



Medical Home Health Care Transition Index for Adolescents and Young Adults Age 18 and older

Introduction:

The **Health Care Transition Index for Adolescents and Young Adults Age 18 and older (HCTI >18)** provides observable indicators related to the organization and delivery of health care transition* support for all young adults, including those with special health care needs. Transition care is an integral component of a high quality medical home**, representing the planned and coordinated transition from child and family-centered pediatric health care to adult-oriented health care. The **Health Care Transition Index for Adolescents and Young Adults Age 18 and over (HCTI \geq 18)** should be used in all health care settings for young adults age 18 and over.

Purpose:

The HCTI \geq 18 invites you to assess the level (Levels 1-4) of your practice in six transition domains: 1) office policy 2) staff and provider knowledge and skills, 3) identification of transitioning youth, 4) preparation, 5) planning and 6) transfer of care. Many practices will not function at the higher index levels (Levels 3 and 4). However these higher levels represent the kinds of transition services and supports that families and young adults say that they need from their medical home. A frank assessment of current practice will best characterize baseline health care transition activity of your practice and help to identify areas for active improvement.

Background:

The HCTI \geq 18 is modeled after CMHI's (Center for Medical Home Improvement) validated Medical Home Index, a primary care office practice self-assessment and classification tool (www.medicalhomeimprovement.org). The HCTI \geq 18 is a measure of health care transition support in practices providing an adult model of care. It views the incorporation of "transition" supports into practices as an evolutionary process, rather than a fully realized status in most settings. The Index is designed to align with the recommendations of the AAP/AAFP/ACP joint clinical report and algorithm on health care transition (Pediatrics, 2011). As a companion tool to the Medical Home Index, the HCTI \geq 18 is intended for use within any setting that is *accepting* youth to transition to adult-oriented care. It may be used *with* the Medical Home Index or as a "stand-alone" tool to assess the implementation of health care transition practices. This adult version is not designed for transition related care provided to youth prior to age 18. For more information about health care transition, visit www.gottransition.org

* **Definition of Health Care Transition:** *The purposeful, planned and timely transition from child and family-centered pediatric health care to patient-centered adult-oriented health care. (Society for Adolescent Medicine, 1993) {Note this definition is repeated on most pages throughout this document}.*

* **Medical Home:** CMHI defines the medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management — across the lifespan.

INSTRUCTIONS:

The Medical Home Health Care Transition Index has six themes including: 1) Office Health Care Transition Policy, 2) Staff and Provider Knowledge and Skill, 3) Identification of Transitioning Youth, 4) Transition Preparation, 5) Transition Planning, and 6) Transfer of care. The HCT Index measures your practice’s progress along a continuum of performance from Level 1 to Level 4 using an aligned Liker scale from 1-8.

For each theme please do the following:

- First:** Read each theme across its *progressive* continuum from Levels 1 to Level 4
Note: To achieve Levels higher than Level 1 your practice must address/perform all activities within each previous level.
- Second:** Select the LEVEL (1, 2, 3 or 4) that best describes how your practice currently addresses transition support and services.
- Third:** When you have selected the Level, then, within that level, indicate whether the **practice** performance is to be scored as:
“PARTIAL” (some activity consistently performed within that level) or
“COMPLETE” (all activity consistently performed within that level).

EXAMPLE:

For the example below, "HCT 1: Office Health Care Transition Policy" "**Level 3**" and "**Partial**" were selected (score of 5 on a scale of 1-8).

Indicator	Level 1 (Basic)		Level 2 (Responsive)		Level 3 (Proactive)		Level 4 (Comprehensive)	
1: Office health care transition privacy and consent policy	Some providers in the practice will accept new patients who are young adults. Office staff is informally aware of receiving new young adult patients 18 years or older. Discussion among the practice staff only occurs if problems arise.		There is a uniform, clearly written practice-wide privacy and consent policy for receiving new patients that discusses the young adult’s right for privacy and consent. This policy is agreed upon by all providers and shared with staff. The care of young adults transferring care from pediatric practices adheres to this policy.		In addition to level 2, the practice has displayed this practice-wide privacy and consent policy (posters, brochures, website, etc.) to explain practice policy for patients by discussing their right for privacy and consent for medical care. These policies are also handed in writing to new patients \geq age 18 at the time of their first visit.		In addition to Level 3, the written health care transition privacy and consent policy addresses guardianship information and who should/should not be given access to patient information. By age 18, guardianship, decision-making, and information access rights are determined and clearly identified in the medical record. Practice services include transition encounters, care coordination, & monitoring of steps/progress.	
	Partial	Complete	Partial	Complete	Partial X	Complete	Partial	Complete

