*Six Core Elements of Health Care Transition™ 3.0*

# An Implementation Guide

**Transitioning Youth to an Adult Health Care Clinician**
*Core Element 3 - Transition Readiness*

got transition®

# I. Purpose, Objectives, and Considerations

## Purpose

Transition readiness is the third element in the Six Core Elements of Health Care Transition™ (HCT). Use of a standardized transition readiness assessment (TRA) to assess youths' HCT readiness skills is helpful in engaging youth and parents/caregivers to set health priorities, addressing self-care skill needs to prepare them for an adult approach to care at age 18, and preparing them to independently use health care services. Clinicians can use the results of the TRA to jointly develop a plan of care with youth and parents/caregivers. Clinicians should begin conducting TRAs at age 14 to 16 and continue throughout the HCT period until the youth has transferred. The final TRA should be included in the transfer package and sent to the receiving adult clinician. The TRA should be at the appropriate reading level, offered in languages common among your clinic population, and concise (no more than one page). *See sample TRAs in the references and in Section III.*

## Objectives

*Conduct* regular TRAs, beginning at age 14 to 16, to identify and discuss with youth and parent/caregiver their needs for self-care and how to use health care services.

*Offer* education and resources on needed skills identified through the TRA.

## Considerations

**CONTENT**

*What information might be considered in assessing transition readiness?*

**Below are some questions and ideas to think about.**

- *Consider the patient population in your practice/system. What HCT skills and knowledge about health care services do they need to learn?*
- *Decide if only the youth or if both the youth and parent/caregiver will complete the TRA.*
- *Review existing TRAs. Decide if you can use an existing TRA, if you need to customize one, or if a new TRA will need to be developed.*
- *Several TRAs are available; several are disease specific, including ones for youth with intellectual and developmental disabilities. The 2018 Clinical Report on HCT includes a list of published TRAs.[1] For examples of some subspecialty disease TRAs from the American College of Physicians subspecialty societies, see Section III.*
- *Got Transition's TRA contains two motivational interviewing questions. Consider adding them to your selected TRA:*
  - *How important is it to you to move to a doctor who cares for adults before age 22?*
  - *How confident do you feel about your ability to move to a doctor who cares for adults before age 22?*
- *Have the youth complete the TRA several times during the HCT preparation process, beginning at age 14 to 16, usually as part of routine preventive or chronic care.*
- *Use the TRA both as a discussion tool and to plan for HCT skill-building education.*
- *It is important to note that TRAs do not predict HCT success. As of June 2020, the available TRAs have not been externally validated.*

**PROCESS**

*What is the process to implement assessment of transition readiness?*

**Below are some questions and ideas to think about.**

- *If an available TRA has been customized or your practice/system has developed its own, check that the reading level is appropriate and do a test with 3-4 youth in your practice (who will be receiving the TRA) of different ages and educational levels to see if they have any difficulty understanding the questions or specific words. If so, make needed changes to the TRA and test again. A similar approach should be taken if the practice/system decides to also have parents/caregivers complete a TRA.*
- *Once the TRA(s) are ready for use, identify and test the clinic process for conducting it. Below are some questions and ideas to think about.*
  - *Identify eligible youth needing a TRA and decide:*
    - *How often will it be offered? Every year? Every other year?*
    - *Will it be sent to the youth and parent/caregiver before the visit via mail, email, or the EMR portal and the completed form be brought to the clinic visit?*
    - *Will it be completed in the clinic at the time of the visit? Will it be completed in a paper form? If yes, determine who will incorporate the completed TRA into the medical record.*
    - *Who will administer the TRA in the clinic? Will it be completed in the waiting room or while waiting for the clinician in the clinic room?*
    - *Will the parents/caregivers be present (if there is no legal supported decision-making document) when youth is completing the TRA or will the youth complete it on their own?*
    - *Who fills out the TRA when there is a legal supported decision-making agreement in place?*
  - *Will it be completed via a tablet during the visit, and if so, will the results be incorporated into the EMR? Who will assist the youth to prioritize needed skill-building education?*
  - *Who will incorporate the needed skills into an HCT plan of care (for more information about an HCT plan of care, see the implementation guide for Core Element 4)?*
  - *Who will offer the identified needed education?*
  - *What materials or online resources are available in the practice for education around the needed skills for the youth/parent/caregiver?*
  - *Determine how education will be incorporated into follow-up appointments and documented in the medical record.*
- *Create a written document to describe the clinic process that each eligible patient will follow to complete the TRA process.*
- *Educate all team members/staff about the process.*

