Outcomes at Ten Years of an Integrated Transition Model
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Background
MetroHealth Comprehensive Care Medical Home Program at MetroHealth is a 55+ year old program located in Cleveland Ohio. CompCare is the only Northeastern Ohio Program that delivers both primary care and multidisciplinary specialty care to children, youth and adults with childhood onset Special Health Care Needs. (CYASHCN) By 2000, the program was serving 550 individual patients with approx. 2500 annual visits. In 2004 an “Adult Provider” role was established within the CompCare Program, allowing seamless transition. Double boarded Internal Med/Peds Providers as well as Medicine Subspecialists are integrated into the Pediatric Clinic and introduced to the patient and families, and assume care throughout the transition years so that by age 25 years they are no longer being cared for by persons trained as Pediatric Specialists.

Staffing in 2000: 3.5 FTE Pediatricians, 1.0 FTE Ped Nurse Practitioner, and 1.0 FE SW /Program Coordinator, and 2 FTE office support staff, 0.5 FTE Nutrition

Method/Procedure
Subjects
- Electronic Medical Review of Epic Medical Records and Registries
- 1478 individual patients
- Age 18 and older 748 (51%)
- Age 21 and over 617 (43%)
- Age 25 and over 482 (33%)
- Sex: 612 female(42%), 866 male (58%)
- Age 19 and older, 301 female (43%), 403 male (57%)
- 3715 outpatient visits

Results
Growth of Number of Adults (over 18 years)

Acuity Calculation and Distribution

Discussion
Data support provider and parent observations that the Adult program has expanded rapidly, and the population of new patients to the program starting around age 18 has required additional supports. RN phone triage was added in 2005, and RN Care Coordinators in 2009. Acuity scale was developed internally starting in 2009 and ideally is to be used for scheduling as well as triage and coordination. In 2011 MH CompCare was awarded a NCQA (National Center for Quality Assurance) Level 3 Medical Home Status, re-certified in 2014.

2015 staffing 2.6 FTE of Physicians (1.0 Neurodevelopmental Disabilities Pediatrician and 1.6 IM/Peds Providers, 1.0 FTE RN phone triage nurse, 3.0 FTE RN Care Coordinators, 0.5 FTE SW and 2.0 office support staff, 0.5 FTE Nutrition

Number one diagnosis at time of referral for new adult patient is “Intellectual Disability” Continued efforts to obtain additional medical records as well as cognitive and educational testing performed prior to this has been difficult for any patient no longer in High School Education, or no longer living with birth parents

Patients have Internal Medicine Subspecialty Evaluation by “adult” providers based on need, Age to transfer inpatient care to adult floors has moved from 25 years in 2000 to 21 years in 2006 and back to 25 years in 2015. RN V Care coordinator concentration will be adjusted to meet change in demographics.
Numbers of Adult Patients by Age