Health Care Transition Index (HCTI) – Young Adult Version

Indicator	Level 1 (<i>Basic</i>)		Level 2 (<i>Responsive</i>)		Level 3 (<i>Proactive</i>)		Level 4 (<i>Comprehensive</i>)	
1: Office health care transition privacy and consent policy	Some providers in the practice will accept new patients who are young adults. Office staff is informally aware of receiving new young adult patients 18 years or older. Discussion among the practice staff only occurs if problems arise.		There is a uniform, clearly written practice-wide privacy and consent policy for receiving new patients that discusses the young adult’s right for privacy and consent. This policy is agreed upon by all providers and shared with staff. The care of young adults transferring care from pediatric practices adheres to this policy.		In addition to level 2, the practice has displayed this practice-wide privacy and consent policy (posters, brochures, website, etc.) to explain practice policy for patients by discussing their right for privacy and consent for medical care. These policies are also handed in writing to new patients \geq age 18 at the time of their first visit.		In addition to Level 3, the written health care transition privacy and consent policy addresses guardianship information and who should/should not be given access to patient information. By age 18, guardianship, decision-making, and information access rights are determined and clearly identified in the medical record. Practice services include transition encounters, care coordination, & monitoring of steps/progress.	
	Partial	Complete	Partial	Complete	Partial	Complete	Partial	Complete
2: Staff and provider knowledge, skills and coordination of care	Specific standards for health care transition training, knowledge and skills and the expectations of providers and staff are variable and dependent upon each individual’s interest and usual practice.		Providers/staff are aware of the AAP/AAFP/ACP joint clinical report on health care transition (Pediatrics 2011) and/or other sources of health care transition “best practice.” When individual families and youth ask for transition assistance the office team meets immediate requests as time and knowledge allows.		In addition to Level 2, providers and staff follow the progressive steps of the HCT joint clinical report (2011); its associated algorithm is posted as a reference. The office team uses encounters, readiness checklists, and other methods to assess young adults transition to monitoring their own health care needs including self-care education, communication with health care providers, and active engagement in coordinating their own care.		In addition to Level 3, in partnership with the young adult and others legally responsible for the health care of the young adult (if necessary), the office team adds skilled care coordination to oversee the ongoing use of transition to self care tools (e.g. for assessment, goal setting, care planning). Information & resources address health and non-health related areas such as work and post secondary school issues. The EHR incorporates the joint clinical report HCT algorithm and provides prompts and templates for HCT activities.	
	Partial	Complete	Partial	Complete	Partial	Complete	Partial	Complete

3: Identification of transitioning young adults	Transitioning young adults are identified during their first encounter in the practice or when providers or staff recognizes the young adult is <u>≥18</u> .	Some transitioning young adults are identified for focused attention, during encounters, and/or in response to questions posed by the young adult and legal guardians. Practice provider/staff time & interest determines the subsequent level of intervention.	In addition to Level 2, transitioning young adults (or a significant sub-group, e.g. those with asthma) are actively identified and enrolled in a HCT registry – a paper or electronic database used to document transition process. Young adults or health surrogate (if needed) transition to self-care skills, and next steps.	In addition to Level 3, team members coordinate care using an electronic HCT registry to track young adults with special health care needs & the complexity of their condition; the team systematically tracks completion of all HCT steps for each young adult.
	Partial Complete	Partial Complete	Partial Complete	Partial Complete
4: Transition preparation	Young adults \geq age 18 are seen alone (if no legal health surrogate is needed).	In addition to Level 1, some young adults can describe their basic health and wellness needs, risk behaviors, allergies, personal and family health history, and insurance coverage. Young adults with chronic conditions also acquire knowledge about their condition and related medications, specialists, and emergency care needs according to their ability.	In addition to Level 2, a practice transition checklist is used to document all young adults’ knowledge of their own health needs; the team provides education and support to the young adults acquisition of self care skills. Transition completion targets knowledge gaps and builds young adult skills; young adult can “teach back” their grasp of each check list item.	In addition to Level 3, youth/legal health surrogates/guardians work with staff and/or transition care coordinator to solidify transition related skills and self-determination. They participate in the development/updating of their portable medical summary. This summary “travels” with each young adult as they move on to other providers, specialists care, or settings (ER, college, military).
	Partial Complete	Partial Complete	Partial Complete	Partial Complete

