Welcome
Healthcare Transfer of Care
Kickoff Meeting

June 29,2022

Agenda

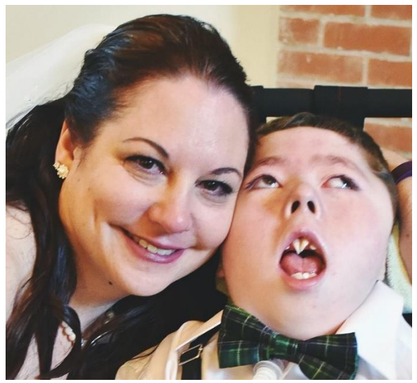
Topic *Presenter(s)*	Duration
Welcome, Thank you RIDOH and Tufts Health Plan & Getting to Know each other *Deborah Garneau, MA, Maternal and Child Health Director, RIDOH* *Colleen Polselli, Special Needs Program Manager Office of Special Needs, RIDOH* *Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Director* *Kim Nguyen-Leite, MHA, CPHQ, PCMH CCE, CTC-RI Program Coordinator*	30 minutes
Got Transitions Overview *Patience White, MD, MA, FAAP, MACP, Co-Project Director Got Transitions, The National Alliance to Advance Adolescent Health*	45 minutes
Review of Objectives & Video *Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Director* *Kim Nguyen-Leite, MHA, CPHQ, PCMH CCE, CTC-RI Program Coordinator*	5 minutes
Review of Deliverables and Timing *Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Director* *Kim Nguyen-Leite, MHA, CPHQ, PCMH CCE, CTC-RI Program Coordinator*	10 minutes

Getting to Know

Rhode Island Department of Health (RIDOH) Team & Family Voice

Colleen Polselli,
Special Needs Program Manager
Office of Special Needs
RI Department of Health

Deborah Garneau, MA
Maternal and Child Health Director
RI Department of Health



Tara Hayes,
Family Voices Manager, RIPIN

Getting to Know the CTC-RI / PCMH Kids Team

Patricia Flanagan,
MD, FAAP,
PCMH Kids
Co-chair

Elizabeth Lange,
MD, FAAP,
PCMH Kids
Co-chair

Pano Yeracaris,
MD, MPH,
CTC Chief
Clinical
Strategist

Susanne Campbell,
RN, MS,
PCMH CCE,
Senior Project
Director

Kim Nguyen-Leite
MHA, CPHQ,
PCMH CCE,
Program
Coordinator II

Getting to Know your Practice Facilitators

Suzanne Herzberg, PhD, MS, OTR/L

Susan Dettling, BS, PCMH CCE

Chad Nevola QI Team

Chad Nevola, MD
Romina Lima, Office Manager
Ariana Forte, Medical Assistant

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Build and implement tools for practice use to facilitate a smooth transition of care for young adults in our ACO from pediatrician to family practice or internal medicine physician. Implement these tools to ease the burden on providers during transition and to improve on the quality of care during the transition process for patients.

Pediatric Practice 2020 Data	
Patient Age	#
Age 12-13	56
Age 14-15	48
Age 16-17	60
Age 18+	65
Total	229
% Medicaid	~31%

What did you learn in year 1?

Transitions are complicated and require far more preparation, organization, policy development and review, and teamwork than previously thought.

What recommendations do you have for Cohort 2?

Start implementing strategies early! Patients will likely need time and multiple discussions to feel reassured enough to participate and proceed.

Richard Ohnmacht QI Team

Richard Ohnmacht, MD
Maureen Coletta, Nurse

Chad Lamendola QI Team

Chad Lamendola, MD
Maureen Coletta, Nurse
Kathleen Rothstein, Nurse Care Manager
Pamela Laramee, Practice Manager

Dr. Ohnmacht Pediatric Practice		Dr. Lamendola Adult Practice	
Patient Age	#	Patient Age	#
Age 12-13	100	Age 18-22	69
Age 14-15	75	Age 23-26	76
Age 16-17	75		
Age 18	65		
Age >18	75		
Total 12-18	315	Total	145
% Medicaid	15	% Medicaid	1

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Use of previously tested and successful strategies to facilitate a smooth, uniform, coordinated and user friendly transition to adult care especially for those patients with special needs.

Establish the framework within our EMR and among our staff to create a more standardized approach to transitioning patients from the Pediatrician's office to our Family Practice. Our goal would be to establish and fine tune a comprehensive approach to the transition of care that creates a long term, comprehensive medical home for pediatric patients as they commence and grow into the doctor patient relationship with their Family Physician and their health care team.

Share something about your practice that others may not know

Dr. Ohnmacht: We have traditionally taken a substantial number of special needs child who are rapidly growing into adults. We have a hard time separating and thus have 8-10 pts 25-35 years old.

ADVANCING INTEGRATED HEALTHCARE

Hello

Hasbro Pediatric Primary Care

Carol Lewis, MD
Gail Davis, RNC
Heather Carvalho, Practice Manager
Nicole Wharton, LPN

Center for Primary Care

Meghan Geary, MD
Danielle Veglia, Practice Manager
Carol Omara, BSN
Dino Messina, MD, PhD

Pediatric Practice	
Patient Age	#
Age 12-13	509
Age 14-15	547
Age 16-17	463
Age 18+	401
Total	1926
% Medicaid	85%

Adult Practice	
Patient Age	#
Age 18-22	138
Age 23-26	443
Total	581
% Medicaid	61.8-70.2%

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

- Expand efforts by identifying and transferring more youth. Testing the transition process with patients aging out of foster care, women with reproductive health issues, and patients with complex care needs.
- Clarifying policy to define a specific age of transfer.
- Ensure that young adult is contacted and keeps the first scheduled appointment with the adult practice.

What did you learn in Year 1

That this is a smoother process and builds on the work that we have already in place in working with families about transitions at the earlier adolescent visits. We also learned that a crucial step is the young adult keeping that first appointment with the adult provider. An opportunity for improvement will be to work on supporting the YA to attend that first adult visit.

What recommendations do you have for Cohort 2?

1) start the discussion of transition at earlier adolescent visits
2) look at strategies to encourage YA attendance at first appointment with adult provider

ADVANCING INTEGRATED HEALTHCARE

Children's Choice Pediatrics

Karim Khanbhai, MD
Erin Sherpa, Medical Assistant
Megan Hawkins, Medical Assistant

Greenwich Medical Associates

Shahid Khan, MD
Kelly Martin, Medical Assistant

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Having timely completion of transfer where patients successfully contact Dr. Khan's office to take the first step in their transition of care. Minimizing loss to follow up and gaps in care.

Children's Choice Pediatrics		Greenwich Medical Associates	
Patient Age	#	Patient Age	#
Age 12-13	204	Age 18-22	35
Age 14-15	316	Age 23-26	79
Age 16-17	434		
Total	1428	Total	114
% Medicaid	46	% Medicaid	24

Share something about your practice that others may not know

Children's Choice Pediatrics:
My practice is in West Warwick. An underserved area before Thundermist arrived. A large rite care population (nhp/ uhc rite care). A lot of indigent and immigrant population.

