

Frequently Asked Questions – Transition Plan Tracker

Last Updated: 2/1/24

This FAQ will be updated to reflect additional questions and answers over time.

To uniformly track transition plans across HTC as part of HRSA funding objectives for the 2022-2027 grant cycle, HRSA is asking that HTCs track transition plans for:

- all patients who participated in a comprehensive care visit -AND-
- are age 12-26 (at time of visit) -AND-
- are not HHT, hemoglobinopathy, or SCD patients.

Data collected from 10/25/2023-5/31/24 will be considered the baseline year. After that, data collected from HTCs will be reported to the Regional Core Center each summer through the HRSA grant cycle (ending 5/31/27). HRSA has asked for the process to work as follows:

- In late June/early July, HTCs run a transition plan tracker report from the Reports page in ATHN Systems, Clinical Manager and send it to their Regional Leadership (similar to the way HTDS reports are gathered);
- Regions will then share their data with the NHPCC;
- The NHPCC will aggregate the data in a national report to HRSA.

In response to multiple queries from HTCs and Regional Core Centers, as of 11/27/23 HRSA has issued new guidance regarding how to handle patients who have already transitioned to adult care:

- If a patient has already transitioned to adult care, centers (adult and lifespan) who work with adults may mark “yes” to the question on the tracker that reads “Is there a transition plan in place?” This is true even if the HTC has not developed a transition plan for the patient. In this scenario, please also answer “not documented” and “not discussed yet.”
- However, if your HTC works with patients who have already transitioned to adult care, and your HTC wishes to track transition plans for such patients, it is also acceptable for you to complete the three questions (Is there a transition plan in place?, Where is the transition plan documented?, and Who has the transition plan been discussed with?) to accurately reflect your HTC’s approach. *This option allows HTCs that do transition planning with patients after transitioning to adult care to accurately reflect their approach.*

Please see the decision trees at the end of this document for a visual representation of HRSA guidance.

The following questions and answers pertain to the Transition Plan Tracker in Clinical Manager, which launched on October 25th, 2023.

TRANSITION PLAN

What is the definition of transition with regard to this? We are a lifespan center and we have patients who are already established with our adult providers. Do we need to have a transition plan for those patients (who are within the age range)?

The Transition Plan Tracker in Clinical Manager focuses on transitioning patients from pediatric to adult healthcare models. HRSA states the following, “Health care transition is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician. Transition from pediatric to

adult health care is part of a larger theoretical framework for transition affecting all youth, young adults, and families, and can include transitions in non-health settings, e.g., education, employment, and living situations.” For your second question, yes, HRSA is asking that all HTC’s, regardless of type (peds, lifespan, adult), track transition plans for all patients within the age range 12-26 and with the diagnoses included (exclusions are hemoglobinopathies, HHT, and sickle cell disease).

What is the definition of a transition plan? Can you share an example?

HRSA purposefully didn’t define what a transition plan was, knowing that HTC’s do such different things that they consider a transition plan. Please connect with your Regional Leaders if you would like to discuss definitions further. Another resource for exploring transition plans further is Got Transition – [resources for pediatric providers](#), [resources for lifespan providers](#), and [resources for adult providers](#).

Is it okay if an HTC does not have a documented transition plan in use right now? I do not think that we would be ready to have a finalized plan in use during this grant year.

The approach with the transition planning tracker is very much “start where you are” and move forward/upward from there! It is totally okay to not have all of this in place now. HRSA, the regions, and NHPCC all understand that. Note, too, that nothing has to be in the EMR tied to transition plan tracking. If that is how your HTC would like it, of course that’s fine, but there is no requirement for the transition plan to be in the EMR tied to tracking for this HRSA objective. If your HTC would like to take some time to decide how you will approach transition planning and using the tracker, that is very appropriate.

In the Transition Plan Tracking pdf tutorial, it’s mentioned that an action plan should be completed for all patients each year a comp care visit is done. Does this mean we submit a new action plan each year for the same patient (age 12-26) as long as a comp visit is done? For example, if an 18 yo patient starts at our HTC and has a comp visit every year, the patient would have 9 action plans submitted by the time of age 27?

As of 11/27/23, HRSA has issued updated guidance about how to track transition plans for patients who have already transitioned to adult care – see note at the top of this document. For HTC’s seeing patients who have already transitioned to adult care, please follow the guidance at the top of this document. *Here is some additional related information:* Based on [Got Transition](#) (the HRSA-supported, evidence-driven framework for transition) – specifically the [Initial Visits core element](#) (primarily pgs 2-4) for receiving adult providers and the [Transition to Adult Approach to Care core element](#) (primarily pgs 2-4) for lifespan providers – it’s possible that a patient would be on a transition plan for some time even after transitioning to an adult center. For example, not all patients who transition from pediatric to adult healthcare will be exactly the same in their skills and knowledge tied to independently ordering all prescriptions, independently making all appointments, managing all relevant insurance changes, etc. Therefore, it’s possible, or even likely, that some patients will be on some kind of transition plan for some time even after they are officially transitioned. This transition plan tracker would capture these individuals. That said, we know that there ARE cases where patients transition from pediatric to adult care and really have checked all the boxes of being ready for that (they are ordering medications independently, making appointments, etc).