---

1.  White PH, Cooley WC, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics.* 2018;142(5);e20182587.

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

3

# II. Quality Improvement Considerations, Tools, and Measurement
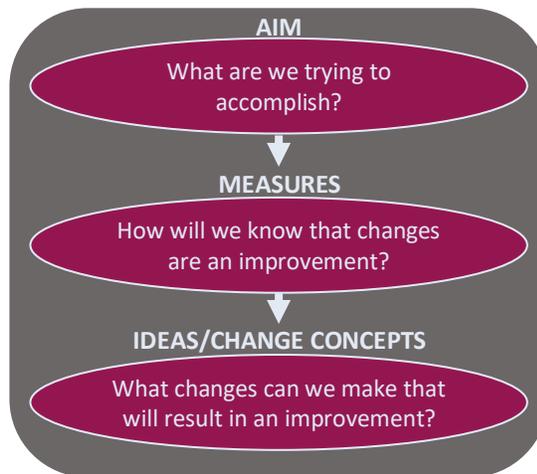
## Quality Improvement Considerations

**What should be thought about when forming a team?** (See *Successful Teams* in the [QI Primer](#))

- Include a representative from all areas of your practice
- Include a youth/parent/caregiver whenever possible
- Depending on what you are aiming to improve, consider any ad hoc members you might need (e.g., information services, lab, pharmacy, supply distribution, etc.)
- Schedule meetings or huddles

**What is the Model for Improvement?**

The Model for Improvement (see *Model for Improvement in the* [QI Primer](#)) is an approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes. The figure here illustrates the three questions that make up the Model for Improvement. This is a simple but robust model widely used for improvement in many industries, including health care.

**AIM**
What are we trying to accomplish?

**MEASURES**
How will we know that changes are an improvement?

**IDEAS/CHANGE CONCEPTS**
What changes can we make that will result in an improvement?

*Adapted from Langley GL, et al. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, 2nd ed. San Francisco: Jossey-Bass Publishers, 2009.*

As you continue to work through this document and the Six Core Elements, you will find that the QI tools and other items below have been customized to each Element for each kind of practice. However, you will find the basic team considerations described above remain the same for most if not all of your QI work.

## Quality Improvement Tools

The most important QI tools to guide a team's improvement work include **Tools 1-5** listed below. Using these tools in the following order will increase your chances of success, but teams can make modifications as needed. For more information and examples, see *Tools for Improvement* in the [QI Primer](#).

- **Tool 1: An aim statement** is a fundamental element of this model and answers the question of what you are trying to accomplish.
- **Tool 2: Key driver diagrams** allow teams to visualize the relationship between the project aim and contributing factors, helping them determine key actions necessary to meet this aim.
- **Tool 3: Process flow maps** can help you visualize the steps in your change process.
- **Tool 4: The simplified failure mode and effects analysis** form helps teams recognize what problems might arise in each step of the process and think of possible solutions.
- **Tool 5: Plan-Do-Study-Act (PDSA) cycles** allow teams to trial and learn from their process changes. Using Tools 1-4 before initiating a PDSA cycle helps teams assess root causes before jumping to solutions.

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

4

## Tool 1: Aim Statement

The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

> *Example Aim Statement*
> We aim to improve care for patients with sickle cell disease by implementing a readiness assessment and assess gaps identified. By [insert date], 90% of patients will have a readiness assessment and 80% of patients identified will have gap addressed.

