New Directions in Health Care Transition Improvement

Got Transition/Center for Health Care Transition Improvement
The National Alliance to Advance Adolescent Health
Presentation Overview

• Making the case for transition improvements
• Background leading to development of Six Core Elements 1.0
• Updated Six Core Elements 2.0
  – New clinical tools/packages
  – Measurement options
• Next Steps
Making the Case for Transition Improvements

• Not just 500,000 youth with special needs transitioning to adult health care annually; it is ALL ADOLESCENTS who must transition from pediatric to adult-centered care.

• There are an estimated 18 million adolescents, ages 18-21, about ¼ of whom have chronic conditions; many more millions if you count those 12-26.

• Majority of youth are ill-prepared for this change.

• Surveys of health care providers consistently show they lack a systematic way to provide transition support from pediatric to adult health.
Making the Case for Transition Improvements

**Health is diminished:**
- Youth often unable to name their health condition, relevant medical history, prescriptions, insurance source
- Adherence to care lower and medical complications increased
- Youth and family worried

**Quality is compromised:**
- Youth, young adults, and families dissatisfied about lack of preparation, information about adult care, vetted adult providers, communication between pediatric and adult providers, and sharing of medical information.
- Discontinuity of care and lack of usual source of care common
- Medical errors reported

**Costs are increased:**
- Preventable ER and hospital use and duplicative tests widespread
AAP/AAFP/ACP Clinical Report on Health Care Transition

- In 2011, Clinical Report on Transition published as joint policy by AAP/AAFP/ACP
- Targets all youth, beginning at age 12
- Algorithmic structure with
  - Branching for youth with special health care needs
  - Application to primary and specialty practices
  - Extends through transfer of care to adult medical home and adult specialists

Age 12 – Youth and family aware of transition policy

Age 14 – Health care transition planning initiated

Age 16 – Preparation of youth and parents for adult approach to care and discussion of preferences and timing for transfer to adult health care

Age 18 – Transition to adult approach to care

Age 18-22 – Transfer of care to adult medical home and specialists with transfer package

"Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home" (Pediatrics, July 2011)
Six Core Elements of Health Care Transition (1.0)

- MCHB’s National Health Care Transition Center (*Got Transition*, led by Carl Cooley and Jeannie McAllister)
- Created:
  - Six Core Elements as quality improvement (QI) strategy aligned with Clinical Report algorithm
  - Corresponding set of sample tools
  - Health Care Transition Indices
    - Pediatric and Adult Versions
    - Modeled after Medical Home Index, developed by Center for Medical Home Improvement
Six Core Elements of Health Care Transition (1.0)

Pediatric Setting

1. Transition Policy
2. Transitioning Youth Registry
3. Transition Preparation
4. Planning
5. Transfer of Care
6. Transfer Completion

Adult Setting

Young Adult Privacy & Consent Policy
Young Adult Registry
Transition Preparation
Transition Planning
Transition and Transfer of Care
Transition Completion
Health Care Transition Learning Collaboratives

- Conducted between 2010-2012 in DC, Boston, Denver, New Hampshire, Minnesota, Wisconsin
- Purpose: to determine if Six Core Elements were feasible and resulted in improvements
- QI Team Leaders: Carl Cooley, Jeannie McAllister, Patience White, Mal Cyr, Laura Pickler, Eileen Forlenza
Results from DC Transition Learning Collaborative

• All pediatric, family medicine, and internal medicine practices created practice-wide policies on transition
• All created a method for tracking transitioning youth with chronic conditions
• Transition readiness assessments conducted with patients in their registry
• Transition plans developed for 1/3 of youth and 45% of young adults
• Of the 350 youth (14 and older) in LC registries, 50 were transferred to adult practices
Lessons Learned

- Feasible to implement Six Core Elements
- Involvement of pediatric, family medicine, and adult practices from outset was key
- Senior leadership engagement critical
- Team-based approach for QI clinical process necessary
- Family and young adult engagement critical, but challenging to sustain
- Need to consider young adults a special population in adult practice
- EHR customization and lack of financial incentives were major hurdles
Additional Feedback on Six Core Elements (1.0)

- More focus on role and responsibilities of adult providers receiving transitioning youth
- Greater clarity of family medicine/med-peds multiple roles in transition process, including when youth do not transfer
- Samples/tools needed refinement
- Measurement indices subject to variable interpretations
- Engagement of youth/young adults and families not strong enough
- Reading levels of samples/tools too high
Fast Forward to Got Transition Center for Health Care Transition Improvement

