TRANSITION PLANNING BY HEALTHCARE PROVIDERS

Document a patient’s achievement of self-care tasks. Determine if the patient:
• understands and can explain her diagnosis
• can name his medications and explain what they are for
• is responsible for taking her own medications
• knows his insurance carrier, and has his own card or a copy
• makes her own medical appointments
• knows the symptoms/signs that require a phone call to a provider
• gets to appointments independently
• meets alone with the provider
• understands risk factors that can worsen his medical conditions

As the patient approaches transition:
While preparation should start with diagnosis, the process of actually transitioning to an adult provider should take about one year.
• Prepare the patient and family for change.
• Provide the patient and family with contact information of a few adult providers.
• Try to match the patient with a new provider as well as you can.
• When choosing potential providers, also be sure they take the patient’s insurance and also are conveniently located and accessible.
• Explain an adult provider’s expectations of an adult patient to provide all healthcare information.
• Encourage families to stay involved, even though patient is now the primary decision maker.
• Assist with insurance sustainability and, if there are immediate changes, evaluate the best time for transition.
• Identify patient resources in the adult setting to ensure continuity of resources after transition or locate community resources to support the patient.
• Troubleshoot with patients in making appointments.
• Ideally make the patient’s first visit with his new provider before his last visit with you, perhaps as a consult visit.
• Copy records (see documents to copy and send below) for the patient.
• Provide a one- or two-page medical summary for the patient to take with her (and fax it to the new provider) that contains up-to-date lists of problems, medications, allergies, contact information for all of the patient’s new and old providers, and an up-to-date treatment plan.
• Refer the patient for Care Coordination and/or a Care Binder if your patient’s care is complex.

Documents to copy and send:
• medical summary
• office visit notes (one year)
• complete list of medications
• hospital admission summaries (past year and any significant ones)
• labs/studies/test results (last six months and any significant or unusual results, both positive and negative)
• radiological reports (past year and all major scans)
• team consults and letters from subspecialists (latest ones and only ones from those who have only been seen once)
• insurance information
• give a copy to the patient