Where Rubber Meets the Road: Bringing Health Care Transition to Your Practice

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Got Transition
Center for Health Care Transition Improvement
Disclosures

The presenter has no disclosures, and no conflicts of interest.
Presentation Learning Objectives

After this presentation, you will be able to:

- Assess a clinic’s HCT activities in which you participate by using the Current Assessment of Health Care Transition Activities
- Discuss the AAP/AAFP/ACP Clinical Report
- Discuss your assessment of the clinic in light of the *Six Core Elements of Health Care Transition*
- Discuss the resources available at Gottransition.org
Assess Your Transition Activities Directions

- Imagine:
  - Identify a routine Med-Peds outpatient clinic in which you participate
  - Think about the transition age youth (14-22) in that clinic and what you/the clinic offers on a routine basis to assist those youth to transition to an adult model of care

- Complete the “Current Assessment of Health Care Transition Activities” that happens in that clinic for youth ages 14-22

- Mark your answers and we will poll everyone's responses and discuss each activity
Background Need for Transition Improvements

- 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, the population affected by transition from pediatric to adult care. All Adolescents need to transition to adult-centered care.

- Emerging young adults (ages 18-25):
  - fare worse than adolescents (ages 12-17) or young adults (ages 26-35).
  - have the highest use of ER among those younger than age 75.
  - most likely to report no health care visits in last 12 months even with the ACA changes in health insurance.

- Without transition support, data show health is diminished, quality of care is compromised, and health care costs are increased*.

- Majority of youth and families are ill-prepared for this change.

- Surveys of health care providers consistently show they lack a systematic way to support youth, families, and young adults in transition from pediatric to adult health care.

National Context for Transition

- ACA: Transition an essential health home service, insurance expansions for young adults
- NCQA medical home standards on transition (plan of care, self-care support, transfer of medical records)
- Healthy People 2020 (discussion of transition planning with health care provider)
- CMS/CMMI focus on transition from hospital to home
State of Health Care Transition from Pediatric to Adult Health Care Approaches
What to do? Where to start?
Background

- What is the ACP/AAFP/ACP Clinical Report on HCT?
- What are the 6 Core Elements?
AAP/AAPF/ACP Clinical Report on Health Care Transition

- In 2011, Clinical Report on Transition published as joint policy by AAP/AAPF/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 adult approach to care/transfer of care to adult medical home and adult specialists

<table>
<thead>
<tr>
<th>Age</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Youth and family aware of transition policy</td>
</tr>
<tr>
<td>14</td>
<td>Health care transition planning initiated</td>
</tr>
<tr>
<td>16</td>
<td>Preparation of youth and parents for adult approach to care and discussion of preferences and timing for transfer to adult health care</td>
</tr>
<tr>
<td>18</td>
<td>Transition to adult approach to care</td>
</tr>
<tr>
<td>18-22</td>
<td>Transfer of care to adult medical home and specialists with transfer package</td>
</tr>
</tbody>
</table>

“Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home” (*Pediatrics*, July 2011)
HCT Quality Improvement: Six Core Elements of Health Care Transition

- Original Six Core Elements, developed in 2011, as QI strategy based on AAP/AAFP/ACP Clinical Report with set of sample tools and transition index.

- HCT Learning Collaboratives (with primary and specialty care practices)
  - Conducted between 2010-2012 in DC, Boston, Denver, New Hampshire, Minnesota, Wisconsin
  - Used well-tested Learning Collaborative methodology from the National Initiative for Children’s Healthcare Quality and pioneered by Institute for Healthcare Improvement
  - Demonstrated Six Core Elements and tools feasible to use in clinical settings and resulted in quality improvements in transition process*

* McManus et al. *Journal of Adol Health* 56:73 2014
Six Core Elements of Transition

1. Transition Policy
2. Transition Tracking and Monitoring
3. Transition Readiness
4. Transition Planning
5. Transfer of Care
6. Transition Completion

- Discuss Transition Policy
- Track progress
- Assess skills
- Develop transition plan
- Transfer documents
- Confirm completion

