



Baylor Transition Medicine Clinic

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Medical Director



Project Background

- Baylor Transition Medicine Clinic (2005) Houston, TX

Provide a medical home to adolescents/young adults with a chronic childhood physical/intellectual disability or chronic disease.

Case management/case coordination services.

Medical and Social Worker consultative services.

Teach health care providers how to care for adolescents/young adults with chronic childhood conditions as they transition in to the adult health care system.



Who We Work With

- **Hospitals:** Texas Childrens Hospital, St. Lukes Hospital, St. Josephs Hospital, Shriners Hospital, Texas Institute for Rehabilitation and Research (TIRR), Harris County Hospital District.
- **Interest Groups/Organizations:** Down Syndrome Association of Houston, Spina Bifida Association Houston Gulf Coast, Asian Family Services, Family to Family, Families CAN program, Project Doc, The ARC of Texas, Brazos Bend Guardianship Services, Texana, ACTION –Transition support group
- **Health Insurances:** Molina, Evercare
- **Agencies:** DARS, DADS – CLASS Waiver Program, Aging and Disability Resource Center (ADRC), United Way of Greater Houston, Houston Center for Independent Living, MHMRA HCS Medicaid Waiver Program, Houston Council for Drug and Alcohol Abuse
- **Schools:** U. of Houston Graduate School of Social Work, UT Health Science Center Dental Branch, Vocational Advancement and Social Skills (VAST) Program at Houston Community College (HCC)
- **Business:** MEDCO, J&R Medical, The Wheelchair Shop, Maximus
- **Government:** Houston Mayor's Office for People with Disabilities, Texas DSHS, Texas DHHS



Clinic Stats:

- Current active patients 326
 - Insurance:
 - Private 109
 - Medicare 47
 - Medicaid 181
 - Ethnicity:
 - Caucasian 135
 - Black 89
 - Hispanic 85
 - Asian 17
 - Age:
 - 17-58
 - Most referrals to the clinic between 17-27
 - Majority Diagnosis – IDCP, Down syndrome, Spina Bifida, Autism, Neuromuscular Disorders, Genetic disorders





What have we learned?

- Transition is a process, not an event.
- Most patients haven't participated in a transition curriculum.
- Big gaps in school transition curriculums.
- Lack of opportunities for employment, supportive employment, adult day hab programs.
- Lack of health care providers in the community who will accept this group of patients.



Social Worker Consults 2008-2011:

- Grant Total 661
 - Person with a disability 64
 - Family Member 290
 - Professional 154
 - Organizations 60
- 28 counties, 8 states



Major Consult Issues

- Guardianship
- Waiver Programs
- Social Security Disability Determination
- Dental Care
- Mental Health
- Adult Medicaid vs. Pediatric Medicaid
- Accessing Case Management via Public Insurance Plans
- Maintaining Nursing Hours/Staying in the community
- Employment/supportive employment/adult day hab programs
- Maintaining Parent Private Health Insurance



Major barriers to this special population of patients receiving health care in the adult health care system.

- Shortages in the adult medical home workforce.
- Financial disincentives to care for this population of patients.
- Deficits in education or experience for adult healthcare providers.
- Limited outcome literature about transition health care and no information about best practices among receiving providers who accept these patients into adult practices.



Okurmura MJ etc, J Gen Intern Med 2008;23(10)

- When adult medical providers were exposed to the process of transitioning young adults in the context of their residency training experiences, they were much more likely to incorporate it into their practices after residency.



Trainees 2008-2011

- Medical students – 30
- Residents -
 - Internal Medicine – 38
 - Combined Internal Medicine-Pediatrics - 18
- Social Workers – 7
- Adolescent Med/Neuropsych Fellows – 4
- Speech Therapist – 1
- Others - 3

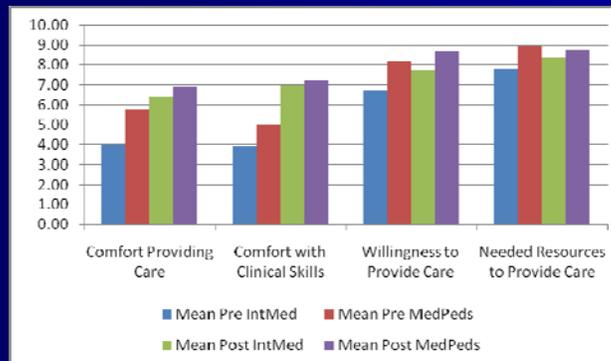


**Internal Medicine/Med-Peds
Residents' Attitudes About
Caring for Adolescent/Young
Adults with Chronic Childhood
Illnesses/Disabilities During a
Transition Medicine
Ambulatory Rotation**

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Figure 1. Increases in Internal Medicine and Medicine-Pediatrics Residents' Comfort and Willingness to Care For CCDD Patients Following a Transition Medicine Rotation



Curriculum for IM/Med-Peds Residents:

- TCDD Waiver Video
- People First Language
- Disease specific practice guidelines
- Social Worker exposure
- Medical Home Model
 - Prevention care
 - Acute illness management
 - Chronic condition management (CCM)
 - Written care plans, portable medical summary, care coordination, co-management techniques, transition plans



Continued Barriers

- *Reimbursement*
 - Enhanced reimbursement/case coordination services payment

- *Lack of health care providers*
 - “buy in” of community physicians



Going Forward

- Partnering/Co-management with a FQHC to deliver health care to adolescent/young adults with chronic childhood conditions.

- Education programs to adult health care providers regarding transition issues, health care needs of adolescent/young adults with chronic childhood conditions.



Conclusion

- Changes needed in UME and GME to train MDs in the principles of health care transition.
 - MDs are not trained in co-management or chronic condition management.
- More training sites to care for this special group of patients.
- Programs that engage community physicians.