Getting to Know the National Alliance to Advance Adolescent Health Team

MARGARET McMANUS, MHS, *Co-Project Director Got Transitions*

Ms. McManus is the President of The National Alliance to Advance Adolescent Health, a nonprofit organization dedicated to improving access to comprehensive health care and insurance coverage for adolescents. Since 2013, with Dr. White, she has overseen project management for Got Transition, a program of The National Alliance. Ms. McManus has over 35 years of experience directing national, state, and private foundation projects on child and adolescent health. These projects have addressed health care transition, youth with special health care needs, health care financing, insurance coverage and benefits, mental/behavioral health workforce, and preventive care. Ms. McManus has a Masters in Health Sciences from the Johns Hopkins Bloomberg School of Public Health.

PATIENCE WHITE, MD, MA, FAAP, MACP, *Co-Project Director Got Transitions*

Dr. Patience White is an adult and pediatric rheumatologist who for over 30 years has been involved in transition issues for children with special health care needs. With Ms. McManus, she is responsible for overall project management for Got Transition and provides technical assistance to health plans, Title V agencies, pediatric and adult primary and specialty care practices and professional societies, and health professional training programs. Over her career, she has been active in academic medicine, clinical care, research, public health and advocacy and is the lead author of the 2018 AAP/AAFP/ACP Clinical Report, “Supporting HCT from Adolescence to Adulthood in the Medical Home”. Dr. White completed a doctor of medicine degree from Harvard Medical School, a Robert Wood Johnson Health Policy fellowship in the US Senate, and a master’s in Education from George Washington University Graduate School of Education and Human Development.

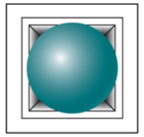
ANNIE SCHMIDT, MPH, *Health Research/Policy Analyst Got Transitions*

Annie Schmidt is responsible for assisting with research and policy analysis related to adolescent health and the development of transition payment options. Ms. Schmidt has been the lead staff person on a number of transition efforts related to Medicaid managed care, value-based payment, a new family transition toolkit, and a clinician toolkit for incorporating transition into adolescent and young adult preventive care. She received her master’s degree in Public Health from the University of North Carolina-Chapel Hill.

Health Care Transition (HCT) Process Improvement: Pediatric to Adult Transition

June 29, 2022

Patience White, MD, MA, FAAP, MACP
Peggy McManus, MHS
Got Transition
The National Alliance to Advance Adolescent Health
Washington DC



The National Alliance
To Advance Adolescent Health

got transition

Disclosures

Patience White and Peggy McManus have no disclosures for this presentation.

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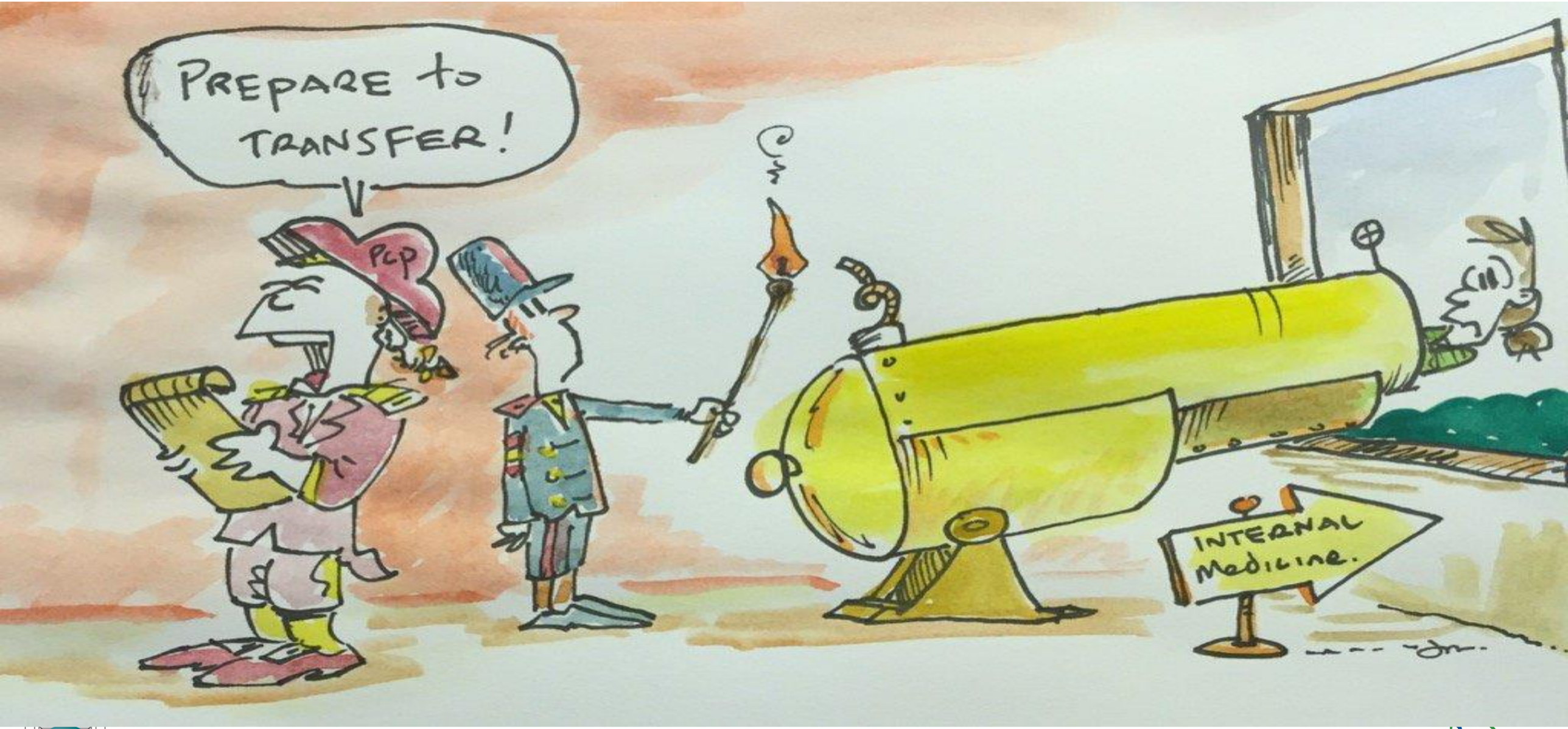
Presentation Objectives

1. To understand the current context of health care transition, HCT outcome evidence and the AAP/AAFP/ACP recommended structured HCT interventions-the Six Core Elements
2. Describe key lessons learned from implementing HCT performance improvement program in 7 RI primary care practices
3. Review tools and resources available through www.gottransition.org



Courtesy of @drmaypole

Transition Background Policy and Data

- AAP/AAFP/ACP recommend that health care transition be part of routine primary, specialty, and behavioral health care for all youth with and without special health care needs
- 2019/2020 National Survey of Children's Health finds:
  - 80% of RI YSHCN and 84% of RI non-YSHCN do NOT receive transition preparation from their health care providers (compared to 76% and 82%, respectively, in US)
  - Among adolescents, ages 12-17, RI has a higher prevalence of special needs (29%) compared to the US (26%)
- Without a HCT process_ inc ED Utilization and Gaps in care
- An estimated 22% of children in Rhode Island (compared with estimated 19% of children in US) have at least one special health care need (Child and Adolescent Health Measurement Initiative (3/16/22)

Outcome Evidence for a Structured Transition Process
Statistically significant improvement in:

Population Health

- Adherence to care, self-care skills, quality of life, self-reported health

Experience of Care

- Increased satisfaction, Reduction in barriers to care

Utilization

- Decrease in time between last pediatric and 1st adult visit, Increase in adult visits
- Decrease hospital admissions and length of stay

The Sources: Gabriel et al., Outcome evidence for structured pediatric to adult health care transition interventions: A systematic review. Journal of Pediatrics. 2017;188:263-269.; Schmidt, A., Ilango, S., McManus, M., Rogers, K., & White, P. (2019). Outcomes of Pediatric to Adult Health Care Transition Interventions: An Updated Systematic Review. J. Pediatr Nurs 2020: 51: 92-107.