AGES 12-14
AGES 14-15-16-17-18
AGES 14-15-16-17-18
AGES 14-15-16-17-18
AGE 18-21
3-6 months after transfer
Six Core Elements 2.0

Three Transition Packages for Practices Available for different transition situations

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: Updated 2.0 versions

- New and improved samples/tools for each package
  - Released June 2014
- Updates based on HCT LC experiences and reviewed by national transition experts
- Aligned with the Six Core Elements
- Currently available on gottransition.org
- Customizable (using Word version) and available in Spanish
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**
(Family Medicine and Med-Peds Providers)

**Integrating Young Adults into Adult Health Care**
(Internal Medicine, Family Medicine, and Med-Peds Providers)
Transition Policy

- Distinctive policy examples in the 3 packages
- Emphasis on adult approach to care and legal changes at age 18, including options for supported decision-making
- Clarity about support offered by practice and ages and expectation for transfer
- This core element was particularly welcomed by families and youth
[Practice Name] is committed to helping our pediatric patients become better prepared for an adult model of health care at age 18 to continue on with our practice as young adults. At about age 14 we will begin to spend time during the visit without the parent present in order to answer questions, set health goals, and support increasing independence with 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. However, we will no longer be allowed to discuss anything with parents about care or share any personal health information without the young adult’s written consent. To allow others to be involved in health care decisions requires that a signed consent form be completed, which we have at the clinic. If an adolescent has a condition that prevents him/her from making decisions, we encourage families to consider options for supported decision-making. Your health is important to us. If you have any questions or concerns, please feel free to contact us.
Transition Policy: Benefits

Why is it important?

- Building consensus
- Addressing fairness
- Meeting expectations of young adults
- Allowing for planning and systematic processes
- Young adults who reviewed the pilot policy said they were grateful for the information
- Now everyone understands (young adults/parents/providers):
  - What is expected in an adult model of care or a new adult practice
  - Confidentiality and consent
TRACKING & MONITORING
Tracking and Monitoring

- Support the practice to focus on initial QI for a pilot population
- Distinctive tracking issues in 3 packages
- Tools available for those with and without electronic health records for tracking documentation options
- Individual Transition Flow Sheet for use in paper chart or EHR
- Registry set up as an Excel file
Sample Individual Transition Flow Sheet

Six Core Elements of Health Care Transition 2.0

Patient Name: ________________  Date of Birth: ________________

Primary Diagnosis: ________________

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

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

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

Adult Model of Care
- Decision-making changes, privacy, and consent in adult care discussed with youth and parent/caregiver (if needed, discussed plans for supported decision-making) ________________ Date

Transfer of Care to Adult Specialists
- Arrange for transfer to adult specialty providers, if needed ________________ 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>First Appointment</th>
<th>Next Scheduled Appointment [Date or Blank]</th>
<th>Communicated with Pediatric Provider [Yes or Blank]</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/6/1995</td>
<td>18 Y</td>
<td>Mary Smith</td>
<td>seizure disorder</td>
<td>3</td>
<td>12/1/2013</td>
<td>1/30/2014</td>
<td>Yes</td>
</tr>
<tr>
<td>12/25/1992</td>
<td>21 Y</td>
<td>Susan Cue</td>
<td>major depressive disorder</td>
<td>2</td>
<td>7/6/2012</td>
<td>2/7/2014</td>
<td>Yes</td>
</tr>
<tr>
<td>1/17/1993</td>
<td>21 Y</td>
<td>Terrence Train</td>
<td>JRA</td>
<td>2</td>
<td>8/16/2013</td>
<td>4/13/2014</td>
<td>Yes</td>
</tr>
<tr>
<td>4/18/1990</td>
<td>23 Y</td>
<td>David Crockett</td>
<td>well</td>
<td>1</td>
<td>11/22/2012</td>
<td>4/13/2014</td>
<td>Yes</td>
</tr>
<tr>
<td>4/2/1995</td>
<td>18 Y</td>
<td>Tom Sawyer</td>
<td>ADHD</td>
<td>2</td>
<td>6/19/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/3/1989</td>
<td>25 Y</td>
<td>Jen Lawrence</td>
<td>cerebral palsy</td>
<td>3</td>
<td>9/14/2012</td>
<td>2/15/2014</td>
<td>Yes</td>
</tr>
<tr>
<td>2/14/1997</td>
<td>26 Y</td>
<td>Sasha Jones</td>
<td>well</td>
<td>1</td>
<td>4/16/2012</td>
<td></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>5/13/2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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#### Transition Registry 1/21/2014