- MCHB’s new Got Transition grantee: The National Alliance to Advance Adolescent Health (Peggy McManus and Patience White, Co-Directors)
- Project Team: Megan Prior, Dan Beck, Corinne Dreskin
- Cabinet Executive Team: Carl Cooley, Jeanne McAllister, Mal Cyr, Eileen Forlenza, Laura Pickler, Teresa Nguyen, Nienke Dosa, Tawara Goode, and Wendy Jones
- Evaluation Consultants: Henry Ireys and KaraAnn Clouse
- MCHB Project Officer: Marie Mann
Got Transition Goals: 2014-2018

1. Transition Quality Improvement Spread
   • Update Six Core Elements and new package of clinical tools and measurement options
   • Collaborate with new transition learning networks in large integrated care systems to promote transition spread

2. Transition Education and Training

3. Young Adult and Family Engagement

4. Transition Policy Interventions

5. Transition Information Dissemination
Process for Updating the Six Core Elements

• Used best ideas/samples from state and national transition QI efforts
• Reviewed QI transition, medical home, and consumer engagement literature
• Obtained extensive feedback from leaders in field
• Actively involved Cabinet and MCHB Project Officer in updating process
Six Core Elements 2.0: What’s New?

Transitioning Youth to Adult Health Care Providers
(Pediatric, Family Medicine, and Med-Peds Providers)

Transitioning to an Adult Approach to Health Care Without Changing Providers
(Family Medicine and Med-Peds Providers)

Integrating Young Adults into Adult Health Care
(Internal Medicine, Family Medicine, and Med-Peds Providers)
Samples/Tools: What’s New?

- 3 New Packages of Improved Samples and Tools
- Aligned with the Six Core Elements 2.0
- Currently available on www.GotTransition.org
- Customizable (using word version)
A further look...

Transitioning Youth to Adult Health Care Providers
(Pediatric, Family Medicine, and Med-Peds Providers)

Transitioning to an Adult Approach to Health Care Without Changing Providers
 Familial Medicine and Med-Peds Providers

Integrating Young Adults into Adult Health Care
(Internal Medicine, Family Medicine, and Med-Peds Providers)
1. Transition Policy: What’s New?

– Distinctive policy issues in the 3 packages
– Greater emphasis on adult approach to care and legal changes at age 18, including options for supported decision-making
– More clarity about ages
[Pediatric Practice Name] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a “pediatric” model of care where parents make most decisions to an “adult” model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult’s consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.
2. Tracking and Monitoring: What’s New?

- Distinctive tracking issues in 3 packages
- Need for tracking options for those with and without electronic health records
- Individual Transition Flow Sheet for use in paper chart or HER
- Excel registry to look at populations
Sample Individual Transition Flow Sheet

Center for Health Care Transition Improvement

Patient Name: ____________________ Date of Birth: ____________
Primary Diagnosis: __________________ Transition Complexity: ____________

Transition Policy
- Practice policy on transition discussed/shared with youth and parent/caregiver ____________ Date ____________

Transition Readiness Assessment
- Conducted transition readiness assessment ____________ Date ____________ Date ____________ Date ____________
- Included transition goals and prioritized actions in plan of care ____________ Date ____________ Date ____________ Date ____________

Medical Summary and Emergency Plan
- Updated and shared medical summary and emergency plan ____________ Date ____________ Date ____________ Date ____________

Adult Model of Care
- Decision-making, privacy, and consent in adult care discussed with youth and parent/caregiver (if needed, discussed plans for supported decision-making) ____________ Date ____________
- Timing of transfer discussed with youth and parent/caregiver ____________ Date ____________
- Selected Adult Provider
  - Name ____________________________ Phone ____________
  - Clinic ____________________________ Fax ____________
  - First appointment complete ____________ Date ____________

Transfer of Care
- Prepared transfer package including:
  - Transfer letter, including effective date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including goals and actions
  - Updated medical summary and emergency care plan
  - Legal documents, if needed
  - Contact factsheet, if needed
  - Additional provider records, if needed
- Sent transfer package ____________ Date ____________
- Communicated with adult provider about transfer ____________ Date ____________
- Elicited feedback from young adult after transfer from pediatric care ____________ Date ____________
## Sample Transition Registry

