



Medical Home Health Care Transition Index for Youth Up to Age 18

Introduction:

The **Health Care Transition Index for Youth Up to Age 18 (HCTI <18)** provides observable indicators related to the organization and delivery of health care transition* support for all youth, 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. This version is used prior to the transition to an adult model of care at age 18 in whatever settings care is received. The **Health Care Transition Index for Young Adults Age 18 and over (HCTI >18)** should be used in all health care settings for young adults from age 18.

Purpose:

The HCTI <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 youth 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 <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 <18 is a measure of health care transition support in pediatric practice. It views the incorporation of "transition" supports into practice 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 <18 is intended for use within any setting that is *preparing* youth for their 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 pediatric version is not designed for settings that are *receiving* transitioning youth into an adult model of care or as young adults transfer into the practice. 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 the progress of your practice along a continuum of performance from Level 1 to Level 4 using an aligned Likert 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 4) which best describes how your practice systematically addresses transition support and services.
- Third:** When you have selected the Level, then within that level, indicate whether the performance of *your practice* is to be scored as:
“PARTIAL” - some activity consistently and systematically performed within that level for all youth or
“COMPLETE” - all activity consistently and systematically performed within that level for all youth.

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) (In addition to Level 1)		Level 3 (Proactive) (In addition to Levels 1 & 2)		Level 4 (Comprehensive) (In addition to Levels 1, 2, 3)	
1: Office health care transition policy	Transition support and services vary among practice providers; staff members are informally aware of these supports and services; families/youth are informed of their individual clinician’s approach to transition as the youth’s needs arise.		There is a uniform, but not necessarily written, transition and transfer of care policy that is agreed upon by all providers and is made clear to staff; families/youth are informed of the office transition policy by age 18 and/or in response to inquiries prior to age 18.		A written transition and transfer of care policy addresses age of transition to adult model of care and (if necessary) age range for transfer to adult health care settings; the policy and its rationale are communicated to families/youth by age 12 during encounters and through brochures, posters, and website content		In addition to Level 3, the written health care transition and transfer of care policy addresses preparation, planning, process for transition to an adult model of care and (if needed) transfer to adult health care settings. 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) – Pediatric 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 policy	Transition support and services vary among practice providers; staff members are informally aware of these supports and services; families/youth are informed of their individual clinician’s approach to transition as the youth’s needs arise.		There is a uniform, but not necessarily written, transition and transfer of care policy that is agreed upon by all providers and is made clear to staff; families/youth are informed of the office transition policy by age 18 and/or in response to inquiries prior to age 18.		A written transition and transfer of care policy addresses age of transition to adult model of care and (if necessary) age range for transfer to adult health care settings; the policy and its rationale are communicated to families/youth by age 12 during encounters and through brochures, posters, and website content		In addition to Level 3, the written health care transition and transfer of care policy addresses preparation, planning, process for transition to an adult model of care and (if needed) transfer to adult health care settings. 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 and skills	Health care transition 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 (2011)(ref) on health care transition 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 youth transition preparation and needs including self-care education & communication with health care providers and actively coordinates transition care.		In addition to Level 3, in partnership with youth & family the office team adds skilled care coordination to oversee the ongoing use of transition tools (e.g. for assessment, goal setting, care planning). Information & resources address health and non-health related transition 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 youth	Transitioning youth are identified during encounters when providers or staff recognizes their advancing age, or by age 18.	Some transitioning youth are identified for focused attention by age 14, during encounters, and/or in response to questions posed by youth or families. Practice provider/staff time & interest determines the subsequent level of intervention.	In addition to Level 2, transitioning youth age 14 and over (or a significant subgroup, e.g. those with asthma) are actively identified and enrolled in an HCT registry – a paper or electronic database used to document transition process, youth & family transition skills, and any next steps.	In addition to Level 3, team members coordinate care using an electronic HCT registry to track youth with special health care needs & the complexity of their condition; the team systematically tracks completion of all HCT steps for each patient.
	Partial Complete	Partial Complete	Partial Complete	Partial Complete
4: Transition preparation	Youth are seen without their family member for portions of encounters after age 14.	In addition to Level 1, by at least age 14, all youth begin a process of knowing their own health and wellness, risk behaviors, allergies, personal and family health history, insurance coverage. Youth 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 assess a youth’s knowledge of their own health needs; the team provides education and support the acquisition of youth’s transition skills Transition preparation targets knowledge gaps and builds youth skills; youth “teach back” their grasp of each check list item.	In addition to Level 3, families/youth work with staff and/or transition care coordinator to develop transition related skills and elevating levels of self-determination. From age 14 they participate in the development of a portable medical summary. This summary “travels” with each youth as they age out of a pediatric model of care.
	Partial Complete	Partial Complete	Partial Complete	Partial Complete
5: Transition planning	Family/youth are expected to identify their preferences with respect to an adult care provider.	Starting at age 14, Family/youth are reminded annually of the practice’s transition/transfer policy and HIPAA requirements. When asked, the practice provides guidance about potential adult primary care and specialty providers.	In addition to Level 2, family/youth/providers start a transition plan by age 14. 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 in the medical record and is updated at designated intervals throughout the transition period.	In addition to Level 3, a transition care coordinator facilitates the transition plan, which contains identified adult providers, insurance planning, payment methods, and readiness checklist results. Youth with special health care needs have an expanded plan including specialty care, legal decision-making level, guardianship, supports and means of funding for future plans
	Partial Complete	Partial Complete	Partial Complete	Partial Complete

6: Transfer of care (when appropriate)	Family/youth are advised and encouraged to seek an adult primary care provider when the youth approaches their physician's upper age limit.	When family & youth inquire about adult primary care providers, they are offered a list of potential adult providers and encouraged to schedule an appointment. Families/youth are also encouraged to discuss the transfer of specialty care with the youth's pediatric specialists.	The practice maintains and updates annually a list of adult primary care practices <i>prepared</i> to take new patients - including young adults with special health care needs. The team assists with planning and with the steps involved in the transfer of the youth's pediatric specialty care.	In addition to Level 3, the practice makes contact with the future adult primary care provider, and when needed, specialty practices to arrange transfer. A transfer of care information package is provided including a portable medical summary, transition plan, an emergency care plan and when needed, a chronic condition fact sheet. The pediatric primary care provider remains available for consultation following the transfer of care.	Partial	Complete
					Partial	Complete

Notes: The Index is a self-assessment and performance measurement tool to be completed by one or more practice providers/staff for quality improvement purposes. It should reflect the respondent's best answers for the entire practice for all or most patients. 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.