Pediatric to Adult Health Care Transition Definition

- **Definition:** Health care transition is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician
- **Transition Goals for Youth/Young Adults and Clinicians:**
  - To improve the ability of youth and YAs to manage their own health and effectively use health services
  - To have an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care
- Reaffirms that TRANSITION ≠ TRANSFER or PLANNING alone
- TRANSITION = planning, transfer and integration into adult care

Medical Professional Societies' Guidance

- 2011 joint AAP/AAFP/ACP Report Clinical Report (CR) on HCT*
- AAP/AAFP/ACP updated CR in **2018** with guidance on evidence informed processes**
- Both CRs target all youth, beginning at age 12
- Algorithmic structure with emphasis on planning:
  - Branching for YSHCN
  - Application to primary and specialty practices
- Extends through transfer of care to adult medical home and adult specialists
- **Recommendations: Focus on all three aspects of transition: planning, transfer and integration into adult care using a QI approach utilizing the Six Core Elements**

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)*

***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; 142:85-104.*

Six Core Elements of HCT Approach

- The Six Core Elements is not a model of care, but a process (road map/clinical pathway) called for in the AAP/AAFP/ACP Clinical Report recommendations
- Tested in quality improvement (QI) learning collaboratives (LC) using the Institute for Healthcare Improvement breakthrough QI research approach
- Customizable for busy practices with different models of care
- Intensity of intervention can be guided by: medical complexity of youth/YAs, social determinants of health, ACEs and availability of practice resources
- Applied in many different systems/models of care: primary* and subspecialty clinics*, Medicaid managed care*, prof org.*, state title V agencies care coordination services*, children's hospitals*, FQHCs, SBHCs, behavioral health settings. All have incorporated the Six Core Element Process and improved their HCT processes.

**Published articles available at www.GotTransition.org*

There are three sets of customizable tools available for different practice settings.

Click below for information and samples of each core element and full Six Core Elements packages.

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN

For use by Pediatric, Family Medicine, and Med-Peds Clinicians

Click for details on each element.

- Six Core Elements Package
- Six Core Elements Package En Español
- Full Implementation Guide

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS

For use by Family Medicine and Med-Peds Clinicians

Click for details on each element.

- Six Core Elements Package
- Six Core Elements Package En Español
- Full Implementation Guide

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE

For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians

Click for details on each element.

- Six Core Elements Package
- Six Core Elements Package En Español
- Full Implementation Guide

Click here to request a customizable version of any tools.

SIX CORE ELEMENTS™ APPROACH AND TIMELINE FOR YOUTH TRANSITIONING FROM PEDIATRIC TO ADULT HEALTH CARE

Summary of Six Core Elements of Transition Approach

*Roles for Pediatric and Adult Practices**

Practice/ Provider	#1 Transition Policy	#2 Tracking and Monitoring	#3 Transition Readiness/ Orientation to Adult Practice	#4 Transition Planning/ Integration into Adult Care	#5 Transfer of Care/Initial Visit	#6 Transition Completion/ Ongoing Care
Pediatric*	Create and discuss with youth/family	Track progress of youth/family readiness for transition	Transition readiness assessment (RA)	Develop transition plan including needed RA skills	Transfer of care with information and communication to adult clinician	Obtain feedback on the transition process
Adult*	Create and discuss with young adult (YA)/ guardian, if needed	Track progress to increase YA's knowledge of health and adult health care system	Share/discuss Welcome and FAQs letter with YA and guardian, if needed	Update transition plan with additional skills required	Communication with pediatric clinician/ Agree on content of the 1-2 initial adult visits/Self-care assessment	Ongoing care/referrals, as needed, with continued self-care skill building

**Providers that care for youth/young adults throughout the life span would complete both sets of core elements without the transfer process*

Transitioning Youth to an Adult Health Care Clinician

Core Element 1 - Welcome and Care Policy/Guide

Purpose

- ✓ Formalize the practice's approach, reduce clinician variability, offer a transparent approach to youth and their families and friends

Content

- ✓ Define practice approach supports offered around HCT youth and family planning, transfer and information on future clinician choice
- ✓ Clarify adult approach to care and legal changes at age 18
- ✓ Reading level should be appropriate
- ✓ Communicate it to all involved early and continually in the process

Core Element 2 - Tracking and Monitoring

Purpose

- ✓ Facilitate systematic data collection to improve quality of care

Content

- ✓ Date of receipt of each core element (e.g., policy shared, transition readiness assessments administered)

Transitioning Youth to an Adult Health Care Clinician

Core Element 3 - Transition Readiness

Purpose

Assess the patient's skills to manage their health and effectively use health care (especially in the new practice setting)

Content

- ✓ Assesses self-care skills related to own health and using health care services
- ✓ Several tools available, some disease specific
- ✓ Got Transition readiness assessment tool has both youth and parental assessments available and includes motivational interviewing questions:
  - Ranks importance of managing their own health
  - Ranks confidence about ability to manage their own health and the new system

Use

- ✓ Completed several times during the preparation process
- ✓ Used as a **discussion tool** to plan skill-building education
- ✓ Does **not predict** transition success
- ✓ Customized to meet the needs of the practice's population

Integrating Young Adults into Adult Health Care

Core Element 3 – Orientation to Adult Practice

Purpose

To engage young adults moving from pediatrics to practices caring for adults

Content

- ✓ Identify adult providers within practices interested in caring for YAs and YAs with SHCN
  - ✓ Establish a process within the practice to welcome and orient new YAs to the practice
  - ✓ **Develop welcome and orientation materials for the practice with FAQs**
    - **How can YA contact the practice for questions?**
    - **Can they access their medical information?**
    - **What are the missed appointment/cancelation policies?**
  - ✓ Share both the practice policy and welcome letter with pediatric practices for distribution to their transitioning YAs
  - ✓ Share before the joint telehealth visit

Transitioning Youth to an Adult Health Care Clinician

Core Element 4 - Transition Planning

Purpose

Establish agreement between youth/family/caregiver and clinicians about set of actions to address priorities and access to current medical information

Content

- ✓ Identify what matters most to the youth beyond health goals
- ✓ Define how learning about health and health care supports patient's overall goals (add assessment skill needs to the plan)
- ✓ **Complete portable medical summary and emergency care plan with "special information"** – non-medical or specifics on how to make office visit easier- for adolescent/young adult (AYA) and the next clinical team, consider adding photo

Integrating Young Adults into Adult Health Care

Core Element 4 – Integration Into Adult Practice

Purpose

To obtain the YA's medical and other information and communicate with the prior clinician

Content

✓ Prior to first visit ask the pediatric practice for a transfer package with:

1. A complete portable medical summary and emergency care plan with "special information" (non medical) about the new YA – if not available, create this with the YA

2. Decision making documents for youth with IDD (if needed):
   - Review supported decision making plan
   - Review the YA's unique communication needs

✓ Review the key next steps in plan of care that need to be attended to in the first visit (This can be covered in a joint telehealth visit)

