Transitioning Youth and Young Adults
into
Primary Adult Care

Project ACCESS
(Adolescents Connecting Care to Engage, Strive, and Succeed)

Guidelines
STAR TRACK Adolescent HIV Program
University of Maryland, School of Medicine

GOAL:
Project ACCESS will assist youth and young adults in self-managing their care so that they can successfully transition to adult services.

OVERVIEW:

- ❑ Medical provider's approval is required throughout transition process.
- ❑ Clients require transition to adult primary care prior to their 25th birthday, and should be appropriately guided as indicated below.
- ❑ Transition to adult care is inclusive of medical, psychosocial and case management care. Continuation of research participation will be based on research protocols.
- ❑ The transitioning process and needed services will be discussed as appropriate and across disciplines as needed.
- ❑ Transition is identified as completed 6 months after the final decision and initial visit to an adult provider, or as of the client's 25th birthday.
- ❑ Clients transitioning up to age 25 may continue to receive psychosocial and case management support if needed, continuing up to 6 months after transition.

Initiation Guidelines:
Linkage to adult services guidelines should be initiated

- Upon intake into the STAR TRACK program
- If currently in care, beginning at the 19th birthday and no later than 6 months from 25th birthday
- If referred client's 24th birthday is in the calendar year
- If clients independently identify a desire to transfer, and are over the age of 18 years of age.
- If the treatment team indicates a need for the client to transition, as evidenced by client's current needs not being met through STAR TRACK.

Overview of Responsibilities:

- The Transition Team, comprised of Primary Care Provider, Case Manager, Social Work, Youth Advocate, Psychiatry, and Outreach is responsible for:
    - Discussing client readiness at all points within the stages of transition
    - Ensuring Project ACESS Guidelines are adhered to

- The STARTRACK care management team is responsible for:
    - Providing supportive care according to their scope of practice during the transition process
    - Communicating relevant information to assist with transition process
    - Indicating necessary change in client's stage in the transition process (as long as they are not facing impending transfer due to age, or medical necessity)

- Care coordinator is responsible for
    - Initiating discussion of transition process according to initiation guidelines
    - Overseeing the transition process and monitoring the client's process
    - Following up with clients for 6 months after transfer to ensure successful linkage to care
    - Ensuring proper documentation is completed internally and with outside agencies or care facilities

- Social Worker is responsible for:
    - Determining, with Primary Care Provider, clients eligible for transition
    - Maintaining updated master list of clients in transition process
    - Coordinating with Care Coordinator to ensure all stages of transition process are appropriately documented

- Outreach Staff is responsible for:
    - Establishing and maintaining links to adult care HIV sites
    - Coordinating with Care Coordinator to ensure required paperwork (e.g. referrals) are provided for client to link to adult care site.

- Youth Advocate will be responsible for providing appropriate support around navigating adult services as needed.

- The Transition Team and STAR TRACK care management team will document all services provided to client regarding transition process

Guidelines for *Project ACCESS:*

The initiation and engagement in Project ACCESS is directly affected by the client's age, medical necessity and readiness. P*roject ACCESS* is staged based and fluid process comprised of two options outlined below:

Option 1 - Long Term Plan

- May be completed within 6 months to 2 years - depending on need, age and readiness of the client
- Option is for clients who do not need imminent transfer within the next 6 months, or who do not have acute medical or other needs that require the need to transition imminently

Option 2 – Short Term Plan

- Must be completed within 6 months or less
- Option is for clients needing imminent transition to adult services

Stage Overview:

The time table of the Stages will be as follows, however will be adjusted accordingly to short or long term option. There may be several appointments within these identified timelines to assist with moving forward in the transition process:

- **Stage I** – Introduction to Project ACCESS process
  - Initiated upon identification of need to transfer and discussion of transition process with client
- **Stage II** – Initiation of Project ACCESS process
  - 2 weeks to 1 month after initial discussion with client
- **Stage III** – Evaluation of Project ACCESS process and identification of transition sites
  - 1-2 month months after Stage II is initiated
- **Stage IV** – Evaluation of transition sites and identification of primary care site
  - 1-2 months after Stage III
- **Stage V** – Initial Visit and Evaluation to Adult Care Services / Primary Care
  - 1- 2 months after Stage IV – based on appointment availability
  - 2 wks -1 month after initial primary care visit
- **Stage VI** – Closure
  - 1-3 months after initial visit and establishment in a primary care site

NOTE: Stage V may be repeated one time if site is inappropriate for client or client needs/financial status changes.

Stage I – Introduction of Project ACCESS

Goal: Client will become aware of and prepared to initiate Project ACCESS.

Objectives:

- Client will begin to identify knowledge, attitude, and beliefs around transitioning.
- Client will be able to identify 3 barriers to transitioning.
- Client, with assistance of *staff* will be able to identify a timeline and option plan.

Roles & Responsibilities:

- Care Coordinator
  - Initiate discussion with client and with care management team
  - Discuss self management and transitioning to adult services with client
  - Assess readiness for transitioning and needs for self management with client

        - Assist client in identifying 3 goals for self management required in the process for Project ACCESS
        - Assist client in identifying an Option Plan for transition
        - Document initiation of discussion and plan by the care coordination team and client to proceed to Stage II in the transition process.
    - Social Work
        - Initiate and continue discussions with client about Project ACCESS
        - Provide supportive counseling around assisting the client toward self management.
        - Assess emotional, psychosocial, and environmental readiness and needs for transitioning and self-management
        - Assist client in identifying 3 goals for self-management required in the process for Project ACCESS
        - Document and communicate with care management team identified needs
    - Primary Provider
        - Support discussion around the process of transition and transitioning to adult services

Stage II – Initiation of Project ACCESS

Goal: Client will formally initiate the process of transition to adult services.

