition pilot project took place over 18 months, with the first 9 months focused on customizing the Six Core Elements with plan officials and recruiting pediatric and adult practices and HSCSN enrollees. The final 9 months were devoted to piloting the new transition process and tools with a group of 35 young adult enrollees with chronic conditions and evaluating the results in terms of changes in HSCSN's transition process and in the pilot groups' receipt of recommended transition core elements as well as their self-care skills, transition needs, and experience with the transition process. Enrollees were selected from 3 pediatric primary care practices serving a large number of HSCSN enrollees. To ensure a smooth transfer, one conveniently located adult practice was also invited to participate.

Sponsoring Organizations

HSCSN and Got Transition were the collaborating partners responsible for this study. HSCSN is a specialty managed care plan that serves almost 6,000 enrollees from birth up to age 26, all of whom are SSI-income eligible and reside in the District of Columbia. Most young adult members have been in this Medicaid plan for many years. HSCSN provides a comprehensive set of health benefits, including behavioral health services, long-term care, and extensive care management support. Care managers within HSCSN are responsible for assessment, care plan development, care coordination, and ongoing monitoring and follow-up via phone and face-to-face visits. They work collaboratively with the enrollee and caregivers, their providers, relevant social service agencies, and others to ensure health care needs are met. Since 2012, HSCSN has offered an insurance transition service for its enrollees, ages 23 years and older, to prepare them for aging out of the plan on their 26th birthday. This involves developing a transition insurance care coordination plan, which includes all of the enrollees' providers and needs for adult disability services. This insurance transition plan does not explicitly address the range of health care transition supports that are part of the Six Core Elements described in the transition intervention below.

Got Transition is a federally-funded national resource center on transition that developed the Six Core Elements of Health Care Transition (2.0) (Got Transition, 2014). It is operated by The National Alliance to Advance Adolescent Health, a nonprofit organization that provides quality improvement assistance, research, and policy analysis to improve the delivery and financing of adolescent health care. Got Transition's co-director participated as a member of the authoring group for the AAP/AAFP/ACP statement on transition (American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group, 2011). The Got Transition authors have led several transition quality improvement efforts and education programs in the District of Columbia and elsewhere using the original and new Six Core Elements.

Young Adult HSCSN Enrollees and Pilot Sample

In 2013, when the planning for this transition project began, HSCSN had a total of 1,417 enrollees, ages 18–25, with mental health, developmental, and complex medical conditions that qualified them as SSI-eligible. Complex medical conditions include, for example, sickle cell disease, cerebral palsy, mitral valve stenosis, and blindness. To understand the transition-related service utilization patterns among this group, HSCSN claims data were initially analyzed. This analysis showed that a sizeable proportion of young adults, ages 22 and over, particularly those with complex medical conditions, were still being seen by pediatric providers. Approximately two-thirds of HSCSN's 18–21 year olds with chronic conditions were under the care of pediatric primary care providers (PCPs) and needed to transfer to adult PCPs in the next couple of years. In addition, a very high proportion of 18–25 year olds with chronic conditions, especially those with developmental disabilities (61%), made no primary care visit in the past year. Not surprisingly, emergency room visit rates for this group were excessive — twice as high as rates for those with complex medical conditions and mental health conditions (42% versus 19% and 20%, respectively). Based on the urgency of transition-related needs among its members, ages 18 and over, HSCSN decided to focus this pilot project on that age group and not on a younger adolescent group.