Side-by-Side Comparison

The Six Core Elements of Health Care Transition™ 3.0 are intended for use by pediatric, family medicine, med-peds, and internal medicine practices to assist youth and young adults as they transition to adult-centered care. They are aligned with the AAP/AAFP/ACP Clinical Report on Health Care Transition.[1] Sample tools, implementation guidance, measurement, and payment resources are available at www.GotTransition.org.

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN *(For use by Pediatric, Family Medicine, and Med-Peds Clinicians)*	TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS *(For use by Family Medicine and Med-Peds Clinicians)*	INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE *(For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians)*
1. Transition and Care Policy/Guide	**1. Transition and Care Policy/Guide**	**1. Transition and Care Policy/Guide**
• Develop a transition and care policy/guide with input from youth and parents/caregivers that describes the practice's approach to transition, an adult approach to care in terms of privacy and consent, and age of transfer to an adult clinician. • Educate all staff about the practice's approach to transition and distinct roles of the youth, parent/caregiver, and pediatric and adult health care team in the transition process, taking into account cultural preferences. • Display transition and care policy/guide somewhere accessible in practice space, discuss and share with youth and parent/caregiver, beginning at age 12 to 14, and regularly review as part of ongoing care.	• Develop a transition and care policy/guide with input from youth/young adults and parents/caregivers that describes the practice's approach to transition and an adult approach to care in terms of privacy and consent. • Educate all staff about the practice's approach to transition and distinct roles of the youth/young adult, parent/caregiver, and health care team in the transition process, taking into account cultural preferences. • Display transition and care policy/guide somewhere accessible in practice space, discuss and share with youth/young adult and parent/caregiver, beginning at age 12 to 14, and regularly review as part of ongoing care.	• Develop a transition and care policy/guide with input from young adults that describes the practice's approach to transition, accepting and partnering with new young adult patients, and an adult approach to care in terms of privacy and consent. • Educate all staff about the practice's approach to transition and distinct roles of the young adult, parent/caregiver, and adult health care team in the transition process, taking into account cultural preferences. • Display transition and care policy/guide somewhere accessible in practice space, discuss and share with young adult at first visit, and regularly review as part of ongoing care.
2. Tracking and Monitoring	**2. Tracking and Monitoring**	**2. Tracking and Monitoring**
• Establish criteria and process for identifying transition-aged youth. • Develop process to track receipt of the Six Core Elements, integrating with electronic medical records (EMR) when possible.	• Establish criteria and process for identifying transition-aged youth/young adults. • Develop process to track receipt of the Six Core Elements, integrating with electronic medical records (EMR) when possible.	• Establish criteria and process for identifying transitioning young adults. • Develop process to track receipt of the Six Core Elements, integrating with electronic medical records (EMR) when possible.
3. Transition Readiness	**3. Transition Readiness**	**3. Orientation to Adult Practice**
• Conduct regular transition readiness assessments, 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 transition readiness assessment.	• Conduct regular transition readiness assessments, 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 transition readiness assessment.	• Identify and list adult clinicians within your practice interested in caring for young adults. • Establish a process to welcome and orient new young adults into practice, including a description of available services. • Provide young adult-friendly online or written Frequently Asked Questions about the practice.

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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.

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Side-by-Side Comparison *(Continued)*

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN *(For use by Pediatric, Family Medicine, and Med-Peds Clinicians)*	TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS *(For use by Family Medicine and Med-Peds Clinicians)*	INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE *(For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians)*
4. Transition Planning	**4. Transition Planning**	**4. Integration into Adult Practice**
• Develop and regularly update the plan of care, including readiness assessment findings, youth's goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents. • Prepare youth and parent/caregiver for an adult approach to care, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information. • Determine need for decision-making supports for youth and make referrals to legal resources. • Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult care. If both primary and subspecialty care are involved, discuss optimal timing for each. • Assist youth in identifying an adult clinician(s) and provide linkages to insurance resources, self-care management information, and community support services. • Obtain consent from youth/parent/caregiver for release of medical information. • Take cultural preferences into account throughout transition planning.	• Develop and regularly update the plan of care, including readiness assessment findings, youth/young adults' goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents. • Prepare youth/young adult and parent/caregiver for an adult approach to care, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information. • Determine need for decision-making supports for youth/young adult and make referrals to legal resources. • Plan with youth/young adult and parent/caregiver for optimal timing of transfer from pediatric to adult specialty care, if needed. • Provide linkages to insurance resources, self-care management information, and community support services. • Obtain consent from youth/young adult/parent/caregiver for release of medical information. • Take cultural preferences into account throughout transition planning.	• Communicate with young adult's pediatric clinician(s) and arrange for consultation assistance, if needed. • Prior to first visit, ensure receipt of transfer package, including final transition readiness assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional clinical records. • Make pre-visit appointment reminder welcoming new young adult and identifying any special needs and preferences.
5. Transfer of Care	**5. Transition to Adult Approach to Care**	**5. Initial Visits**
• Complete transfer package, including final transition readiness assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional clinical records. • Confirm date of first adult clinician appointment. • Prepare letter with transfer package, send to adult clinician, and confirm adult clinician's receipt of transfer package. • Communicate with selected adult clinician about pending transfer of care. • Confirm the pediatric clinician's responsibility for care until youth/young adult is seen by an adult clinician. • Transfer youth/young adult when their condition is as stable as possible.	• Address any concerns youth/young adult has about transferring to an adult approach to care. • Clarify an adult approach to care (shared decision-making, privacy and consent, access to information), adherence to care, preferred methods of communication, and health literacy needs. • Conduct self-care skills assessment if not recently completed and discuss young adult's needs for self-care and how to use health care services. • Offer education and resources on needed skills identified through the self-care skills assessment. • Review youth/young adult's health priorities as part of their plan of care. • Continue to update and share with youth/young adult their medical summary and emergency care plan.	• Prepare for initial visit by reviewing transfer package with appropriate team members. • Address any concerns young adult has about transferring to adult care and take into account any cultural preferences. • Clarify an adult approach to care (shared decision-making, privacy and consent, access to information), adherence to care, preferred methods of communication, and health literacy needs. • Conduct self-care skills assessment if not recently completed and discuss their needs for self-care and how to use health care services. • Offer education and resources on needed skills identified through the self-care skills assessment. • Review young adult's health priorities as part of their plan of care. • Update and share with young adult their medical summary and emergency care plan.
6. Transfer Completion	**6. Ongoing Care**	**6. Ongoing Care**
• Contact youth/young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm attendance at first adult appointment. • Elicit anonymous feedback from youth/young adult and their parent/caregiver on their experience with the transition process. • Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed. • Build ongoing and collaborative partnerships with adult primary and specialty care clinicians.	• Assist youth/young adult in connecting with specialists and other support services, as needed. • Continue with ongoing care management tailored to each youth/young adult and their cultural preferences. • Elicit anonymous feedback from youth/young adult and their parent/caregiver on their experience with the transition process. • Build ongoing and collaborative partnerships with specialty care clinicians.	• Communicate with pediatric practice confirming completion of transfer into adult practice and consult with pediatric clinician(s), as needed. • Assist young adult in connecting with adult specialists, as needed, and provide linkages to insurance resources, self-care management information, and community support services. • Obtain consent from young adult for release of medical information. • Continue with ongoing care management tailored to each young adult and their cultural preferences. • Elicit anonymous feedback from young adult on their experience with the transition process. • Build ongoing and collaborative partnerships with other primary and specialty care clinicians.

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