Objectives:

- Client will identify their specific needs to successfully actualize their Project ACCESS plan, as evidenced by the client's ability, with care coordinator and social worker, to prioritize and identify required steps.
- Client will identify their attitudes and beliefs regarding primary care sites – pros and cons.
- Client will initiate discussion with Care Coordinator and Social Worker their knowledge, attitudes, and beliefs on transitioning their care.

Roles

- Care Coordinator
    - Discuss differences between adult and Adolescent/Pediatric care services
    - Client will write out, with the assistance of *Project ACESS* team, a plan of care to transition to adult services which includes the following:
        - A time line for transitioning
        - Items required for self management in order to facilitate transition. (e.g. insurance, housing, and/or job support)
- Social Work
    - Provide supportive counseling in discussing differences between adult and Adolescent/Pediatric care services.

- Provide support around insurance, housing, employment, and external supportive resources to assist the client in self managing.
- Review plan of care with medical and psychosocial providers for input.
- Document changes needed in plan of care and supportive counseling needs.

- Psychologist
  - Provide supportive counseling about their feelings and potential barriers to transitioning to adult services.
- Primary Provider
  - Give input into requirements and provide assistance for the client to proceed in *transition* process.
- Outreach
  - Give input into requirements and provide assistance (as appropriate) for the client to proceed in the *transition* process.
- Youth Advocate
  - Provide appropriate support around navigating adult services as needed.

Stage III - Evaluation of Transition Process and Identification of Transition Sites

Goal: Client will demonstrate active participation in the transition process and efficiency in self management skills.

Objective

- Client will, with assistance of *transition* team, evaluate needs identified in stage 2.
- Client will, with assistance of *transition* team, identify 3 potential sites for transitioning and schedule visits.
- Client and *transition* team will re-evaluate plan and make changes as needed for the client's self management.

Roles

- Care Coordinator
  - Assist client in reviewing *Project ACCESS* care plan and adjust as needed with client. This plan must include the following:
    - Timeline for transitioning
    - Items required for self management (e.g. insurance, housing, job support)
  - Care coordinator will assist client with identifying 3 sites to visit.
  - Care coordinator will assist the client in developing a plan for visiting primary care sites.
  - Communicate with care management team the updated *Project ACCESS* plan.
- Social Work
  - Provide supportive counseling around transitioning to adult services, and offer external supportive resources, as needed.

        - Assist with follow-up for wrap around services and self management.
        - Document changes in transition plan and supportive counseling needs.
        - Provide supportive counseling during adult site visits and assess barriers.
    - Primary Provider & Psychologist
        - Give input into requirements and provide assistance for the client to proceed in *transition* process.
    - Outreach
        - Give input into requirements and provide assistance for the client to proceed in *transition* process.
    - Youth Advocate
        - Provide appropriate support around preparation to visit adult sites.
        - Continue to provide appropriate support around navigating adult services, as needed.

Stage IV - Evaluation of Transition Sites and Primary Care Site Identification

Goal: Client demonstrates positive self management behavior as evidenced by the ability to independently identify a desired primary care site and necessary steps for successful transfer.

Objectives:

- Client will, with minimal assistance, be able to identify pros and cons of visits of sites and identify site for transfer.
- Client will, with minimal assistance, complete list of needs for successful transfer. (tool to be used here)
- Client will schedule initial primary care appointment with adult site.

Roles

- Care Coordinator
    - Provide support to the client in reviewing, updating and completing their *transition* plan.
    - Communicate with care management team the updated plan.
    - Ensure a release of medical information to new sites is in chart and that appropriate medical records are obtained to transition to adult services.
- Social Work
    - Provide support to the client in reviewing, updating, and completing their plan of care.
    - Ensure a release of mental health information is in chart and that appropriate mental health and psychosocial information is relayed to adult site.
- Primary Provider
    - Provide support in the transitioning process.

        - Provide necessary medical information and summary of history of client to the adult medical provider once release of information is signed and in the cart.
    - Youth Advocate
        - Provide Support in transitioning as appropriate or identified by care management team

Stage V - Initial Visit and Evaluation of Adult Care Services/Primary Care

Goal: Client will actively participate in adult care site services.

Objectives:

- Client attends initial primary care visit and schedules a follow up visit with adult care site.
- Client will independently identify any further requirements or questions needing clarification for transfer.
- Client will have return visit with pediatric or adolescent care site to evaluate transition process.
- Client will indicate satisfaction with visited transfer site.

Roles

- Care Coordinator
    - Provide support to the client in completing *transition* plan.
    - Communicate with care management team completion of *Project ACCESS* process.
    - Assess if client needs to repeat stage IV or continue to stage VI.
- Social Work
    - Provide support the client in completing *transition* plan.
    - Assess and provide supportive counseling around any potential barriers to transition to adult services.
- Primary Provider
    - Document successful transition, as applicable in cart
- Youth Advocate
    - Provide support in transition process, as appropriate.

Stage VI– Closure

Goal: To effectively close the case and complete formal evaluation of case closure and transition process.

Objectives:

- Self management team evaluates transition process.
- Documentation of closure.

Roles

- Care Coordinator
    - Contact client 1-3 months after transition to ensure adherence to care.

        - Discuss/review transition process with client.
- Social Work
    - Assist with follow up, if required.
- Primary Provider
    - Assist with follow up, if required.