<table>
<thead>
<tr>
<th>Name</th>
<th>Transfer Package Received</th>
<th>Contacted Young Adult Before First Visit [Date or Blank]</th>
<th>Policy Shared with Young Adult [Yes or Blank]</th>
<th>Self-Care Assessment Administered [Date or Blank]</th>
<th>Plan of Care Updated and Shared with Young Adult [Date or Blank]</th>
<th>Medical Summary and Emergency Care Plan Updated and Shared with Young Adult [Date or Blank]</th>
<th>Elicted Feedback from Young Adult about Transition and Experience with Care [Yes or Blank]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan Cue</td>
<td>Yes</td>
<td>6/32/2013</td>
<td>Yes</td>
<td>8/16/2013</td>
<td>8/16/2013</td>
<td>8/16/2013</td>
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<tr>
<td>Terrence Train</td>
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<td>8/16/2013</td>
<td>Yes</td>
<td>9/20/2013</td>
<td>9/20/2013</td>
<td>9/20/2013</td>
<td></td>
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<tr>
<td>Dewey Carn</td>
<td>Yes</td>
<td>7/9/2013</td>
<td>Yes</td>
<td>9/20/2013</td>
<td>9/20/2013</td>
<td>9/20/2013</td>
<td>Yes</td>
</tr>
<tr>
<td>David Crockett</td>
<td>Yes</td>
<td>7/9/2013</td>
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<td>12/22/2012</td>
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<tr>
<td>Tom Sawyer</td>
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<td>Yes</td>
<td>12/22/2012</td>
<td>12/22/2012</td>
<td>12/22/2012</td>
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<tr>
<td>Jen Lawrence</td>
<td>Yes</td>
<td>8/26/2012</td>
<td>Yes</td>
<td>9/14/2014</td>
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<tr>
<td>Sasha Jones</td>
<td>Yes</td>
<td>4/3/2012</td>
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<td>9/14/2014</td>
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<td></td>
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<tr>
<td>Enrique Montoya</td>
<td>Yes</td>
<td>4/16/2012</td>
<td>Yes</td>
<td>9/14/2014</td>
<td>9/14/2014</td>
<td>9/14/2014</td>
<td></td>
</tr>
</tbody>
</table>

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**got transition?**
Transition Registry: Why Is It Important?

- Creation of a paper or electronic database used to document/track youth with special health care needs as they move through the transition process.
- Systematically identifies youth and young adult patients needing self-care management assistance and planning for an adult model of care.
- Helps to individualize patient visits consistent with transition clinical recommendations.
Element #3: Transition Readiness / Orientation to the Adult Practice

**PEDIATRIC COMPONENT**

- Assess readiness for an adult approach to care with transition skill readiness assessments several times during the transition process.
- If the youth is leaving your practice, locate adult practices interested in collaborating / receiving prepared youth/young adults.

