

## Appendix A: 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.) **Please return to Carolyn Karner (ckarner@ctc-ri.org) by May 14, 2021.**

Practice Name: \_\_\_\_\_

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



# Current Assessment of Health Care Transition Activities *(Continued)*

TRANSITION READINESS				
Level 1	Level 2	Level 3	Level 4	Score
Clinicians vary in terms of the age when youth begin to have time alone during office visits without parents/caregivers present.	Clinicians consistently offer youth time alone during office visits without parents/caregivers present.	Starting between the ages of 12 and 14, the practice consistently offers youth time alone during office visits without parents/caregivers present.	Starting between the ages of 12 and 14, the practice consistently offers youth time alone during office visits without parents/caregivers present.	<i>(out of 4)</i>
Clinicians seldom discuss changes in privacy and consent at age 18.	Clinicians sometimes discuss changes in privacy and consent at age 18.	Starting between the ages of 14 and 16, clinicians consistently discuss transition readiness skills and changes in adult-centered care, including changes in privacy and consent at age 18.	Starting between the ages of 14 and 16, clinicians consistently discuss transition readiness skills and changes in adult-centered care, including changes in privacy and consent at age 18.	
Clinicians seldom assess transition readiness skills.	Clinicians sometimes assess transition readiness skills.	Clinicians consistently assess transition readiness skills, but most wait until the age of transfer.	Clinicians consistently assess transition readiness skills, starting at ages 14 to 16.	
	A standardized transition readiness skills assessment is sometimes used.	A standardized transition readiness skills assessment is consistently used.	A standardized transition readiness skills assessment is consistently used.  Clinicians consistently document discussion of privacy and consent in medical records.  Clinicians consistently document transition readiness needs and goals in the medical record or plan of care with goals and action steps.	
TRANSITION PLANNING				
Level 1	Level 2	Level 3	Level 4	Score
Clinicians seldom create a medical summary or emergency care plan.	Clinicians sometimes create a medical summary or emergency care plan.	Clinicians consistently create a medical summary and emergency care plan.	Clinicians consistently partner with youth and parents/caregivers to create their medical summary and emergency care plan.	<i>(out of 4)</i>
The practice does not have a list of adult clinicians for youth to transfer to.	Clinicians have information on how to find an adult doctor, which is shared with youth and parents/caregivers close to the time of transfer.	The practice has information on how to find an adult doctor or a list of adult clinicians, which is consistently shared with youth and parents/caregivers.	The practice has information on how to find an adult doctor and a list of adult clinicians, and the practice assists youth in identifying an adult clinician to transfer to.	
Clinicians seldom create a plan of care with goals and action steps.	Clinicians sometimes create a plan of care with goals and action steps.	Clinicians consistently create a plan of care with goals and action steps.	Clinicians consistently partner with youth and parents/caregivers to create a plan of care with goals and action steps.	
		The plan of care with goals and action steps is sometimes shared with youth and parents/caregivers.  Clinicians sometimes determine needs for decision-making supports prior to age 18.	The plan of care with goals and action steps is consistently shared with youth and parents/caregivers.  Clinicians consistently determine needs for decision-making supports prior to age 18.	



## Current Assessment of Health Care Transition Activities *(Continued)*

TRANSFER OF CARE				
Level 1	Level 2	Level 3	Level 4	Score
Clinicians send Y/YAs' medical information to adult clinicians.	Clinicians send Y/YAs' medical information and medical summary to adult clinicians.	The practice sends a transfer package to adult clinicians, which includes the plan of care with goals and action steps, latest transition readiness assessment, medical summary and emergency care plan, and, if needed, legal documents.	The practice sends a transfer package to adult clinicians, which includes the plan of care with goals and action steps, latest transition readiness assessment, medical summary and emergency care plan, and, if needed, legal documents.	(out of 4)
			The practice communicates with adult clinicians about pending transfer of care.	
			The practice confirms the pediatric clinician's responsibility for care until Y/YA is seen in the adult practice.	
TRANSFER COMPLETION				
Level 1	Level 2	Level 3	Level 4	Score
Clinicians have no formal process for follow-up with Y/YAs to confirm whether they attended their first visit with the adult clinician.	Clinicians encourage Y/YAs to inform them whether they attended their first visit with the adult clinician.	The practice communicates with the adult practice confirming completion of transfer/ first appointment.	The practice communicates with the adult practice confirming completion of transfer/ first appointment.	(out of 4)
		The practice offers consultation assistance, if needed.	The practice offers consultation assistance, if needed.	
			The practice elicits feedback from Y/YAs about the HCT supports received.	
YOUTH/YOUNG ADULT AND PARENT/CAREGIVER FEEDBACK				
Level 1	Level 2	Level 3	Level 4	Score
Clinicians have no formal process to obtain feedback from Y/YAs and parents/caregivers about the HCT supports received.	Clinicians sometimes ask Y/YAs and parents/caregivers for feedback about the HCT supports received.	The practice sometimes obtains feedback from Y/YAs and parents/caregivers using an HCT feedback survey.	The practice always obtains feedback from Y/YAs and parents/caregivers using an HCT feedback survey.	(out of 4)
		The practice involves Y/YAs and parents/caregivers in developing and/or reviewing an HCT feedback survey.	The practice involves Y/YAs and parents/caregivers in developing and/or reviewing an HCT feedback survey.	
			The practice involves Y/YAs and parents/caregivers in developing strategies to improve the practice's HCT support.	

# Current Assessment of Health Care Transition Activities *(Continued)*

YOUTH/YOUNG ADULT AND PARENT/CAREGIVER LEADERSHIP				
Level 1	Level 2	Level 3	Level 4	Score
Clinicians sometimes involve Y/YAs and parents/caregivers in reviewing the practice's HCT resources (e.g., transition and care policy/guide, transition readiness assessment).	Clinicians sometimes involve Y/YAs and parents/caregivers in reviewing and disseminating HCT resources (e.g., transition and care policy/guide, transition readiness assessment).	The practice consistently involves Y/YAs and parents/caregivers in reviewing and disseminating HCT resources (e.g., transition and care policy/guide, transition readiness assessment).	The practice consistently involves Y/YAs and parents/caregivers in creating, reviewing, and disseminating HCT resources that are consistently shared with Y/YAs and parents/caregivers (e.g., transition and care policy/guide, transition readiness assessment).	<i>(out of 4)</i>
		The practice includes Y/YAs and parents/caregivers as active members of an advisory council for transition or a transition quality improvement team.	The practice ensures equal representation of Y/YAs and parents/caregivers in strategic planning related to HCT.	
			The practice involves Y/YAs and parents/caregivers in educating staff and/or other Y/YAs and parents/caregivers about HCT.	

SCORE	Possible Level	Actual Level
Transition and Care Policy/Guide	4	
Tracking and Monitoring	4	
Transition Readiness	4	
Transition Planning	4	
Transfer of Care	4	
Transfer Completion	4	
Youth/Young Adult and Parent/Caregiver Feedback	4	
Youth/Young Adult and Parent/Caregiver Leadership	4	
<b>Total Score</b>	<b>32</b>	

This form is being completed to assess:

- An individual provider     
  An individual practice     
  A practice network/system

Date scored: \_\_\_\_\_

