Current Assessment of Health Care Transition Activities for Transitioning Youth to Adult Health Care Providers

Six Core Elements of Health Care Transition 2.0

Introduction

Got Transition has developed two different measurement approaches, described below, to assess the extent to which the ***Six Core Elements of Health Care Transition 2.0*** are being incorporated into clinical processes. Both are aligned with the AAP/AAFP/ACP's Clinical Report on Transition and the ***Six Core Elements.*** These instruments are available at www.GotTransition.org.

Current Assessment of Health Care Transition Activities

This is a qualitative self-assessment method that allows individual providers, practices, or networks to determine the level of health care transition support currently available to youth and families transitioning from pediatric to adult health care. It is intended to provide a current snapshot of how far along a practice is in implementing the ***Six Core Elements.***

Health Care Transition Process Measurement Tool

This is an objective scoring method, with documentation specifications, that allows a practice or network to assess progress in implementing the ***Six Core Elements*** and, eventually, dissemination to all youth ages 12 and over. It is intended to be conducted at the start of a transition improvement initiative as a baseline measure and then repeated periodically to assess progress.

Instructions for completing the Current Assessment of Health Care Transition Activities

Each of the ***Six Core Elements*** can be scored between **1 (basic)** and **4 (comprehensive).**

If the level is partially but not fully completed, scoring should be at the lower level.

A table to total scores is available on the final page of this tool.

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Six Core Elements of Health Care Transition 2.0

Element	Level 1	Level 2	Level 3	Level 4	Score
1. Transition Policy	Clinicians vary in their approach to health care transition, including the appropriate age for transfer to adult providers.	Clinicians follow a uniform but not a written policy about the age for transfer. The approach for transition planning differs among clinicians.	The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information and addresses the practice's transition approach and age of transfer. The policy is not consistently shared with youth and families.	The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information, a description of the practice's approach to transition, and age of transfer. Clinicians discuss it with youth and families beginning at ages 12 to 14. The policy is publicly posted and familiar to all staff.	
2. Transition Tracking and Monitoring	Clinicians vary in the identification of transitioning youth, but most wait until close to the age of transfer to identify and prepare youth.	Clinicians use patient records to document certain relevant transition information (e.g., future provider information, date of transfer).	The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete some but not all transition processes.	The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete all "Six Core Elements of Health Care Transition 2.0," using EHR if possible.	
3. Transition Readiness	Clinicians vary in terms of the age when youth begin to have time alone during preventive visits without the parent/caregiver present. Transition readiness is seldom assessed.	Clinicians consistently offer time alone for youth after age 14 during preventive visits without the parent/caregiver present. They usually wait to assess transition readiness/self- care skills close to the time of transfer.	The practice consistently offers clinician time alone with youth after age 14 with clinicians during preventive visits, and clinicians discuss transition readiness/self-care skills and changes in adult-centered care beginning at ages 14 to 16, but no formal assessment tool is used.	The practice consistently offers clinician time alone with youth after age 14 during preventive visits. Clinicians use a standardized transition readiness assessment tool. Self-care needs and goals are incorporated into the youth's plan of care beginning at ages 14 to 16.	
4. Transition Planning	Clinicians vary in addressing health care transition needs and goals. They seldom make available a plan of care (including medical summary and emergency care plan and transition goals and action steps) or a list of adult providers.	Clinicians consistently address transition needs and goals as part of the plan of care. They usually provide a list of adult providers close to the time of transfer.	The practice partners with youth and families in developing and updating their plan of care with prioritized transition goals and preferences for securing an adult provider. This plan of care is regularly updated and accessible to youth and families.	The practice has incorporated transition into its plan of care template for all patients. All clinicians are encouraged to partner with youth and families in developing transition goals and updating and sharing the plan of care. Clinicians address needs for decision-making supports prior to age 18. The practice has a vetted list of adult providers and assists youth in identifying adult providers.	

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Current Assessment of Health Care Transition Activities for Transitioning Youth to Adult Health Care Providers (continued)

Six Core Elements of Health Care Transition 2.0

Element	Level 1	Level 2	Level 3	Level 4	Score
5. Transfer of Care	Clinicians usually send medical records to adult providers in response to transitioning patient requests.	Clinicians consistently send medical records to adult providers for their transitioning patients.	The practice sends a transfer package that includes the plan of care (including the latest transition readiness assessment, transition goals/actions, medical summary and emergency care plan, and, if needed, legal documents, and a condition fact sheet).	The practice sends a complete transfer package (including the latest transition readiness assessment, transition goals/actions, medical summary and emergency care plan, and, if needed, legal documents, and a condition fact sheet), and pediatric clinicians communicate with adult clinicians, confirming pediatric provider's responsibility for care until young adult is seen in the adult practice	
6. Transfer Completion	Clinicians have no formal process for follow-up with patients who have transferred to new adult providers.	Clinicians encourage patients to let them know whether or not the transfer to new adult provider went smoothly.	The pediatric practice communicates with the adult practice confirming completion of transfer/first appointment and offering consultation assistance, if needed.	The practice confirms transfer completion, need for consultation assistance, and elicits feedback from patients regarding the transition experience.	
Youth and Family Feedback	The practice has no formal process to obtain feedback from youth and families about transition support.	The practice obtains feedback from youth and families using a transition survey.	The practice involves youth and families in developing or reviewing the transition survey and conducts the survey with eligible youth and families.	The practice involves youth and families in developing or reviewing the transition survey, conducts the survey with eligible youth and families, and involves youth and families in developing strategies to address areas of concern identified by the transition survey.	
Youth and Family Leadership	Clinicians provide youth and families with tools and information about health care transition.	The practice involves youth and families in creating and implementing education programs for practice staff related to transition.	The practice includes youth and families as active members of a youth advisory council for transition or a transition quality improvement team.	The practice ensures equal representation of youth and families in strategic planning related to health care transition.	

The table at right can be used to total the number of points that your practice obtained on the pediatric version of the Current Assessment of Health Care Transition Activities.

This form is being completed to asses:

☐ An Individual Provider

☐ An Individual Practice

☐ A Practice Network

Transition Activities	Score	
	Possible	Score
Transition Policy	4	
Tracking and Monitoring	4	
Transition Readiness	4	
Transition Planning	4	
Transfer of Care	4	
Transfer Completion	4	
Youth and Family Feedback	4	
Youth and Family Leadership	4	
Total	32	