Current Assessment of Health Care Transition Activities for Transitioning to an Adult Approach to Health Care Without Changing 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 to an adult approach to health care but not changing providers. 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 and young adults ages 12 to 26. 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 preparing youth for an adult approach to care.	Clinicians follow a uniform but not a written transition policy about preparing youth for an adult approach to care. The approach for transition planning differs among clinicians.	The practice has a written transition policy or approach about preparing youth for an adult approach to care, developed with input from youth and families, which includes privacy and consent information. The policy is not consistently shared with youth and families.	The practice has a written transition policy or approach about preparing youth for an adult approach to care, developed with input from youth and families, which includes privacy and consent information. 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 18 to identify and prepare youth for an adult approach to care.	Clinicians use patient records to document certain relevant transition information (e.g., legal documents related to supported decision-making).	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 to prepare for an adult approach to care.	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/self-care 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 close to the age of 18.	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 an adult approach to care beginning at ages 14 to 16, but no formal transition readiness/self-care 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/ Integration into Adult Approach to Care	Clinicians vary in addressing health care transition needs and goals. They seldom make available to youth/young adults a plan of care (including medical summary and emergency care plan and transition goals and action steps.)	Clinicians consistently address transition needs and goals as part of the plan of care, but seldom update and share the plan with youth/young adults.	The practice partners with youth/young adults in developing and updating their plan of care with prioritized transition goals. This plan of care is regularly updated and accessible to youth/young adults.	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 for all patients. The practice assists youth in identifying adult specialty providers, if needed.	

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Current Assessment of Health Care Transition Activities for Transitioning to an Adult Approach to Health Care Without Changing Providers (continued)

Six Core Elements of Health Care Transition 2.0

Element	Level 1	Level 2	Level 3	Level 4	Score
5. Transfer to Adult Approach to Care	Clinicians vary in discussing privacy and consent issues at age 18.	Clinicians consistently discuss privacy and consent issues at age 18.	Clinicians discuss privacy and consent issues at age 18 and document in medical records.	All young adults ages 18 and older sign privacy and consent forms allowing others to be present at the visit, if needed.	
6. Transfer Completion/ Ongoing Care	Clinicians have no formal process for feedback with young adults who have transitioned to an adult approach to care	Clinicians encourage some patients to let them know whether or not the transition to an adult approach to care went smoothly.	The practice elicits feedback from most young adults regarding the transition to an adult approach to care.	The practice uses a standardized survey to elicit feedback from young adults regarding the transition to an adult approach to care.	
Youth, Family, and Young Adult Feedback	The practice has no formal process to obtain feedback from youth, families, and young adults about the transition to an adult approach to care.	The practice obtains feedback from youth, families, and young adults about the transition to an adult approach to care using a transition survey.	The practice involves youth, families, and young adults in developing or reviewing the transition survey and conducts the survey with eligible youth and families.	The practice involves youth, families, and young adults in developing or reviewing the transition survey, conducts the survey with eligible youth, families, and young adults, and involves youth, families, and young adults in developing strategies to address areas of concern identified by the transition survey.	
Youth, Family, and Young Adult Leadership	Clinicians provide youth, families, and young adults with information about transition to an adult approach to care.	The practice involves youth, families, and young adults in creating and implementing education programs for practice staff related to the transition and special health needs of young adults.	The practice includes youth, families, and young adults as active members of a quality improvement team.	The practice ensures equal representation of youth, families, and young adults in ongoing strategic planning related to the care of young adults.	

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/Integration into Adult Approach to Care	4	
Transfer to Adult Approach to Care	4	
Transfer Completion/Ongoing Care	4	
Youth, Family and Young Adult Feedback	4	
Youth, Family and Young Adult Leadership	4	
Total	32	