Transitioning Youth to an Adult Health Care Clinician

Core Element 5 – Transfer of Care

Purpose

Ensure completion and sharing of transfer package with new provider and support engagement of the patient with a new team

Content / Transfer Checklist

- ✓ Transfer *letter*
- ✓ Medical summary and emergency care plan: key medical and non medical info, including latest RA
- ✓ *Communicate directly* with the new clinician(s), use of telemedicine with joint telehealth visit-see example from Got Transition
- ✓ *Clarify roles* of each provider going forward and clearly communicate the plan to the youth/family/caregiver (e.g. different roles of PCP and subspecialists in adult medicine)
- ✓ *Transfer* when chronic disease is *stable* and *stagger transitions* if many clinicians involved
- ✓ Transfer to PCP medical home first

Integrating Young Adults into Adult Health Care

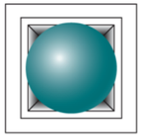
Core Element 5 – Initial 1-2 visits at Adult Practice

Purpose

Ensure completion and sharing of transfer package with new provider and support engagement of the patient with a new adult clinician/ team

Content

- ✓ Consider pre-visit call/text/nurse visit to welcome YA to the practice (this can be accomplished in a joint telehealth visit)
- ✓ Agreement on topics to be covered in first 1-2 visits among the adult clinicians seeing YA in the practice
- ✓ Review, update, and share medical summary and emergency care plan
- ✓ Review transition readiness assessment and/or administer self-care assessment to address unmet self-care skill needs
- ✓ Review and update plan of care, if needed



Transitioning Youth to an Adult Health Care Clinician

Core Element 6 – Transfer Completion

Purpose

- ✓ Confirms the beginning of care by the new clinician, starting of the new role of referring clinician and clarity of both clinicians'/teams' roles

Content:

- ✓ Communicate with new practice confirming completion of transfer (patient came to appointment with all the needed information)
- ✓ Confirm roles going forward of the referring and accepting clinicians (Pediatric specialists as a consultants as needed, adult PCP and adult specialist roles)
- ✓ **Obtain young adult and pediatric provider feedback anonymously after last referring clinician visit**
  - Customizable HCT feedback surveys available at GotTransition.org

Integrating Young Adults into Adult Health Care

Core Element 6 – Transfer Completion/Ongoing Care

Purpose

To close the loop on the "warm handoff"; communication to ensure a smooth transfer of care; complete skill building to manage health/health care

Content

- ✓ Confirm transfer completion with pediatric clinician
- ✓ Complete self-care assessments
- ✓ Offer/refer to self-care skill building education, as needed
- ✓ Ask for consultation with pediatric provider, as needed
- ✓ Assist YA to connect with adult specialists or primary care or other support services, as needed
- ✓ Elicit **feedback** from YAs about their transition and assess experience with adult care

Current Assessment of Health Care Transition Activities

for Transitioning Youth to an Adult Health Care Clinician

Instructions: Each of the Six Core Elements, Youth/Young Adult and Parent/Caregiver Feedback, and Youth/Young Adult and Parent/Caregiver Leadership sections should be scored as Level 1, 2, 3, or 4. To be scored at a certain level, all of the criteria must be met. (No partial scores.)

Measurement Option:
Current Assessment of HCT Activities

TRANSITION AND CARE POLICY/GUIDE

Level 1	Level 2	Level 3	Level 4	Score
Clinicians vary in their approach to HCT, including the age of transfer to adult clinicians.	Clinicians follow a uniform but not a written transition and care policy/guide about the age of transfer to adult clinicians.	The practice has a written transition and care policy/guide.	The practice has a written transition and care policy/guide.	_____ *(out of 4)*
		The transition and care policy/guide includes privacy and consent information, a description of the practice's approach to HCT, and age of transfer.	The transition and care policy/guide includes privacy and consent information, a description of the practice's approach to HCT, and age of transfer.	
		Clinicians sometimes discuss/share the transition and care policy/guide with youth and parents/caregivers.	Clinicians consistently discuss/share the transition and care policy/guide with youth and parents/caregivers, beginning at ages 12 to 14.	
		The transition and care policy/guide is familiar to some staff.	The transition and care policy/guide is publicly displayed and familiar to all staff.	
			The transition and care policy/guide was developed with input from youth and parents/caregivers.	

TRACKING AND MONITORING

Level 1	Level 2	Level 3	Level 4	Score
Clinicians vary in their process of identifying transition-aged youth, but most wait until close to the age of transfer to identify them.	Clinicians follow a uniform process to identify transition-aged youth.	The practice has an individual transition flow sheet or registry for identifying and tracking transition-aged youth, or a subgroup of youth with chronic conditions, close to the time of transfer.	The practice has an individual transition flow sheet or registry for identifying and tracking transition-aged youth, or a subgroup of youth with chronic conditions, starting between the ages of 12 and 14.	_____ *(out of 4)*
	Clinicians use youths' medical records to document relevant HCT information (e.g., discussed transition, future clinician name).	The practice tracks youths' receipt of some but not all of the Six Core Elements.	The practice tracks youths' receipt of all of the Six Core Elements.	

HCT - health care transition, Y/YA - youth/young adult

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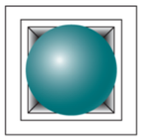
Measurement Option:

Youth/parent/caregiver feedback survey

- Includes summary questions on the Youth/Young Adult Feedback survey:
  - How ready did you feel to move to an adult doctor or other health care provider?
  - Answer: Very, Somewhat, Not at all
  - Do you have any ideas for your past doctor or other health care provider about making the move to an adult health care easier?



The National Alliance To Advance Adolescent Health

Sample Health Care Transition Feedback Survey for Youth/Young Adults

This is a survey about what it was like for you to move from pediatric to adult health care. Your answers will help us improve our health care transition process. Your name will not be linked to your answers.

DID YOUR PAST DOCTOR OR OTHER HEALTH CARE PROVIDER... *Please check the answer that best fits at this time.*	YES	NO
Explain the transition process in a way that you could understand?	☐	☐
Give you guidance about the age you would need to move to a new adult doctor or other health care provider?	☐	☐
Give you a chance to speak with them alone during visits?	☐	☐
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	☐	☐
Help you gain skills to manage your own health and health care (e.g., understanding current health needs, knowing what to do in a medical emergency, taking medicines)?	☐	☐
Help you make a plan to meet your transition and health goals?	☐	☐
Create and share your medical summary with you?	☐	☐
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	☐	☐
Advise you to keep your emergency contact and medical information with you at all times (e.g., in your phone or wallet)?	☐	☐
Help you find a new adult doctor or other health care provider to move to?	☐	☐
Talk to you about the need to have health insurance as you become an adult?	☐	☐

Overall, how ready did you feel to move to an adult doctor or other health care provider?

☐ Very ☐ Somewhat ☐ Not at all

Do you have any ideas for your past doctor or other health care provider about making the move to adult health care easier?

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Six Core Elements of Health Care Transition™

IMPLEMENTING THE SIX CORE ELEMENTS

These Implementation Guides are intended to help clinicians/practices/systems carry out and support health care transition (HCT) improvements using the Six Core Elements of HCT 3.0 for their patients transitioning to adult-centered care with or without changing their clinician. Each guide below contains practical guidance, resources, and examples for conducting HCT quality improvement (QI) in a range of health care settings, using the Model for Improvement as its framework. Each guide contains specific QI considerations, tools, and measures for each core element.