### Six Core Elements of Health Care Transition 2.0

#### Transition Registry

**1/21/2014**

<table>
<thead>
<tr>
<th>DOB</th>
<th>Age</th>
<th>Name</th>
<th>Primary Diagnosis</th>
<th>Transition Complexity*</th>
<th>Date Last Seen</th>
<th>Next Scheduled Appointment (Date or Blank)</th>
<th>Date of first appointment with adult provider (Date or Blank)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/4/1995</td>
<td>18 Y</td>
<td>Mary Smith</td>
<td>seizure disorder</td>
<td>3</td>
<td>12/13/2013</td>
<td>Highlighted if no apt</td>
<td>Highlighted if not done by 22</td>
</tr>
<tr>
<td>12/25/1997</td>
<td>18 Y</td>
<td>Susan Cue</td>
<td>congenital heart disease</td>
<td>1</td>
<td>7/6/2013</td>
<td>8/6/2014</td>
<td></td>
</tr>
<tr>
<td>1/17/1993</td>
<td>21 Y</td>
<td>Terrence Train</td>
<td>JPA</td>
<td>2</td>
<td>6/16/2013</td>
<td>6/7/2014</td>
<td></td>
</tr>
<tr>
<td>6/17/2002</td>
<td>11 Y</td>
<td>Devin Carn</td>
<td>asthma</td>
<td>1</td>
<td>6/19/2013</td>
<td>12/21/2014</td>
<td></td>
</tr>
<tr>
<td>4/16/1996</td>
<td>17 Y</td>
<td>David Crockett</td>
<td>well</td>
<td>1</td>
<td>12/22/2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/14/1999</td>
<td>14 Y</td>
<td>Sasha Jones</td>
<td>well</td>
<td>1</td>
<td>4/16/2012</td>
<td>2/20/2014</td>
<td></td>
</tr>
<tr>
<td>2/3/1994</td>
<td>19 Y</td>
<td>Enrique Montoya</td>
<td>well</td>
<td>1</td>
<td>5/13/2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Complexity Scoring:
1<= Low Complexity
2= Moderate Complexity
3= High Complexity

#### Transition Registry

**1/21/2014**

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Shared with Youth/Family (Yes or Blank)</th>
<th>Readiness Assessment Administered (Date or Blank)</th>
<th>Plan of Care Updated and Shared with Youth/Family (Date or Blank)</th>
<th>Medical Summary and Emergency Care Plan Updated and Shared with Youth/Family (Date or Blank)</th>
<th>Adult Provider Identified (Yes or Blank)</th>
<th>Transfer Package Sent to Adult Provider (Yes or Blank)</th>
<th>Communicated with Adult Provider (Yes or Blank)</th>
<th>Elicted Feedback about Transition from Youth and Family (Yes or Blank)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Smith</td>
<td>Yes</td>
<td>8/13/2013</td>
<td>8/13/2013</td>
<td>8/13/2013</td>
<td>Yes</td>
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<td></td>
<td></td>
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<tr>
<td>Susan Cue</td>
<td>Yes</td>
<td>7/6/2013</td>
<td>7/6/2013</td>
<td>7/6/2013</td>
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<td>Terrence Train</td>
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<td>8/16/2013</td>
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<td>8/16/2013</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Devin Carn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>David Crockett</td>
<td>Yes</td>
<td>12/22/2012</td>
<td>12/22/2012</td>
<td>12/22/2012</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tom Jawyer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jen Lawrence</td>
<td>Yes</td>
<td>9/14/2013</td>
<td>9/14/2013</td>
<td>9/14/2013</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sasha Jones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrique Montoya</td>
<td></td>
<td>5/13/2013</td>
<td>5/13/2013</td>
<td>5/13/2013</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Transition Readiness: What’s New?

– Updated versions for youth and families
– Lowered literacy level (now 5.7)
– New validated questions on importance and confidence
Sample Transition Readiness Assessment for Youth
Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what you already know about your health and how to use health care and the areas that you need to learn more about. If you need help completing this form, please ask your parent/caregiver.