## Tool 2: Key Driver Diagram

Key driver diagrams (KDDs) require teams to identify their theories or "key drivers" which lead to outcomes. They help teams see relationships and organize work, especially in complex systems. They are frequently used for analysis, organization, and communication to direct improvement work. For more information and examples, see *Tools for Improvement* in the *QI Primer*.
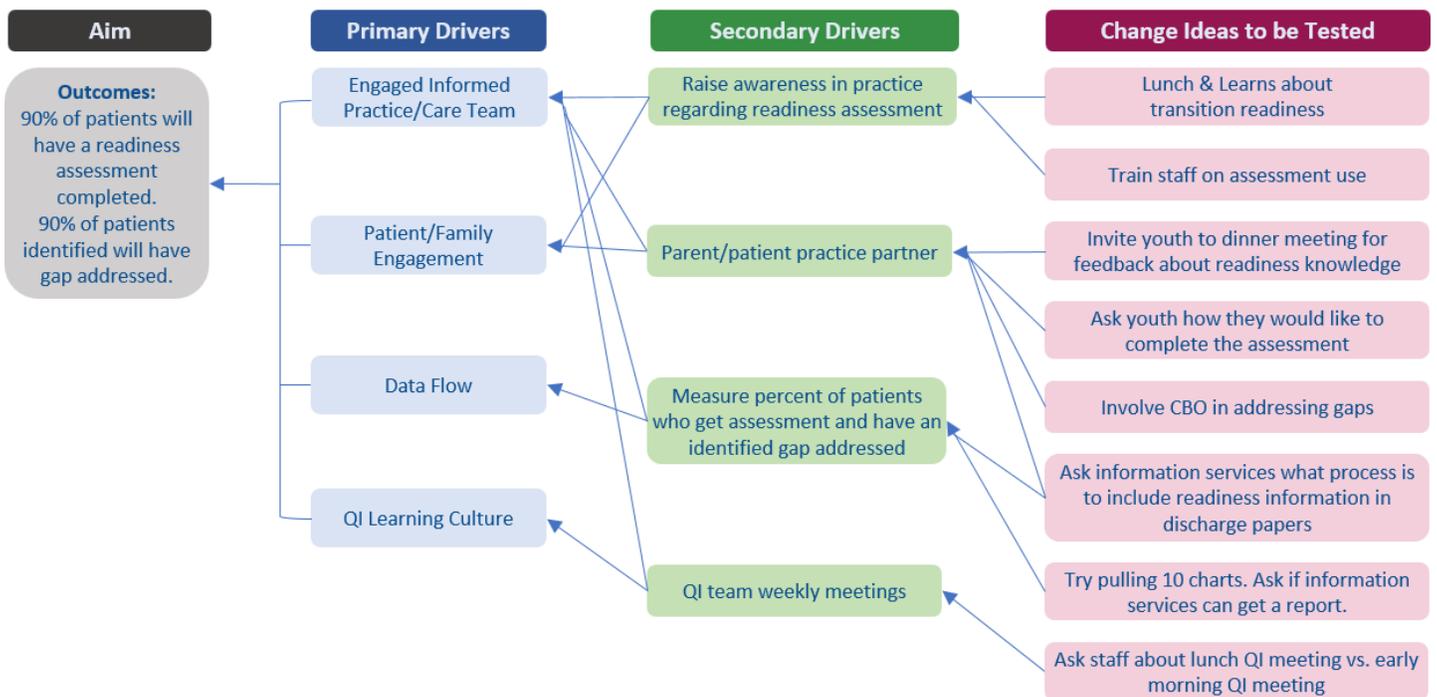


*Adapted from ST3P UP, a collaborative sponsored by Patient Centered Outcomes Research Institute® (PCORI) Award MCSC-1608-35861 Titled A Comparative Effectiveness of Peer Mentoring Versus Structured Education Based Transition Programming For The Management Of Care Transitions In Emerging Adults With Sickle Cell Disease.*

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

5

## Tool 3: Process Flow Map

A flow map is a visual display of the separate steps in a process placed in sequential order. It is extremely helpful in documenting different views of the same process. It can show the sequence of actions, materials/inputs entering and leaving the process, decision points, and people involved. Flow maps can be used to document steps in the process of either how things are or how things could be. Posting the flow map gives staff an opportunity to clarify the steps in the process and can uncover conflicting understandings. For more information and examples, see *Tools for Improvement* in the *QI Primer*.
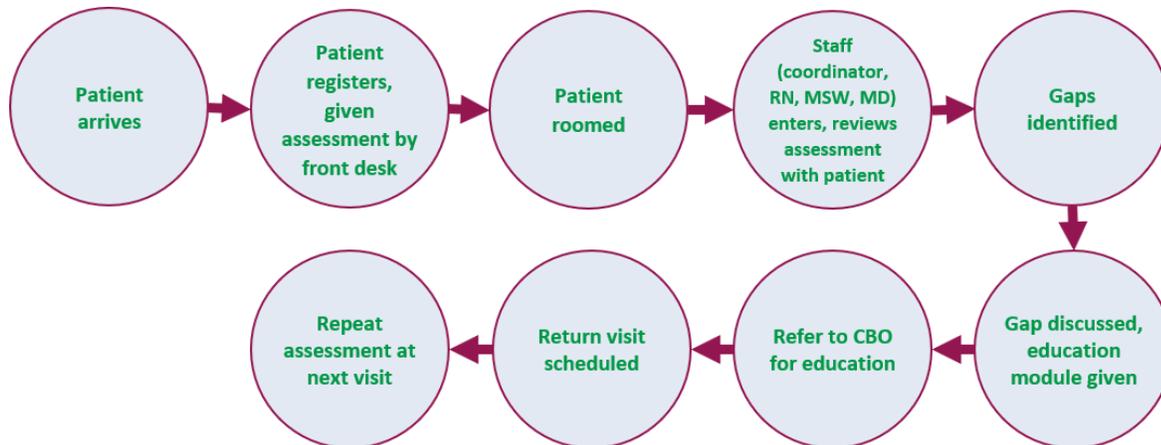