How to Implement the Six Core Element of Health Care Transition includes steps that a health care delivery system or individual practice can consider when utilizing a QI process to implement for the Six Core Elements.

For additional information about the QI framework and methods described in the Implementation Guides, please refer to the ***Quality Improvement Primer***.

Implementation Guides Customized to HCT are Available at GotTransition.org

How to Implement the Six Core Elements of Health Care Transition™ 3.0

- A practical step-by-step supplement to the Six Core Elements
- Organized into nine steps that a health care delivery system or individual practice can consider when implementing a quality improvement (QI) process for health care transition (HCT)

Step 1: Secure Senior Leadership Support

Step 2: Form the HCT Quality Improvement Team

Step 3: Develop an HCT Improvement Plan

Step 4: Raise Awareness about HCT Activities

Step 5: Implement the Six Core Elements of HCT

Step 6: Plan for Sustainability

Step 7: Plan for Spread

Step 8: Communicate Successes

Step 9: Tips for Success

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN

For use by Pediatric, Family Medicine, and Med-Peds Clinicians

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Transition Readiness
Guide | Examples

Transition Planning
Guide | Examples

Transfer of Care
Guide | Examples

Transfer Completion
Guide | Examples

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS

For use by Family Medicine and Med-Peds Clinicians

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Transition and Care Policy/Guide
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Tracking and Monitoring
Guide | Examples

Transition Readiness
Guide | Examples

Transition Planning
Guide | Examples

Transition to Adult Approach to Care
Guide | Examples

Ongoing Care
Guide | Examples

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE

For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians

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Orientation to Adult Practice
Guide | Examples

Integration into Adult Practice
Guide | Examples

Initial Visits
Guide | Examples

Ongoing Care
Guide | Examples

Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Transitioning Youth to an Adult Health Care Clinician

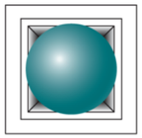
Core Element 1 - Transition and Care Policy/Guide

I. Purpose, Objectives, and Considerations

II. Quality Improvement Considerations, Tools, and Measurement

III. Sample Transition and Care Policies/Guides

IV. Additional Resources



The National Alliance To Advance Adolescent Health

https://www.gottransition.org/6ce/?leaving-ImplGuide-policy

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Considerations: Sample Questions

Content

What should be included in the transition and care policy/guide?

- At what age will your practice start the HCT planning process?
- When are youth expected to leave your practice?
- What will your practice offer youth and parents/caregivers to assist them in transition—e.g., a readiness assessment, plan of care that includes transition, medical summary, transfer package?
- What will your practice do to prepare youth for changes in privacy and consent that happen at age 18?

Considerations: Sample Questions

Process

What is the process to develop the transition and care policy/guide?

- Does it describe the practice's approach to transition, including privacy and consent information?
- Is the reading level appropriate for your youth and parents/caregivers?
- How to engage youth and parents/caregivers in the development process?

What is the process to implement the transition and care policy/guide? (Consider creating a process Flow diagram)

- Whose job is it to share and discuss the HCT policy/guide with the youth and parent/caregiver?
- Whose job is it to ask if the youth and parent/caregiver have any questions?
- Review the process with youth and family and create a written document to describe the clinic approach to implement the process outlined above.
- Educate all team members/staff about the process.

Quality Improvement Tools Customized to Each Core Element in each of the three Packages

The most important QI tools to guide a team's improvement work include Tools 1-5 listed*:

- Tool 1: An aim statement
- Tool 2: Key driver diagrams
- Tool 3: Process flow maps
- Tool 4: The simplified failure mode and effects analysis
- Tool 5: Plan-Do-Study-Act (PDSA) cycles

*For more information and examples, see Tools for Improvement in the QI Primer.

Sample Transition and Care Policies/Guides

As you develop your transition policy, you should strive for a 6th grade reading level using common words with a concise message, plenty of white space, and an easily readable format.

Please see the QI Primer for information about health literacy, including strategies for implementation https://www.gottransition.org/6ce/?quality-improvement-primer

Examples from other programs are available for each Six Core Element:

Transition and Care Policies/Guides:

- Sample Transition and Care Policies/Guides at Different Reading Levels
- Sample Transition and Care Policies/Guides in Different Clinical Settings
- Sample Transition and Care Policies/Guides for Youth with Specific Conditions
- Sample Transition and Care Policies/Guides in Video Format

QI Primer: Using Quality Improvement to Improve the Health Care Transition Process

A companion piece to use with the Six Core Elements of Health Care Transition™

Intended to help practices understand quality improvement (QI) and apply it to their work

Gives breakdown of Quality Improvement's:

- History
- Relationship to research
- Benefit to health care teams and patients

I. What is Quality Improvement?
II. Selecting Improvement Projects
III. Successful Teams
IV. The Model for Improvement
V. Measuring for Improvement
VI. Tools for Improvement
VII. Sustaining Improvement
VIII. Spreading Improvement
IX. Health Literacy
X. Co-Production
XI. Resources and References

The National Alliance To Advance Adolescent Health

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Sustainability: Key Strategies

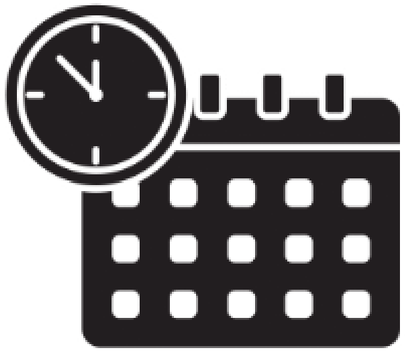
- Assign ownership of sustaining to an individual
- Hardwire sustainability into your systems
- Continue measuring to monitor sustainability
- Continue involving senior leadership

HCT pilot example from the first Cohort of RI HCT Project

Overview of HCT Pilot

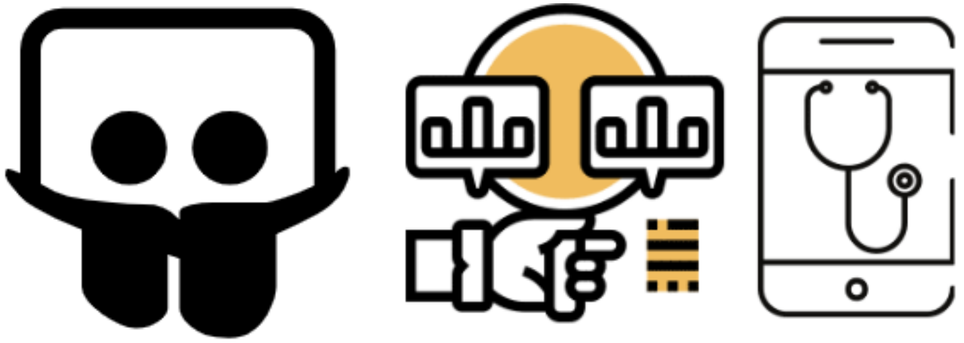
7 Dyads

Transitioning youth
with and without SHCN



12 Months

May 2021 – April 202



Peer Learning

Tools for Tracking/Assessments

Joint Communication and Visits

Youth Feedback

The National Alliance To Advance Adolescent Health

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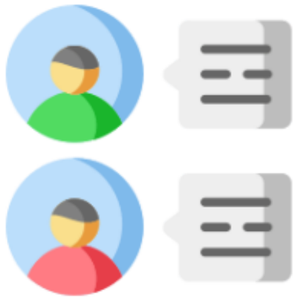
Data Summary

