Children and Youth with Special Health Care Needs (CYSHCN) and Care Transitions in the Medical Home

Develop a Care Transition Team

Gather a Team

1. **Choose members to serve on the Care Transitions team.** Depending on the size of the medical home, the team may be very small (two or three members) or large (five or six members). At a minimum, the Care Transitions Team should include several individuals with different responsibilities in the medical home, such as care coordination specialists, pediatric/adult care nurses, medical directors, pediatric/adult care and possibly an information technology staff member (if the home uses electronic health records). If possible, include outside consultants such as a consultant pharmacist, prescribing clinician, and/or family representative. Staff may already consult with these individuals and developing new relationships may not be required to start a program. Including medical home leadership will help the program receive adequate support and attention, and improve the likelihood that it will succeed.

2. **Familiarize the team with CYSHCN Transitions.** It is likely that many staff may be new to transitions care. The team must learn about helping CYSHCN transition to adult care and understand why it is important. There are many online resources that team members can review. GOT Transitions Web site is a good place to start and includes links to many relevant resources, including the following:

   a. Got Transition's Transitioning Youth to Adult Health Care Providers
   b. Transitioning to an Adult Approach to Health Care Without Changing Providers
   c. Integrating Young Adults into Adult Health Care
   d. Six Six Core Elements of Health Care Tranistion 2.0

   A bibliography of journal articles is also provided below.

3. **Appoint two champions to promote the importance of pediatric to adult care transitions in the medical home**. These individuals should lead the effort and be responsible for program outcomes. Two champions are recommended to increase the chance that the care transitions program always has a leader through periods of staff change. These champions should have the following qualities:

   a. A basic knowledge of care transitions
   b. An interest in playing a leadership role in the medical home
   c. The respect of his or her peers
   d. An understanding of how to be a good team player
   e. An understanding of the importance of improving care transitions for CYSHCN

4. **Assign initial roles and responsibilities.** Assign roles and responsibilities within the team for initial tasks like scheduling meetings and conducting the readiness assessment, as well as long-term tasks like monitoring the program. Suggested roles include:
    a. Champions: develop agendas and policies, lead training, provide leadership and support
    b. Care Transition staff: Help develop training, review use of tools, remind staff to use tools, help solve problems with implementation
    c. Monitoring staff: Abstract data for monitoring, develop findings and communicate them