## Tool 4: Simplified Failure Mode and Effects Analysis (sFMEA)

Simplified Failure Mode and Effects Analysis (sFMEA) is a proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change and help generate ideas to prevent those possible failures. This is a good companion to the flow map – a flow map lets you see the process as it is, and the sFMEA helps you look more closely to identify breakdowns. The example below has a few solutions filled in, to illustrate how teams might start completing an sFMEA. For more information and examples, see *Tools for Improvement* in the *QI Primer*.
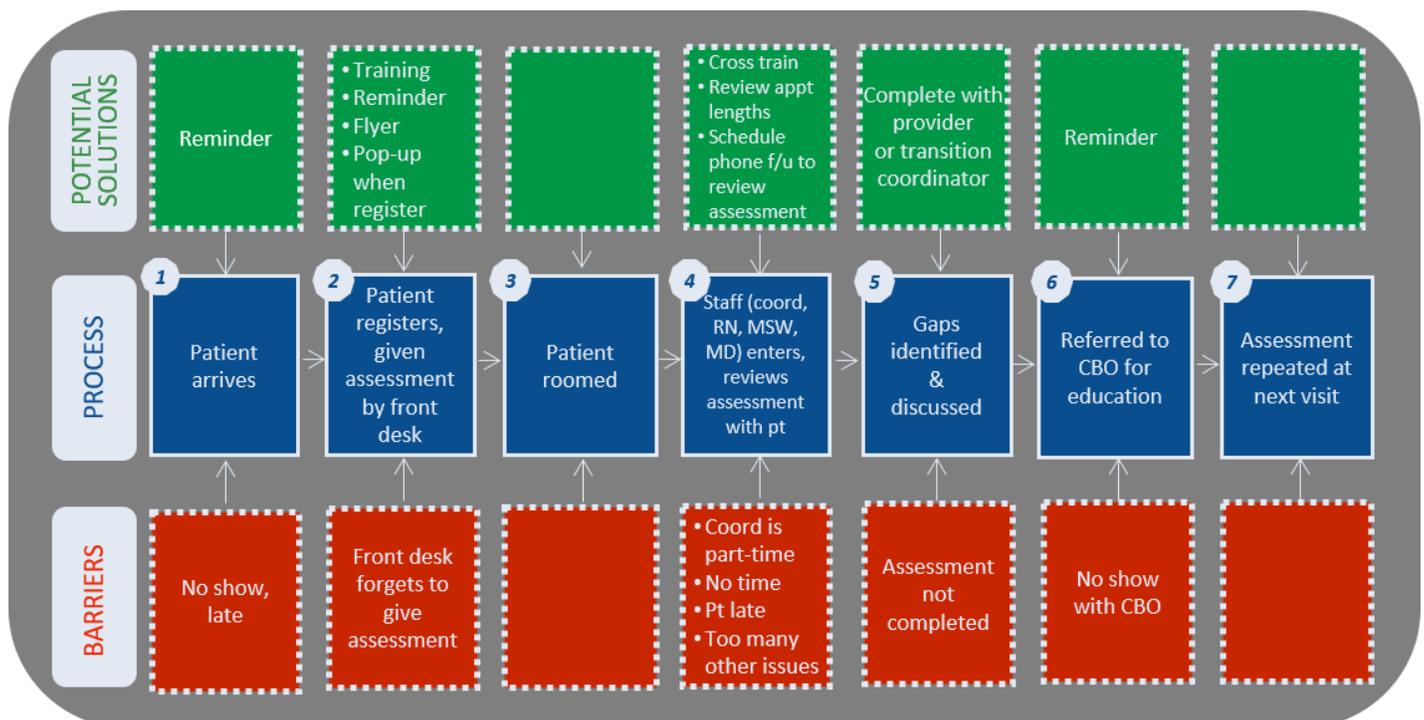