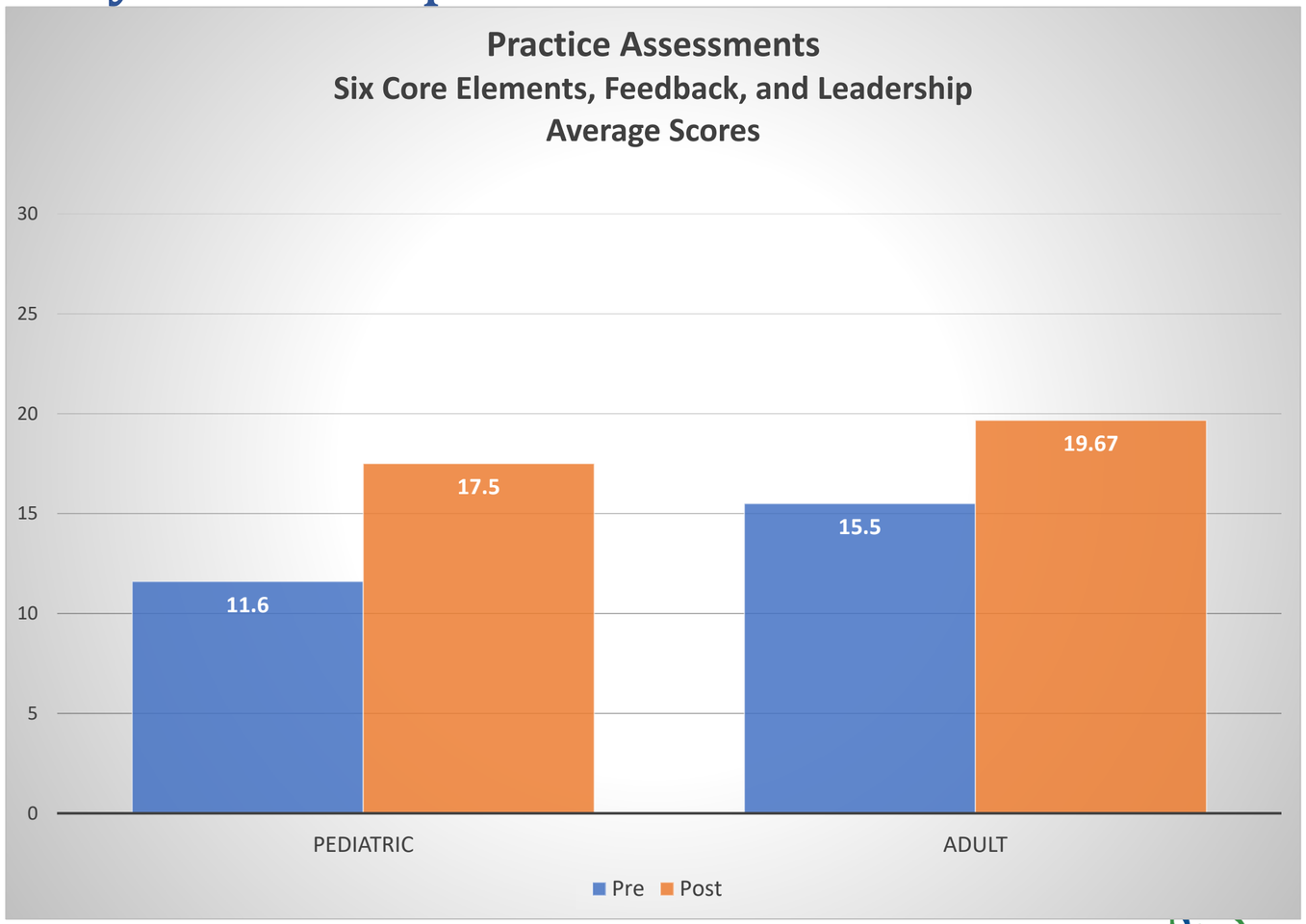
Learning Collaborative May 2021 – April 2022

Total # of patients transferred = 29

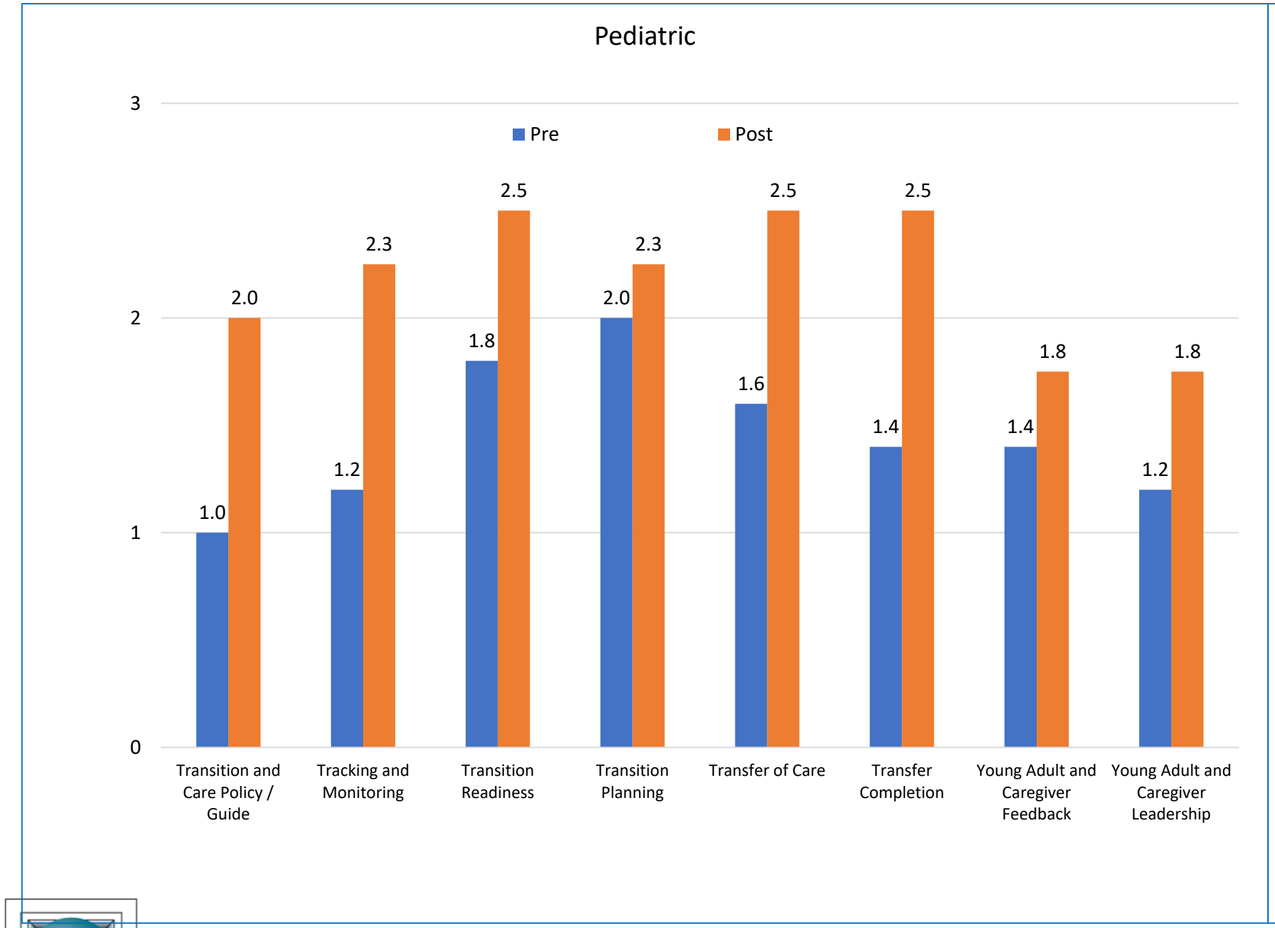
Total # of patients awaiting transfer = 12