Our HTC is concerned that our data in the Transition Tracking Report might not be representative or won't reflect well on our transition-related work if we follow the 11/27 HRSA guidance about already transitioned patients (noted at top of FAQ). What should we do about this?

The Transition Tracker was originally designed to only capture the number of patients in the 12-26yo. age range who have a healthcare transition plan. Follow-up questions regarding discussion and documentation were therefore designed to be relevant to this group. However, the Tracker and its accompanying report have evolved to now also capture the number of patients in the 12-26yo. age range who have already transitioned to an adult provider. HRSA made this decision with the intention of capturing the transition-related work that *all* HTCs are doing. Questions about plan discussion and documentation were not originally designed with this latter group in mind. HRSA acknowledges that HTCs marking 'Yes' to having a transition plan--in order to capture patients who have already transitioned to adult care, as opposed to having a transition plan--will likely have low numbers for plan discussion and documentation, as these questions were not designed with those patients in mind. *Optional:* When reporting, HTCs can choose to add a note to their Regions to say 'X number of patients' are in this situation (have transitioned to adult care as opposed to have a transition plan); this will help illustrate why documentation and discussion numbers are lower while the number for "having a plan" is higher.

How should an HTC track patients who are cognitively delayed such that they are not expected to take on management of their own care?

HRSA would like for the HTC's answers in such cases to reflect what is happening. If the HTC is creating a transition plan – even one that is focused on the caregiver's preparation for moving the patient to adult care – then "yes" should be marked for "Is there a transition plan in place?". If there is not a transition plan created yet or there may never be a transition plan due to the circumstances, then please respond to that question with a "no" and you can then note the reason why there isn't a transition plan in the Tracker in Clinical Manager. Similarly, with the subsequent questions on documentation and discussion, please answer based on what is occurring and the specifics with that patient. HRSA encourages HTCs to share their experience with the Tracker—anything positive or negative—with regional leadership via the mid-year reporting survey. Your feedback to regional leadership will provide context to the transition plan data you report in the Tracker, and in turn the Regional Core Center can share this feedback in their NCC report to HRSA.

DATA COLLECTION & REPORTING

Will HTCs submit a transition plan annually? Some of our patients have >1 comprehensive visit/year.

HTCs should record a transition plan no more than one time per year for eligible patients (ages 12-26, have comp care visit, and with an included diagnosis).

Should HTCs enter data from prior to October 25th, 2023?

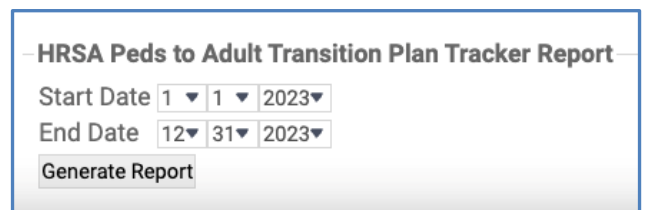
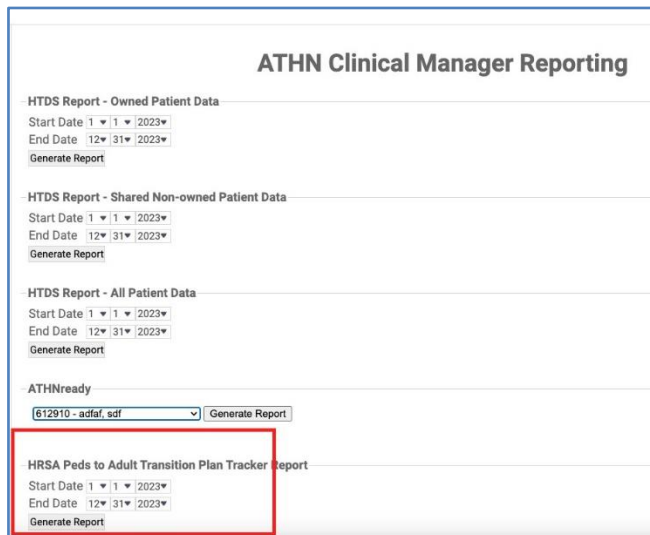
No, there is no need to enter data from before October 25th, 2023. The baseline data collection period is October 25th to May 31st, 2024. Information on transition plans from prior to October 25th is not needed.

I am concerned that the baseline data is just now being collected. If we have been doing transition planning on 100% of patients in this age group since beginning to work towards this HRSA goal a year ago, how will we increase from that baseline by 25%?