*Adapted from the copyrighted Simplified Failure Mode Effects Analysis Worksheet (sFMEA) from Cincinnati Children's Hospital Medical Center. This version of the sFMEA has been modified and has been reprinted with permission.*

Six Core Elements of Health Care Transition™ 3.0
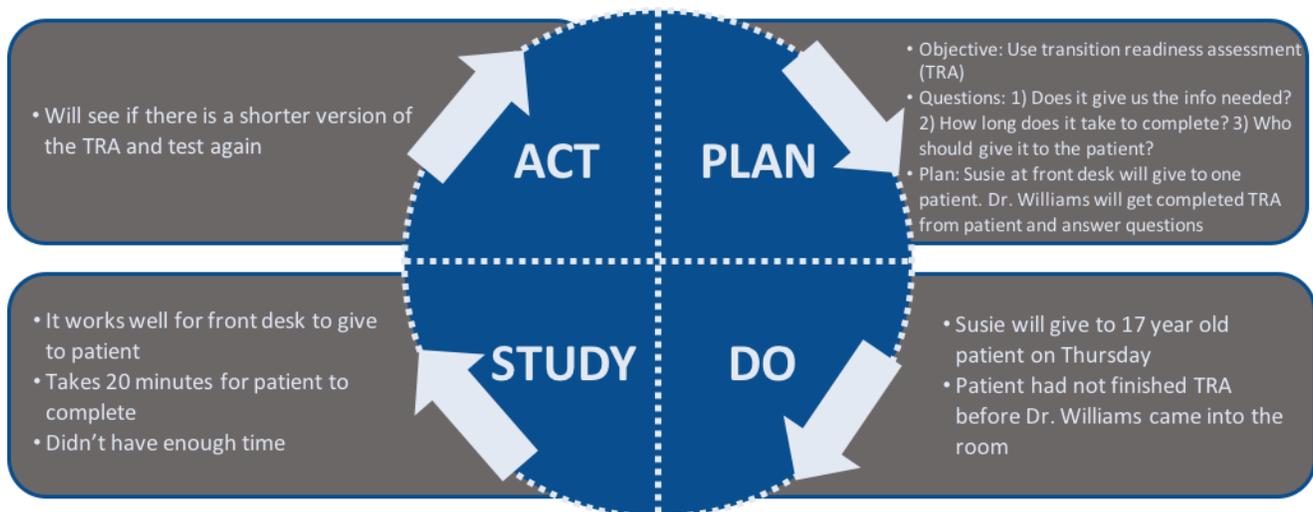An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician

6

## Tool 5: PDSA Cycles

PDSA cycles are a structured test of a process change. These are meant to be done rapidly, for example one patient, one afternoon, with one doctor. To accelerate learning and improvement, small tests with reflection allow for change ideas to be adapted, adopted, or abandoned easily within busy healthcare settings. Learning to do rapid cycle testing is key to keeping the momentum going; it is not necessary to schedule a full separate meeting, just a quick huddle allows teams to plan the next cycle. For more detailed explanation and a blank form, see *Model for Improvement* in the *QI Primer*. This effort includes:

- **Plan** the test: who, what, where, when;
- **Do** try the change and observe what happens;
- **Study** reflect on what was learned from the test; and
- **Act** decide next steps based on the reflection.

---

*Examples of Ideas to Test*

- Test the readiness assessment on one patient
- Test the process of completing readiness assessment on one patient

---

ACT
- Will see if there is a shorter version of the TRA and test again

PLAN
- Objective: Use transition readiness assessment (TRA)
- Questions: 1) Does it give us the info needed? 2) How long does it take to complete? 3) Who should give it to the patient?
- Plan: Susie at front desk will give to one patient. Dr. Williams will get completed TRA from patient and answer questions

STUDY
- It works well for front desk to give to patient
- Takes 20 minutes for patient to complete
- Didn't have enough time

DO
- Susie will give to 17 year old patient on Thursday
- Patient had not finished TRA before Dr. Williams came into the room

*Adapted from AHEC QI 101, a Quality Improvement course sponsored by Charlotte Area Health Education Center.*

# Quality Improvement Measurement

This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of HCT Activities or the HCT Process Measurement Tool in the Six Core Elements package can be used by teams to track progress of specific core elements or the overall HCT process. For more information and examples, see *Measuring for Improvement* in the QI Primer.

