



Starting a Transition Improvement Process Using the Six Core Elements of Health Care Transition

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Introduction: Experience has offered some basic lessons to help start or improve a transition process for youth transitioning to adult care. Below are suggested **initial** steps that are applicable whether youth are moving from a pediatric practice and/or pediatric approach to care to an adult practice and/or adult approach to care. These are intended for use in pediatric, family medicine, med-peds, and internal medicine practices (both primary care and specialty practices), and health systems. The four steps are interrelated and often occur at the same time, and the tips for success have been learned from transition improvement projects across the United States. Transition tools and measurement resources to accompany these suggestions are available at: www.gottransition.org.

Step 1: Securing Senior Leadership Support

- Gain explicit support of key senior leader(s) who are in a position to develop long-range goals and are willing to:
 - Publicly and actively back the project
 - Ensure dedicated time from both administrative support and clinical transition improvement team to pilot incorporating the Six Core Element tools into the clinic process
 - Ensure availability of resources, such as health information technology
 - Align with other strategic activities
 - Endorse/guide expansion from pilot to full scope
 - Communicate with senior leader counterparts when needed (e.g. between pediatric and adult institutions or settings)

Step 2: Forming the Transition Improvement Team

- Include key stakeholders:
 - Pediatric care champion(s)
 - Adult care champion(s)
 - Care coordinator(s)/key support staff (see below)
 - Consumers -- young adults who have transitioned and parents of youth in transition
 - Plan to support their time unless they are paid staff members
 - Be flexible about meeting times to accommodate participation
 - Consider recruiting more than one youth and family consumer so their views and opinions are always represented
 - Articulate role and provide training if needed (including from other consumers who have taken leadership roles in the practice)
 - Others (part of team or participate on *ad hoc* basis)
 - Clinic support staff (nursing, social work, front desk) from both pediatric and adult practices/clinics
 - Electronic health record (EHR) representative
 - Data administrator who can pull system/practice data to support the initiation and evaluation the process
 - Senior leader
 - Payer(s)

Step 3: Defining Transition Processes for Improvement

- Create a Health Care Transition (HCT) Charter (goals and plan) that includes:
 - Overall aim: population, target goals, timeline, success indicators
 - Scope (single clinic, primary care, specialty care, institution-wide)
 - Population – all youth vs. special health care needs vs. selected conditions
 - Rationale – why now? (Consider having pediatric and adult providers involved complete the [Current Assessment of HCT Activities](#) tool to document the need)
 - Strategies/drivers in the practice/system that can augment to push the project to meet charter’s goals
 - Key challenges and barriers within system that need to be overcome
 - Timeline for improvement activities
 - Measures of success
 - Evaluation plan for transition process improvements (click here for [Current Assessment of HCT Activities](#) or [HCT Process Measurement](#) tools) and outcome measures (e.g., health care utilization, cost of care, transfer completion, continuity of primary care) and transition experience of youth (click here for [HCT Feedback Survey for Youth](#))

Step 4: Dedicating Time to Implement Transition Improvements

- Schedule regular meetings for the transition team
 - Use efficient meeting techniques so participants feel their time is well used
 - Meet twice monthly or more at start to jump start the charter and improvement process

- Adopt a clear methodology for the change or improvement process (e.g. use of PDSA rapid cycles)
- Be sure everyone on the team understands and buys into the transition charter
- Collect and share regular improvement feedback and data collected with all team members
- Consider how the process can be enhanced by EHR improvements. However, even if all the transition tools are available in the EHR, busy providers may ignore them unless they have been a part of the process and buy-in to their usefulness

Tips for Success

- Tips for success
 - Don't reinvent the wheel:
 - Connect with other transition improvement efforts regionally and/or nationally to learn and share best practices
 - Review each of the six core elements: do you need to customize?
 - Be sure the tools for each of the core elements go through a quality improvement process: plan/do/study/act (PDSA) cycle to be sure the staff, families, and youth have a chance to review, "try out," make changes, and approve
 - Plan how to incorporate tools into clinic work flow and test in a similar PDSA cycle process, as above, so that if the provider champion is not there, the transition process still moves forward
 - Discuss and clearly articulate roles of pediatric and adult provider teams
 - Start with manageable scale (e.g. pilot the process changes first and then disseminate)
 - Don't start with transitioning the most complex patients – aim for early wins to test the process
 - Plan a process that starts early (ages 12-14), but also plan a fast track process for "20 year olds" still in the pediatric system
 - Follow the evaluation plan in the charter to track the transition project's progress and impact
 - Include plan for spread/dissemination once the initial pilot of the processes have been tried and found to be helpful
 - Include public relations and marketing strategy in participating organizations

For questions, please contact Patience White, MD, MA at pwhite@thenationalalliance.org.

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