Date: 

Name: 

Date of Birth: 

<table>
<thead>
<tr>
<th>Transition Importance and Confidence</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important is it to you to prepare for change to an adult doctor before age 22?</td>
<td></td>
</tr>
<tr>
<td>0 (not) 1 2 3 4 5 6 7 8 9 10 (very)</td>
<td></td>
</tr>
<tr>
<td>How confident do you feel about your ability to prepare for change to an adult doctor?</td>
<td></td>
</tr>
<tr>
<td>0 (not) 1 2 3 4 5 6 7 8 9 10 (very)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Health</th>
<th>Yes, I know this</th>
<th>I need to learn</th>
<th>Someone needs to do this... Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know my medical needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can explain my medical needs to others.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my symptoms including ones that I quickly need to see a doctor for.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know what to do in case I have a medical emergency.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my own medicines, what they are for, and when I need to take them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know my allergies to medicines and medicines I should not take.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I carry important health information with me every day. (e.g. insurance card, allergies, medications, emergency contact information, medical summary)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand how health care privacy changes at age 18 when legally an adult.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can explain to others how my customs and beliefs affect my health care decisions and medical treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Using Health Care                                                                                          |                  |                |                               |
| I know or I can find my doctor's phone number.                                                           |                  |                |                               |
| I make my own doctor appointments.                                                                      |                  |                |                               |
| Before a visit, I think about questions to ask.                                                          |                  |                |                               |
| I have a way to get to my doctor's office.                                                              |                  |                |                               |
| I know to show up 15 minutes before the visit to check in.                                               |                  |                |                               |
| I know where to go to get medical care when the doctor's office is closed.                              |                  |                |                               |
| I have a file at home for my medical information.                                                        |                  |                |                               |
| I have a copy of my current plan of care.                                                                |                  |                |                               |
| I know how to fill out medical forms.                                                                   |                  |                |                               |
| I know how to get referrals to other providers.                                                          |                  |                |                               |
| I know where my pharmacy is and how to refill my medicines.                                             |                  |                |                               |
| I know where to get bloodwork or x-rays if my doctor orders them.                                       |                  |                |                               |
| I have a plan so I can keep my health insurance after 18 or older.                                       |                  |                |                               |
| My family and I have discussed my ability to make my own health care decisions at age 18.               |                  |                |                               |
4. Transition Planning: What’s New?

- New template for plan of care that incorporates health into youth’s overall priorities
- New combined medical summary and emergency care plan
- New sample condition fact sheet
Sample Plan of Care
Six Core Elements of Health Care Transition 2.0

Instructions: This sample plan of care is a written document developed jointly with the transitioning youth to establish priorities and a course of action that integrates health and personal goals. Motivational interviewing and strength-based counseling are key approaches in developing a collaborative process and shared decision-making. Information from the transition readiness assessment can be used to guide the development of health goals. The plan of care should be dynamic and updated regularly and sent to the new adult provider as part of the transfer package along with the latest transition readiness assessment, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents.

Name: ______________________
Primary Diagnosis: ____________
Date of Birth: ________________
Secondary Diagnosis: __________

What matters most to you as you become an adult? How can learning more about your health condition and how to use health care support your goals?

<table>
<thead>
<tr>
<th>Prioritized Goals</th>
<th>Issues or Concerns</th>
<th>Actions</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Date Complete</th>
</tr>
</thead>
</table>

Initial Date of Plan: ________________
Last Updated: ________________
Parent/Caregiver Signature: ____________
Clinician Signature: ________________
Care Staff Contact: ________________
Care Staff Phone: ________________
# Sample Medical Summary and Emergency Care Plan

**Six Core Elements of Health Care Transition 2.0**

This document should be shared with and carried by youth and families/caregivers.

<table>
<thead>
<tr>
<th>Date Completed</th>
<th>Date Revised</th>
</tr>
</thead>
</table>

**Contact Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Nickname:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.O.B.</td>
<td>Preferred Language:</td>
</tr>
<tr>
<td>Parent (Caregiver):</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Cell #:</th>
<th>Home #:</th>
<th>Best Time to Reach:</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Mail:</td>
<td>Best Way to Reach:</td>
<td>Text</td>
<td>Phone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Insurance Plan:</th>
<th>Group and ID #:</th>
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</thead>
</table>

**Emergency Care Plan**

<table>
<thead>
<tr>
<th>Emergency Contact:</th>
<th>Relationship:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Emergency Care Location:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Common Emergent Presenting Problems**

<table>
<thead>
<tr>
<th>Suggested Tests</th>
<th>Treatment Considerations</th>
</tr>
</thead>
</table>

**Special Concerns for Disaster:**

<table>
<thead>
<tr>
<th>Allergies and Procedures to be Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be avoided</th>
<th>Why?</th>
</tr>
</thead>
</table>

**Diagnoses and Current Problems**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Details and Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td></td>
</tr>
</tbody>
</table>

- Behavioral
- Communication
- Feeding & Swallowing
- Hearing/Vision
- Learning
- Orthopedic/Musculoskeletal
- Physical Anomalies
- Respiratory
- Sensory
- Stamina/Fatigue
- Other
5. Transfer of Care: What’s New?