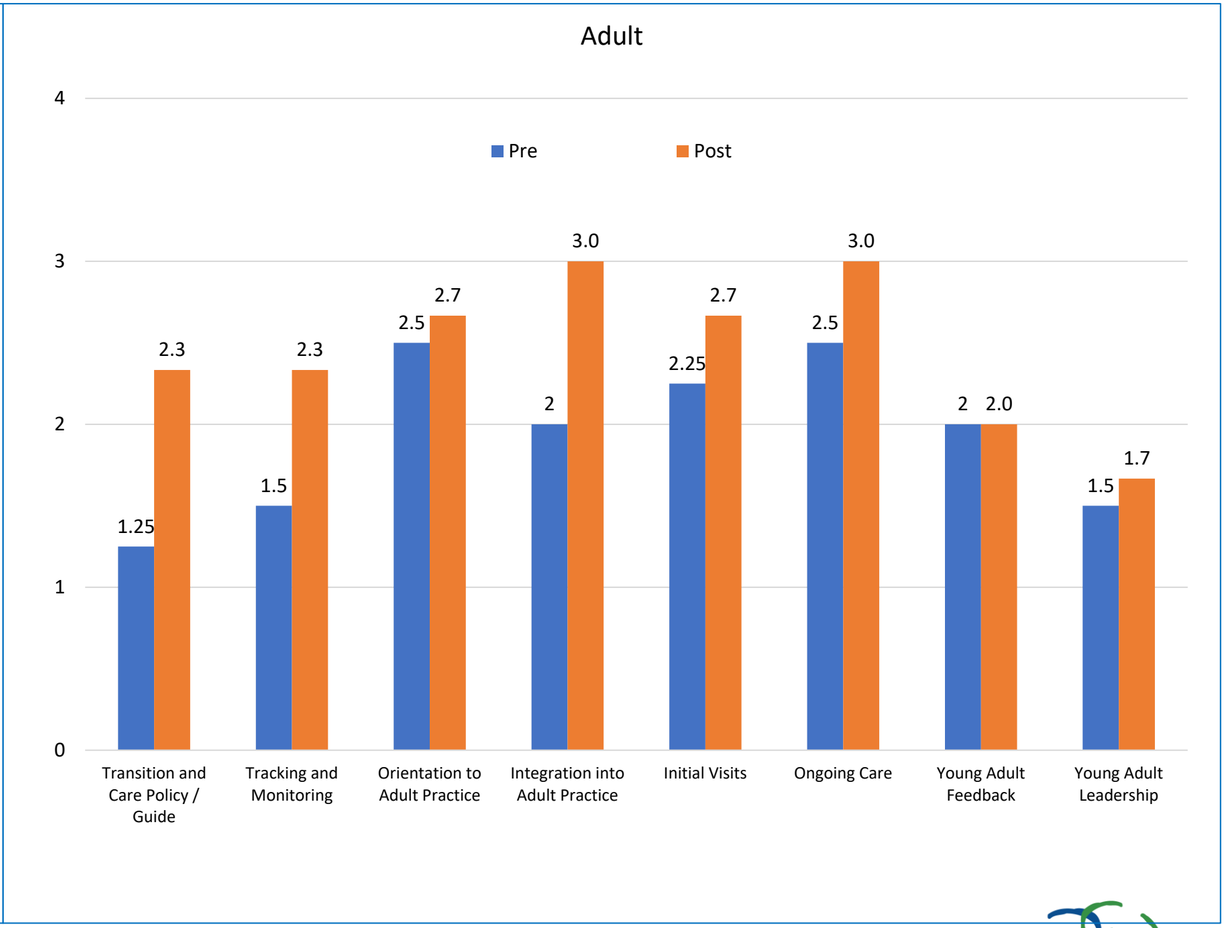


Total # of youth surveys received = 17



Practice Assessments





of patients transferred

Dyad	Transferred	Scheduled to be Transferred	# of surveys received
PCHC – Randall	5	0	5
PCHC – Chafee	6	0	5
PCHC - Capitol	4	3	4
Hasbro PPC / CPC	4	1	3
Nevola/Grande	1	4	0
Coastal Waterman/East Providence	5	3	5
Coastal NBP / EGPC	4	1	0
Total	**29**	**12**	**22**

Results from Youth Surveys: 17 received

DID YOUR PAST PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER…	
Explain the transition process in a way that you could understand?	100% Yes
Give you a chance to speak with them alone during visits?	100% Yes
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	100% Yes
Create and share your medical summary with you?	82.4%Yes
DID YOUR NEW ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER…	
Address any of your concerns about your move to a new practice/doctor?	88.24% Yes
Give you guidance about their approach to accepting & partnering with new young adults?	88.24% Yes
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	94.1% Yes

Successes to Carry Forward - Practices

- Policy
- Workflows, Documentation and Systems
- Communication- Youth provided feedback on the process using assessments
- Spread

Youth and Young Adult Resources at Gottransition.org

TOP RESOURCES

Click into any resource or view all Youth & Family resources here.

Do you want to learn about transitioning to adult health care? (Infographic)

Health Care Transition Timeline for Youth and Young Adults [En Español]

What is Health Care Transition (HCT)? (Animated Video)

More

More

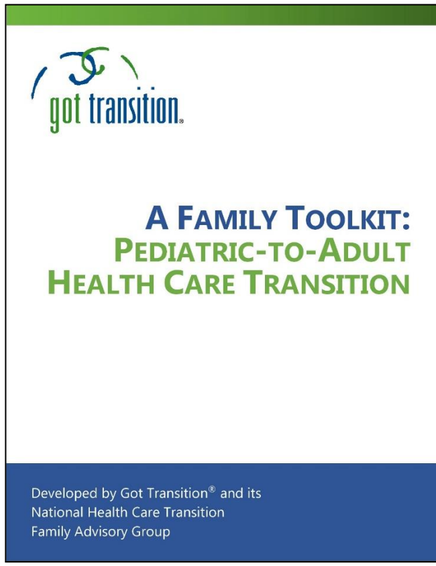
Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones [En Español]

Turning 18: What it Means for Your Health [En Español]

Questions to Ask Your Doctor About Transitioning to Adult Health Care (for Youth and Young Adults) [En Español]

Family Resources at www.gottransition.org
Got Transition's Family HCT Toolkit

- Got Transition and its National Family Advisory Group (10 representatives from National Family groups) have developed a new Family HCT Toolkit to help families throughout the transition process.
- The resource help to answer questions families may have about transition:
  - *When should my child and I start to think and talk about transition?*
  - *What are the recommended HCT services?*
  - *What questions can my child and I ask our doctor about transitioning to adult care?*
  - *How does my role and my child's role change throughout the transition process?*
  - *How can I learn if my child needs help with decision-making?*
  - *What are some of the legal changes in health care that happen at age 18?*
  - *What are the differences between pediatric and adult care?*
  - *How ready is my child to transition to adult care and manage their own health and health care?*



Resources & Research

Health care transition is the process of moving from a child/family-centered model of care to an adult/patient-centered model of care. The sections below include links to national resource centers and transition-related resources selected based on their relevance to a national audience.