<p>5: Transition planning</p>	<p>Practice will answer basic questions about the office by phone upon request of families/youth/young adults who are preparing to transition to the practice. There is interest by providers in learning about patients with pediatric onset chronic conditions.</p>	<p>Practice encourages a “walk through visit” for new young adult patients to meet office staff and learn about practice privacy and consent policy. Opportunity for families/youth/young adults to answer questions exists. At the first encounter, some young adults are given the opportunity to complete a one page medical summary documenting their medical and family history, diagnosis/condition, medications, and allergies</p>	<p>In addition to Level 2, if a patient has an unfamiliar pediatric onset condition, providers are willing to access a brief “fact sheet” about the condition and seek additional information as needed. Young adult and providers review the transition plan forwarded by the prior practice. The transition plan includes <i>all</i> actions needed in near & longer term to meet needs & goals; it also lists responsible persons for each action. The transition plan is continually updated becoming a chronic care plan, if needed, and is placed in the medical record.</p>	<p>In addition to Level 3, a transition care coordinator facilitates the transition process to the adult model of care. The transition plan becomes a health maintenance plan, containing identified specialty providers, if needed, well care needs and wellness goals, insurance planning, payment methods, and capacity for self care checklist results. Young adults with special health care needs have an expanded plan including specialty care, legal decision-making level, supports and means of funding for future plans.</p>
	<p>Partial Complete</p>	<p>Partial Complete</p>	<p>Partial Complete</p>	<p>Partial Complete</p>
<p>6: Transfer of care (when appropriate) or transition to adult model of care</p>	<p>Information for how to make an appointment and directions to the new or ongoing practice/clinic are available either on a website or phone prompt.</p>	<p>In addition to Level 1, office staff has resources to either mail or e-mail insurance paperwork, office policies and other practice information to prospective new young adult patients in preparation for adult model of care.</p>	<p>In addition to Level 2, the practice staff ask young adult patients before their first visit if there are additional considerations to help make their transition into the adult model of care successful such as: Extra time Communication needs Mobility needs Parking Assistance getting into the practice Need for specialty care</p>	<p>In addition to Level 3, the practice contacts the prior primary care provider to arrange transfer. The practice maintains and updates a list of adult specialty practices <i>prepared</i> to take young adult patients - including young adults with chronic conditions. A transfer of care information package is updated including a portable medical summary, care plan, emergency care plan and when needed, a chronic condition fact sheet. The pediatric primary care provider is consulted following the transfer of care.</p>
	<p>Partial Complete</p>	<p>Partial Complete</p>	<p>Partial Complete</p>	<p>Partial Complete</p>

Notes: The Index is a self-assessment and measurement tool to be completed by one or more practice providers/staff for quality improvement purposes. It is designed to reflect a range from fairly basic levels of HCT performance (Level 1) to quite comprehensive levels of HCT performance (Level 4). It is also designed to provoke reflection on the part of the practice making the completion of the Index a learning experience. Each indicator has a possible score of 1 through 8 or (Level 1 - Partial) to (Level 4 - Complete). The range of possible raw scores is 6 (all 6 indicators at Level 1 - Partial) to 48 (all 6 indicators at Level 4 - Complete). Scores will be transformed into a standard score based on a maximum of 100. Indicator 6 (transfer of care) may not apply to youth in a family medicine practice for whom a transfer of primary care may not occur. However, specialty care transfer may still be relevant, so that in such cases, the indicator could be scored based on the practice's support of transfers of specialty care from pediatric to adult specialists.