- New sample transfer letter
- Transfer Checklist
Dear Adult Provider,

_Name_ is an _age_ year-old patient of our pediatric practice who will be transferring to your care on _date_ of this year. _His or her_ primary chronic condition is _condition_ and _his or her_ secondary conditions are _conditions_. _Name’s_ related medications and specialists are outlined in the enclosed transfer package that includes _his or her_ medical summary and emergency care plan, plan of care, and transition readiness assessment. _Name_ acts as _his or her_ own guardian, and is insured under _insurance plan_ until age _age_.

I have had _name_ as a patient since _age_ and am very familiar with _his or her_ health condition, medical history, and specialists. I would be happy to provide any consultation assistance to you during the initial phases of _name’s_ transition to adult health care. Please do not hesitate to contact me by phone or email if you have further questions.

Thank you very much for your willingness to assume the care of this young _man or woman_.

Sincerely,
6. Transfer Completion: What’s New?

- New transition feedback surveys for youth and families
- Several questions adapted from new questions under development for National Survey of Children’s Health
# Sample Health Care Transition Feedback Survey for Youth

Six Core Elements of Health Care Transition 2.0

This is a survey about your experiences changing from pediatric to adult health care. You may choose to answer this survey or not. Your responses to this survey are confidential.

1. How often did your previous healthcare provider explain things in a way that was easy to understand?
   - Always
   - Usually
   - Sometimes
   - Never

2. How often did your previous healthcare provider listen carefully to you?
   - Always
   - Usually
   - Sometimes
   - Never

3. Did your previous healthcare provider respect how your customs or beliefs affect your care?
   - A lot
   - Some
   - A little
   - Not at all

4. Did your previous healthcare provider discuss with you or have an office policy that informs you at what age you may need to transfer to a new provider who treats mostly adults?
   - Yes
   - No

5. Did you talk with your previous healthcare provider without your parent or guardian in the room?
   - Yes
   - No

6. Did your previous healthcare provider actively work with you to gain skills to manage your own health and health care (e.g., know your medications and their side effects, know what to do in an emergency)?
   - A lot
   - Some
   - A little
   - Not at all

7. Did your previous healthcare provider actively work with you to think about and plan for the future (e.g., take time to discuss future plans about education, work relationships, and development of independent living skills)?
   - A lot
   - Some
   - A little
   - Not at all

8. How often did you schedule your own appointments with your previous healthcare provider?
   - Never
   - Sometimes
   - Usually
   - Always

9. Did your previous healthcare provider explain legal changes in privacy, decision-making, and consent that take place at age 18?
   - Yes
   - No

10. Did your previous healthcare provider actively work with you to create a written plan to meet your health goals and needs?
    - Yes
    - No

11. Did your previous healthcare provider create and share with you your medical summary?
    - Yes
    - No

12. Did your previous healthcare provider have information about community resources?
    - Yes
    - No

13. Do you know how you will be insured as you become an adult?
    - Yes
    - No
Measurement Options

1. Current Assessment of Health Care Transition Activities
   • Qualitative self-assessment tool modeled after index
   • Provides a snapshot of where practice is in implementing transition processes
   • New questions on consumer feedback and leadership
<table>
<thead>
<tr>
<th>Element</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transition Policy</td>
<td>Clinicians vary in their approach to health care transition, including the appropriate age for transfer to adult providers.</td>
<td>Clinicians follow a uniform but not a written policy about the age for transfer. The approach for transition planning differs among clinicians.</td>
<td>The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information and addresses the practice’s transition approach and age of transfer. The policy is not consistently shared with youth and families.</td>
<td>The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information, a description of the practice’s approach to transition, and age of transfer. Clinicians discuss it with youth and families beginning at ages 12 to 14. The policy is publicly posted and familiar to all staff.</td>
<td></td>
</tr>
<tr>
<td>2. Transition Tracking and Monitoring</td>
<td>Clinicians vary in the identification of transitioning youth, but most wait until close to the age of transfer to identify and prepare youth.</td>
<td>Clinicians use patient records to document certain relevant transition information (e.g., future provider information, date of transfer).</td>
<td>The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete some but not all transition processes</td>
<td>The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete all “Six Core Elements of Health Care Transition 2.0,” using EHR if possible.</td>
<td></td>
</tr>
</tbody>
</table>
Measurement Options