**ADULT COMPONENT**

- Develop and share your practice policy emphasizing the Confidentiality and Consent components (modified if decision making support is needed) and welcome and orientation materials for your practice’s approach to an adult model of care- being explicit about this process is key to having the youth/young adult understand their role in self care.
- Assess YA self Care skills.
### Transition Importance and Confidence

*On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

<table>
<thead>
<tr>
<th></th>
<th>0 (not)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 (very)</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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### My Health

*Please check the box that applies to you right now.*

<table>
<thead>
<tr>
<th></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

<table>
<thead>
<tr>
<th></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 or I can find my doctor’s phone number.</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Self Care Assessment for Young Adults

- Literacy level (Grade 5.7)
- Validated questions on importance and confidence
- Young adults and caregivers appreciate reviewing/learning what general skills are needed to be successful in an adult practice
- Young adult’s self-care assessment incorporated into adult approach to care visit
Transition Planning

Integration Into Adult Model of Care or Adult Practice

- Make sure the Y/YA HCT Plan of care incorporates health into young adult’s overall priorities (key issue for the GT young adult review panel)
  Templates available

- Develop/ update combined medical summary and emergency care plan – pay special attention to the section where you can state what is special about this youth to assist the next provider in engaging the youth in a new health care relationship

- Share Medical Summary, ECP and HCT Plan of Care with youth/young adult so they have a copy to share when needed

- For those youth joining your practice suggest a pre-visit welcome call and send reminder text for first visit
# 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>
<tbody>
<tr>
<td>Form completed by:</td>
<td></td>
</tr>
</tbody>
</table>

## Contact Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Nickname:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Preferred Language:</td>
</tr>
<tr>
<td>Parent (Caregiver):</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell #:</th>
<th>Home #:</th>
<th>Best Time to Reach:</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Mail:</td>
<td></td>
<td>Best Way to Reach:</td>
</tr>
<tr>
<td>Health Insurance/Plan:</td>
<td>Group and ID #:</td>
<td></td>
</tr>
</tbody>
</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>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Special Concerns for Disaster:

## Allergies and Procedures to be Avoided

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## To be avoided

<table>
<thead>
<tr>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Medical Procedures:

- [ ]
Transition Planning

- Plan specialty transfer if needed
- Develop, if not received from pediatric practice, and regularly update a plan of care
- Provide linkages to insurance information, culturally appropriate community supports, self care management information
- Youth with intellectual challenges (if needed):
  - Review supported decision making plan
  - Understand their unique communication needs
Transfer of Care if/when needed

Your practice responsibility when transferring to a new adult provider

Transfer letter to the new adult provider with:

- Appropriate documentation
- Statement that the youth’s care is covered by your practice until first visit
- Offer to be a consultant as needed

- Readiness assessment
- Medical summary and emergency care plan
- Plan of care & decision support documents
- Condition fact sheet, if needed
Sample Transfer of Care Checklist
Six Core Elements of Health Care Transition 2.0

Patient Name: ____________________ Date of Birth: ____________

Primary Diagnosis: ________________ Transition Complexity: ________________

- Prepared transfer package including:
  - Transfer letter, including effective of date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including transition goals and pending actions
  - Updated medical summary and emergency care plan
  - Guardianship or health proxy documents, if needed
  - Condition fact sheet, if needed
  - Additional provider records, if needed

- Sent transfer package _____________ Date

- Communicated with adult provider about transfer _____________ Date
Transfer of Care / Initial Adult Practice Visit

Your practice responsibility when accepting a Y/YA into your practice

Suggestions on what youth prefer from their provider prior to and during initial visit

- Pre-visit contact recommended
- At first 2 visits, discussion about:
  - Discuss transfer concerns/orientation to adult care/practice
  - Discuss young adult’s partnership with adult provider (privacy and confidentiality) and best approach to communication (phone, text, email)
  - Decision making support (if needed) or review legal documents provided (guardianship)
  - Review medical summary and update emergency care plan with young adult.
  - Review transition readiness assessment/administer self-care assessment and review and update plan of care
TRANSFER COMPLETION + ONGOING CARE
Transfer Completion / Ongoing Care

- Transition feedback surveys
- Learn how the integration into the adult practice is going
- Several questions adapted from new questions under development for National Survey of Children’s Health and AHRQ survey on transition
- Asking for feedback can build a bond between the young adult and the new practice so they will return to the new adult provider

Sample Health Care Transition Feedback Survey for Youth
Six Core Elements of Health Care Transition 2.0

This is a survey about your experience 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 health care provider explain things in a way that was easy to understand?
   - Always
   - Usually
   - Sometimes
   - Never