*Example Data Collection Check Sheet*

- ☐ Assess the need for education
    - o Have clinician track for 1 week the number of patients who have a gap identified
    - o Track the areas in which gaps appear
- ☐ Track the number of patients who complete the education module
- ☐ Track the number of patients referred to a CBO for further education
- ☐ If possible, track the number of patients the CBO sees from referrals
- ☐ Note what is achieved by either the module or the CBO referral

| | Mon | Tues | Wed | Thurs | Fri |
|---|---|---|---|---|---|
| # pts put in database | ||| | ||| | |||| | ||| | | |
| # pts finished module | | || | | | | | |
| # pts referred to CBO | | | | | | | | |

Data display is important for teams to assess the impact of the changes they are making. In QI, run charts are most often used. Run charts are a dynamic display of data over time. They require no statistical calculations and should be easily understood. Use a clear title. Data points are plotted around a median line. When possible, adding annotations to the chart to explain when certain changes were introduced can make the chart more informative and robust.



Percent of Patients With One Completed Readiness Assessment in Last Year
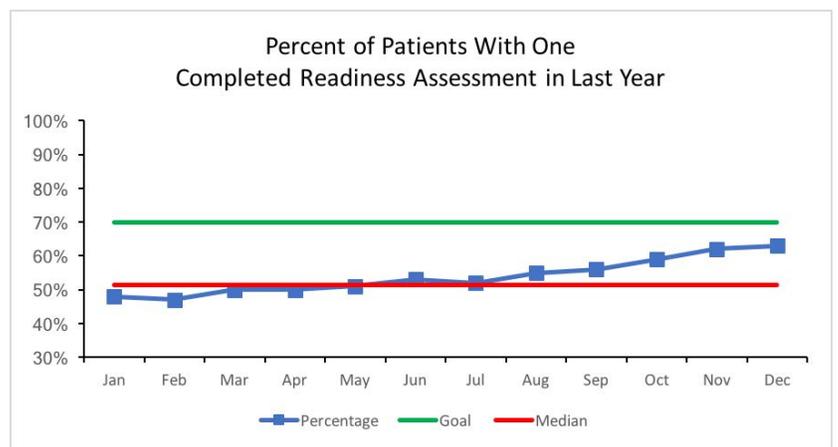
# Sustain & Spread

For strategies on how to sustain and spread your work, please see Steps 6 and 7 in *How to Implement the Six Core Elements of Health Care Transition*.

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

8

# III. Sample Transition Readiness Assessments

### Sample Transition Readiness Assessments from the Six Core Elements of HCT™
- Sample transition readiness assessment for youth from Got Transition's "Transitioning Youth to an Adult Health Care Clinician" *(click here)*
- Sample transition readiness assessment for parents/caregivers from Got Transition's "Transitioning Youth to an Adult Health Care Clinician" *(click here)*

### Sample Transition Readiness Assessments for Youth with Specific Conditions
- Sample transition readiness assessment for youth with intellectual and developmental disabilities from the American College of Physicians *(click here)*
- Additional condition-specific transition readiness assessments from the American College of Physicians *(click here)*

### Sample Transition Readiness Assessments for School Health Settings
- Sample transition readiness assessment for students from Children's National Medical Center's school-based health centers *(click here)*
- Sample transition readiness assessment for students receiving mental and behavioral services from Mary's Center's school mental health program *(click here)*
- Sample health care transition readiness assessment for students with an Individualized Education Program (IEP) from Got Transition *(click here)* and sample goals for educators to use in the IEP *(click here)*

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

9

# IV. Additional Resources

- Turning 18: What It Means for Your Health *(click here)*
- Health Care Transition Timeline for Youth and Young Adults *(click here)*
- Health Care Transition Timeline for Parents/Caregivers *(click here)*
- Online Quiz for Youth/Young Adults: Are you ready to transition to adult health care? *(click here)*
- Online Quiz for Parents/Caregivers: Is your child ready to transition to adult health care? (*click here*)
- Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones *(click here)*
- Questions to Ask Your Doctor About Transitioning to Adult Health Care (for Youth and Young Adults) *(click here)*
- Questions to Ask Your Child's Doctor About Transitioning to Adult Health Care (for Parents and Caregivers) *(click here)*
- System Differences Between Pediatric and Adult Health Care *(click here)*
- Planning to Move from Pediatric to Adult Care? Here's How They Can Differ *(click here)*

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

10

Six Core Elements of Health Care Transition™ 3.0
**An Implementation Guide: Transitioning Youth to an Adult Health Care Clinician**

11