HRSA made the decision that it wanted a standard way for every HTC to collect the information on transition planning this past spring 2023, so ATHN worked as quickly as possible to develop the plan for that with Regional Leadership and the QI Data Workgroup (which includes HTC staff). Previous to October 25, 2023, HTCs couldn't uniformly track transition plans for the baseline. Some HTCs may already be doing transition planning very thoroughly with their patients in this age range, but because HTCs may do this in various ways, HRSA asked for a uniform approach. The Transition Plan Tracker in Clinical Manager is that uniform approach. *HRSA has been clear that if HTCs are already performing well in this objective (based on comparing the baseline data collection of uniform tracking that runs Oct 25, 2023-May 31, 2024 to later years of data), then there is nothing to worry about – this is a success! There isn't a penalty for high performance.* The hope is that over the next few years of this funding cycle, we are able to see widescale improvements in transition planning as an intermediate step toward successful transitions to adult healthcare. It sounds like you are well on your way to meeting this objective based on your current workflow, and this tool will be the approach to sharing that success with your region and HRSA.

I was looking in ATHN reports for the report to run in December. Has it been added yet to the reports production folder?

The report is available on the main Reports screen, entitled 'HRSA Peds to Adults Transition Plan Tracker Report'. Please see the following screen shots for reference:



What if a patient has a transition plan in place from their comp care visit last year, and then this year something happens during their comp care visit that prevents us from addressing transition (ex: there is an acute issue, or an emotional event, and it isn't appropriate or possible to address transition at this comp care visit), should we mark that they have a transition plan or not?

If the patient has not transitioned to adult care yet, please mark that the patient does not have a transition plan, because the transition plan tracker is designed to be updated annually. Therefore, if the transition plan is not reviewed and updated, then a no answer is most appropriate here. Once you mark no, the subsequent questions (about documentation and who the plan has been discussed with) will not show up for the person doing data entry.

What documentation needs to be in the EMR in order for the data manager (or other staff who will complete the transition plan tracker in Clinical Manager) to complete the transition plan tracker? Does HRSA have plans to audit HTC's for background documentation?

HRSA does not require that any information be in the EMR. Whether or not an HTC tracks transition in an EMR is the HTC's choice. The HTC staff should decide on their own process for how the staff member responsible for entering data into Clinical Manager will get the information to complete the tracker. That is likely to look different at different HTC's, but ensuring that the person doing data entry has access to the information needed is indeed key to being able to report your HTC's transition plan data via this tracking system. At this time, HRSA does not have any plans to audit HTC's for background information supporting the tracking in Clinical Manager.

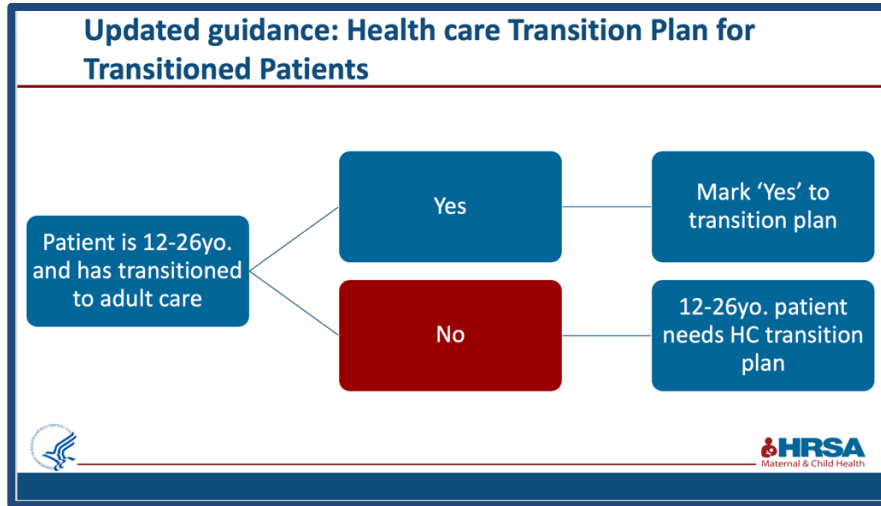
ADULT HTC's & TRANSITION PLAN TRACKING

Does an adult center really need to do a transition plan every year for patients who have already transitioned from pediatric to adult care?

As of 11/27/23, HRSA has issued updated guidance about how to track transition plans for patients who have already transitioned to adult care – see note at the top of this document. Based on [Got Transition](#) (the HRSA-supported, evidence-driven framework for transition), it's possible that a patient would be on a transition plan for some time even after transitioning to an adult center. For example, not all patients who transition from pediatric to adult healthcare will be exactly the same in their skills and knowledge tied to independently ordering all prescriptions, independently making all appointments, managing all relevant insurance changes, etc. Therefore, it's possible, or even likely, that some patients will be on some kind of transition plan for some time even after they are officially transitioned. This transition plan tracker would capture these individuals. That said, we know that there ARE cases where patients transition from pediatric to adult care and really have checked all the boxes of being ready for that (they are ordering medications independently, making appointments, etc).

Do you have a question that is not addressed here? Please submit to support@athn.org.

Decision tree for patients who have transitioned to adult care



Overall decision tree on using the Transition Plan Tracker

Note: If your HTC serves adults and your practice is to complete transition plans for those who have already transitioned to adult care, please have your responses on the tracker reflect your HTC's actual process related to documenting and discussing transition plans.