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

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

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

5. Did your previous health care 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

6. How often did you schedule your own appointments with your previous health care provider?
   - Never
   - Sometimes
   - Usually
   - Always

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

8. Did your previous health care provider actively work with you to create a written plan to meet
Transfer Completion / Ongoing Care

Follow up responsibilities of provider:

- Confirm transfer completion with past/next provider
- Reach out and ask for/offer consultation with past/next provider as needed
- Build ongoing collaborative relationship with pediatric primary and specialty care providers
- Have a list of adult specialty providers willing to care for young adults as needed
Measurement Options
Measurement Options

1. Initial Health Care Transition Assessment

- 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
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 Integrating Young Adults into Adult Health Care

*Six Core Elements of Health Care Transition 2.0*

### A) Implementation Requirement

<table>
<thead>
<tr>
<th>A. Young Adult Transition and Care Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed a written transition and care policy that describes the practice's approach to accepting and partnering with new young adults</td>
</tr>
<tr>
<td>Included information about privacy and consent in transition policy</td>
</tr>
<tr>
<td>Posted policy in public clinic spaces</td>
</tr>
<tr>
<td>Educated staff about transition policy and their role in transition process</td>
</tr>
<tr>
<td>Designated practice staff to incorporate Six Core Elements into clinical processes</td>
</tr>
</tbody>
</table>

**Transition Policy Implementation Subtotal:** 14

### B) Young Adult Engagement Requirement

<table>
<thead>
<tr>
<th>B. Young Adult Engagement Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included input from young adults in developing policy</td>
</tr>
</tbody>
</table>

### C) Dissemination in Practice/Network

<table>
<thead>
<tr>
<th>C. Dissemination in Practice/Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Patients in Practice:</td>
</tr>
<tr>
<td>1–10%</td>
</tr>
<tr>
<td>11–25%</td>
</tr>
<tr>
<td>26–50%</td>
</tr>
<tr>
<td>51–75%</td>
</tr>
<tr>
<td>76–100%</td>
</tr>
<tr>
<td>Possible</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>Actual</td>
</tr>
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</table>

**Total Score Points:** 15

<table>
<thead>
<tr>
<th>1. Transition Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing policy with young adults, ages 18–26 (letter or visit)</td>
</tr>
</tbody>
</table>

**Transition Policy Dissemination Subtotal:** 5
New Got Transition Center for HCT Improvement Goals: 2014-2018

1. Build on Transition Quality Improvement work and disseminate to larger populations and practices
2. Transition education and training
3. Young adult and family engagement
4. Transition policy interventions
5. Transition information dissemination
Integrated Care Systems working with Got Transition on HCT QI

- Partnership in implementing and evaluating new Six Core Elements packages
- Pediatric and adult provider (includes Med-Peds and Family Medicine) teams participating
- Coaching support to networks by Got Transition
- **Goal:** to learn about dissemination of transition QI and ROI

Cleveland Clinics
Primary Care

Health Partners (MN)
Primary Care

Henry Ford Health System (MI)
Primary Care

Kaiser Northern California
Primary Care

University of Rochester
Specialty Care

Walter Reed National Military Medical Center (MD)
Specialty Care
Health Care Transition Resources

Listed below are resources related to health care transition and organized by topic. This is not an exhaustive list, but rather a selection of current external transition work relevant to a national audience. To submit new or existing resources, please contact info@GotTransition.org.

**Six Core Elements of Health Care Transition**

Listed in the table below are PDFs of the sample tools used in the Six Core Elements of Health Care Transition. Complete packages are available to download and customize for your practice or plan.