2. Health Care Transition Process Measurement Tool

• Objective scoring method with documentation requirements
• Measures implementation of Six Core Elements, consumer feedback and leadership, and dissemination
• Intended to be conducted at start of QI initiative as baseline measure and repeated to assess progress
# Measurement Tool: Policy Example

**Health Care Transition Process Measurement Tool for Transitioning Youth to Adult Health Care Providers** (continued)

**Six Core Elements of Health Care Transition 2.0**

## A) Implementation in Practice/Network

<table>
<thead>
<tr>
<th>Implementation in Practice/Network</th>
<th>--</th>
<th>Possible</th>
<th>Actual</th>
<th>Possible Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transition Policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed a written transition policy/statement that describes the practice’s approach to transition</td>
<td>Yes = 4</td>
<td>Transition policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included information about privacy and consent at age 18 in transition policy/statement</td>
<td>Yes = 2</td>
<td>Transition policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posted policy/statement (public clinic spaces, practice website etc.)</td>
<td>Yes = 2</td>
<td>Photo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educated staff about transition policy/statement and their role in transition process</td>
<td>Yes = 2</td>
<td>Date(s) of program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated practice staff to incorporate <em>Six Core Elements</em> into clinical processes</td>
<td>Yes = 4</td>
<td>Job description</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transition Policy Subtotal:** 14

## B) Youth and Family Feedback and Leadership

<table>
<thead>
<tr>
<th>Youth and Family Feedback and Leadership</th>
<th>Yes or No</th>
<th>Possible</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included youth and families in developing policy</td>
<td>Yes = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## C) Dissemination in Practice/Network

**Percent of Patients in Practice Receiving Transition Elements:**

<table>
<thead>
<tr>
<th>Score Points:</th>
<th>1–10%</th>
<th>11–25%</th>
<th>26–50%</th>
<th>51–75%</th>
<th>76–100%</th>
<th>Possible</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transition Policy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sharing policy with families and youth ages 12–21 (letter or visit)**

**Transition Policy Subtotal:** 5
Next Steps: Dissemination of Six Core Elements Packages

• New Six Core Elements Packages now available for:

  - Transitioning Youth to Adult Health Care Providers
    (Pediatric, Family Medicine, and Med-Peds Providers)
  - Transitioning to an Adult Approach to Health Care Without Changing Providers
    (Family Medicine and Med-Peds Providers)
  - Integrating Young Adults into Adult Health Care
    (Internal Medicine, Family Medicine, and Med-Peds Providers)

• Launch of new website with interactive health professional page in spring
• Spanish and low literacy versions of packages available in summer
• Feedback welcome: info@gottransition.org
Next Steps: Transition Learning Networks with 4 Large Integrated Care Systems

- Kaiser Northern California – primary care
- Health Partners (MN) – primary care
- Henry Ford Health System (MI) – primary care
- Walter Reed National Military Medical Center (MD) – specialty care
  - Partnership in implementing and evaluating new Six Core Elements Packages
  - Pediatric and adult teams participating
  - Coaching support to networks by Got Transition
  - Goal: to learn about spread of transition QI and ROI
Next Steps: State Title V Transition Planning Group

• CSHCN Directors and Adolescent Coordinators from MD, OH, OR, RI, TX, and WI
  – Goal: to expand leadership development with implementation and evaluation of updated Six Core Elements packages
    • Building partnerships between pediatric and adult providers/systems of care and engaging state public health adolescent health and chronic disease programs
    • Expanding youth/young adult/family leadership in transition quality improvement
Conclusion

• Time is now to bring transition from pediatric to adult health care to the forefront
• Transition support is a need for all youth, and especially those with chronic conditions
• Transition is a concern of many providers, but not yet a common standard of primary and specialty care practices
• We hope the updated version of the Six Core Elements and the 3 new packages of clinical samples/tools will accelerate quality improvements in health care transition