Click on each section for resources related to the topic.

Additional www.gottration.org Resources

- School based Health Center Playbook on Health Care transition: https://tools.sbh4all.org/health-care-transition/health-care-transition-home/
- 2022 Coding and Reimbursement Tip Sheet with clinical vignettes:

  https://gottransition.org/resource/2022-coding-tip-sheet
- Incorporating Health Care Transition Services into Preventive Care for Adolescents and Young Adults: a Toolkit for clinicians: https://www.gottransition.org/resource/?clinician-toolkit-preventive-care
- Readiness assessment for youth with IDD and caregivers and medical summary template: https://www.acponline.org/system/files/documents/clinical_information/high_value_care/clinician_resources/pediatric_adult_care_transitions/gim_dd/idd_transitions_tools.pdf

Presentation Objectives

1. To understand the current context of health care transition, HCT outcome evidence and the AAP/AAFP/ACP recommended structured HCT interventions-the Six Core Elements
2. Describe key lessons learned from implementing HCT performance improvement program in 7 RI primary care practices
3. Review tools and resources available through www.gottransition.org

Thank You and Questions

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HealthCareTransition

@GotTransition2

Visit www.GotTransition.org

Healthcare Transfer of Care QI Objectives for New Dyads

Pediatric and adult team **partners will work together** to improve transition of care for youth as they transition from pediatric to adult care.

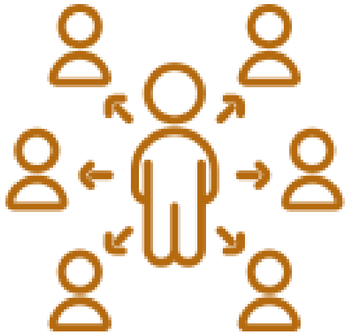
New teams will be asked to **test the transfer of care concept** on a small sample of identified “transfer of care” young adults. The first 4 months will be “start-up” with customization of content and process followed by an 8-month pilot period for the 4-5 transferring patients, including a final pediatric visit, a joint communication telehealth visit with pediatric and adult primary care providers and transferring patient, and an initial adult visit.

Teams will apply selected Core Elements from Got Transition’s approach, using the performance improvement process, and **develop and implement a more intentional and structured approach to the transfer of care process.**

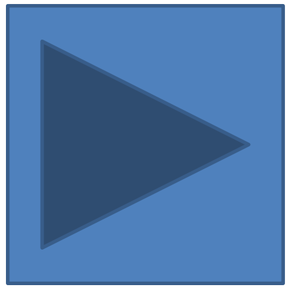
Healthcare Transfer of Care QI Objectives for Extended Participation Practices

Pediatric and adult team **partners will continue to work together** to improve transition of care for youth as they transition from pediatric to adult care.

Expand and improve upon existing transition activities to include additional populations of patients, refine policies, and increase knowledge.



Spread knowledge of transfer of care activities within system of care. **Engage and learn** from other providers, specifically adult and family medicine, about transfer of care experiences and barriers.



Up Next:

Patient-family Presentation

https://downloads.aap.org/DOCHW/MeganandCarlyLearningSession.mp4

Baseline Survey Results
New Dyads

Pediatric	Average (Range of 1-4)	Adult	Average (Range of 1-4)
Transition and Care Policy / Guide	1.5	Transition and Care Policy / Guide	2
Tracking and Monitoring	1	Tracking and Monitoring	1.5
Transition Readiness	2	Orientation to Adult Practice	2
Transition Planning	1.5	Integration into Adult Practice	1.5
Transfer of Care	1.5	Initial Visits	2
Transfer Completion	1	Ongoing Care	2
Youth/Young Adult & Parent/Caregiver Feedback	1	Young Adult Feedback	1
Youth/Young Adult & Parent/Caregiver Leadership	1	Young Adult Leadership	1

Pediatric Current Assessment of Health Care Transition Activities
Adult/Family Current Assessment of Health Care Transition Activities

New Dyad Timeline
June 2022 - May 2023

1 Project Start-Up
Kick-off meeting
Monthly meetings scheduled

2 Transition planning
Pediatric: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation
Adult: plan for tracking of patients

3 Customize transfer/receive tools

4 Customize transfer completion process
Pediatric: PDSA cycles on Core Elements 4, 5, 6
Adult: Customize process for initial visit; PDSA cycles on Core Elements 3,4,5

5 Start to test HCT Transfer Pilot with 5 Pediatric Patients (Mo.5-7)
Adult: Receive and review transfer packet

6 Schedule and complete final pediatric visits
Pediatric: Complete transfer package

7 Continue month 6 activities and plan joint Communication/Telehealth Call for Each Transferring Patient

8 Joint Communication/Telehealth Call for Each Transferring Patient

9 Prepare for Initial Adult Visit and confirm initial appointment was completed

10 Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey

11 & 12 Wrapping it up : Peer Learning Collaborative Meeting
Complete assessment of HCT activities, analyze pre/post improvement, plan for sustainability and spread

Hasbro & CPC Timeline
June 2022 - May 2023

1 Project Start-Up
Kick-off meeting
Monthly meetings scheduled

2 Set goals, select priority, and set timeline for the project, considering: - Pt. engagement/preventing missed appts - Spread of program - Accommodating large numbers of transferring patients

3 Formalize and begin to implement a performance improvement plan

4 Third year residents identify 3 YA each for transfer

5 Invite patients/families to partner in transfer process

6 Review elements of final transition visit and initial adult visit, including

7 Schedule and complete final pediatric visits.
Following final pediatric visits, complete transfer package and share with patient and adult PCP.

8 Start integration into adult care
Review who is responsible for scheduling visit (patient, adult practice, pediatric practice)

9 Prepare for Initial Adult Visit and confirm initial appointment was completed

10 Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey

11 & 12 Wrapping it up : Peer Learning Collaborative Meeting
Complete assessment of HCT activities, analyze pre/post improvement, plan for sustainability and spread

Chad Nevola, MD
June 2022 - May 2023

1 Project Start-Up
Kick-off meeting
Monthly meetings scheduled

2 Review goals, select priorities, and set timelines for "system of care approach" to facilitate improved transfer of care for patients.

3 Using quality improvement methodology (ie. Plan, Do, Study, Act – PDSA) determine aim statement, tests of change and measurement for system of care sustainability and spread

4 Begin to implement performance improvement plan

5 - 11 Continue with activities of performance improvement plan and each month share tests of change and progress with Practice Facilitator

11 & 12 Wrapping it up : Peer Learning Collaborative Meeting
Complete assessment of HCT activities, analyze pre/post improvement, plan for sustainability and spread

Milestone Documents

	Link
New Pediatric Practice	https://public.3.basecamp.com/p/pAHxD6poUSkwXzh8Tiv6Geeu
New Adult Practice	https://public.3.basecamp.com/p/DoX1GXh6XK57sDtnHGpmmkzz
Extended Participation – Hasbro & CPC	https://public.3.basecamp.com/p/QLEdxDhSaqoFw9DyTphKhwzu
Extended Participation – Chad Nevola, MD	https://public.3.basecamp.com/p/PWbgAz2khbeQbBm46jWCXYCL

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