<table>
<thead>
<tr>
<th>Transitioning Youth to Adult Health Care Providers (Pediatric, Family Medicine, and Med-Peds Providers)</th>
<th>Transitioning to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Med-Peds Providers)</th>
<th>Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, and Med-Peds Providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complete Package</strong></td>
<td><strong>Complete Package</strong></td>
<td><strong>Complete Package</strong></td>
</tr>
<tr>
<td>Full Package</td>
<td>Full Package</td>
<td>Full Package</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td>Editable Version</td>
<td>Editable Version</td>
<td>Editable Version</td>
</tr>
<tr>
<td><strong>Summary of Six Core Elements</strong></td>
<td><strong>Summary of Six Core Elements</strong></td>
<td><strong>Summary of Six Core Elements</strong></td>
</tr>
<tr>
<td>Transitioning Youth to an Adult Health Care Provider</td>
<td>Transitioning Youth to an Adult Approach to Health Care Without Changing Providers</td>
<td>Integrating Young Adults into Adult Health Care</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td><strong>1) Transition Policy</strong></td>
<td><strong>1) Transition Policy</strong></td>
<td><strong>1) Transition Policy</strong></td>
</tr>
<tr>
<td>Transition Policy</td>
<td>Transition Policy</td>
<td>Young Adult Transition and Care Policy</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td><strong>2) Transition Tracking and Monitoring</strong></td>
<td><strong>2) Transition Tracking and Monitoring</strong></td>
<td><strong>2) Transition Tracking and Monitoring</strong></td>
</tr>
<tr>
<td>Individual Transition Flow Sheet</td>
<td>Individual Transition Flow Sheet</td>
<td>Individual Transition Flow Sheet</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td>Transition Registry</td>
<td>Transition Registry</td>
<td>Transition Registry</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td><strong>3) Transition Readiness</strong></td>
<td><strong>3) Transition Readiness</strong></td>
<td><strong>3) Transition Readiness</strong></td>
</tr>
<tr>
<td>Transition Readiness Assessment for Youth</td>
<td>Transition Readiness Assessment for Youth</td>
<td>Welcome and Orientation of Young Adults</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td>Transition Readiness Assessment for Parents/Caregivers</td>
<td>Transition Readiness Assessment for Parents/Caregivers</td>
<td></td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td></td>
</tr>
<tr>
<td><strong>4) Transition Planning</strong></td>
<td><strong>4) Transition Planning</strong></td>
<td><strong>4) Transition Planning</strong></td>
</tr>
<tr>
<td>Plan of Care</td>
<td>Plan of Care</td>
<td>Plan of Care</td>
</tr>
<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
</tr>
<tr>
<td>Medical Summary and Emergency Care Plan</td>
<td>Medical Summary and Emergency Care Plan</td>
<td>Medical Summary and Emergency Care Plan</td>
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<tr>
<td>En Español</td>
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</tr>
<tr>
<td>Condition Fact Sheet</td>
<td>Condition Fact Sheet</td>
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<tr>
<td>En Español</td>
<td>En Español</td>
<td>En Español</td>
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</tbody>
</table>
Examples of Got Transition’s National Efforts

- ACP Council on Subspecialty Societies Transition Project: 11 subspecialty societies signed up to customize some of the Six Core Elements for several of their diseases
- Updating the 2011 Clinical Report for AAP/AAFP/ACP
- Support States Title V Maternal and Child Health programs on statewide HCT efforts who have chosen transition as one of their focuses for their block grant
- Develop HCT payment strategies
- Building Young Adult/Family/nursing leaders for HCT
- Tip Sheets available at Gottransition.org
  - Starting a Transition Improvement Process
  - Coding and Reimbursement Strategies
  - Incorporating Transition into EPIC EHR
Presentation Learning Objectives

After this presentation, you will be able to:

- Assess your clinic’s HCT activities by scoring your clinic using the Current Assessment of Health Care Transition Activities (see attached)
- Discuss the AAP/AAFP/ACP Clinical Report and the new *Six Core Elements of Health Care Transition*
- Discuss the resources available to start a HCT quality improvement process at your clinic
Thank You and Questions

gottransition.org
See link to new Transition CME sponsored by HSCSN, download the Six Core Element 2.0 packages and start making HCT quality improvements in your practice

pwhite@thenationalalliance.org
Please provide us with your contact information so that we can add you to our mailing list.

HealthCareTransition

@gottransition2