



# Health Care Transition Process Measurement Tool for Integrating Young Adults into Adult Health Care 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](http://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 young adults 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 young adults ages 18–26. 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 Health Care Transition Process Measurement Tool

Each of the *Six Core Elements* can be scored according to whether some or all of the implementation steps has been completed. Scores for each step vary depending on complexity or importance. For example, developing a written transition policy has a score of 4; that is, if this step is completed, a practice or network would receive a score of 4. If it is not completed, the score is 0. Posting the transition policy has a score of 2, and similarly, not posting it would be a 0.

In addition to evaluating implementation and young adult engagement, this measurement tool assesses dissemination to all eligible young adults, ages 18 to 26, within a practice or network. That is, if a practice or plan starts with a subset of young adults with special needs, they would likely be reaching 10% or less of eligible patients for a score of 1 point. If they are implementing the *Six Core Elements* for all eligible young adults with and without chronic conditions, they would score at the maximum level of 5 points.

A table to total implementation, young adult engagement, and dissemination scores is available on the final page of this tool. Practices and plans may elect to just score implementation and engagement at the outset of a transition quality improvement initiative and score dissemination after the *Six Core Elements* have been incorporated into ongoing clinical processes.



# 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   | Yes or No | Possible  | Actual | Possible Documentation              |
|---|-----------|-----------|--------|-------------------------------------|
| <b>1. Young Adult Transition and Care Policy</b>  |           |           |        |                                     |
| Developed a written transition and care policy that describes the practice's approach to accepting and partnering with new young adults     |           | Yes = 4   |        | Transition policy                   |
| Included information about privacy and consent in transition policy   |           | Yes = 2   |        | Transition policy                   |
| Posted policy in public clinic spaces   |           | Yes = 2   |        | Photo                               |
| Educated staff about transition policy and their role in transition process   |           | Yes = 2   |        | Date(s) of program                  |
| Designated practice staff to incorporate <i>Six Core Elements</i> into clinical processes   |           | Yes = 4   |        | Job description                     |
| <b>Transition Policy Implementation Subtotal:</b>   |           | <b>14</b> |        |                                     |
| <b>2. Transition Tracking and Monitoring</b>  |           |           |        |                                     |
| Established criteria and process for identifying transitioning target population to enter into registry or individual transition flow sheet |           | Yes = 3   |        | Screenshot or copy of registry/list |
| Incorporated transition core elements into clinical processes (e.g. EHR templates, progress notes, care plans)                              |           | Yes = 4   |        | Screenshot or copy of chart         |
| <b>Tracking and Monitoring Implementation Subtotal:</b>   |           | <b>7</b>  |        |                                     |
| <b>3. Transition Readiness/Orientation to the Adult Practice</b>  |           |           |        |                                     |
| Identified providers in practice interested in caring for young adults  |           | Yes = 2   |        | List of providers                   |
| Established a process to orient new young adults into practice  |           | Yes = 2   |        | Welcome letter/materials            |
| <b>Transition Readiness Implementation Subtotal:</b>  |           | <b>4</b>  |        |                                     |
| <b>4. Transition Planning/Integration into Adult Practice</b>   |           |           |        |                                     |
| Established a process to ensure receipt of transfer package from pediatric providers before first visit                                     |           | Yes = 2   |        | Sample plan of care                 |
| Made available list of community support resources  |           | Yes = 2   |        | List of resources                   |
| <b>Transition Planning Implementation Subtotal:</b>   |           | <b>4</b>  |        |                                     |
| <b>5. Transfer of Care/Initial Visit</b>  |           |           |        |                                     |
| Adopted a self-care assessment tool for use in practice   |           | Yes = 3   |        | Self-care assessment                |
| Developed a plan of care template that incorporates transition readiness assessment findings, goals, and prioritized actions                |           | Yes = 3   |        | Sample plan of care                 |
| Developed a medical summary and emergency care plan templates   |           | Yes = 3   |        | Portable medical summary            |
| <b>Transfer of Care Implementation Subtotal:</b>  |           | <b>9</b>  |        |                                     |
| <b>6. Transfer Completion/Ongoing Care</b>  |           |           |        |                                     |
| Have mechanism to systematically obtain feedback from young adults about experience with adult care   |           | Yes = 3   |        | Survey or interview questions       |
| <b>Transfer Completion Implementation Subtotal:</b>   |           | <b>3</b>  |        |                                     |

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## Health Care Transition Process Measurement Tool for Integrating Young Adults into Adult Health Care (continued)

Six Core Elements of Health Care Transition 2.0

| B) Young Adult Engagement Requirement  | Yes or No | Possible | Actual |
|--|-----------|----------|--------|
| Included input from young adults in developing policy  |           | Yes = 2  |        |
| Included input from young adults in developing or reviewing health care transition feedback survey |           | Yes = 2  |        |
| Involved young adults in the implementation of staff education on young adult care                 |           | Yes = 2  |        |
| Included young adults as active members of the advisory council or quality improvement team        |           | Yes = 3  |        |
| <b>Youth and Family Engagement Subtotal:</b>   |           | <b>9</b> |        |

| C) Dissemination Requirement  |          |          |          |          |          | Possible  | Actual |
|---|----------|----------|----------|----------|----------|-----------|--------|
| Percent of Patients in Practice Receiving Transition Elements:  | 1–10%    | 11–25%   | 26–50%   | 51–75%   | 76–100%  |           |        |
| <b>Score Points:</b>  | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |           |        |
| <b>1. Transition Policy</b>   |          |          |          |          |          |           |        |
| Sharing policy with young adults, ages 18–26 (letter or visit)  |          |          |          |          |          | 0 to 5    |        |
| <b>Transition Policy Dissemination Subtotal:</b>  |          |          |          |          |          | <b>5</b>  |        |
| <b>2. Transition Tracking and Monitoring</b>  |          |          |          |          |          |           |        |
| Percentage of young adults in practice tracked in registry/list   |          |          |          |          |          | 0 to 5    |        |
| <b>Transition Tracking and Monitoring Dissemination Subtotal:</b>   |          |          |          |          |          | <b>5</b>  |        |
| <b>3. Transition Readiness/Orientation into Adult Practice</b>  |          |          |          |          |          |           |        |
| Administering transition readiness assessment tool periodically to patients ages 18–26                              |          |          |          |          |          | 0 to 5    |        |
| <b>Transition Readiness Dissemination Subtotal:</b>   |          |          |          |          |          | <b>5</b>  |        |
| <b>4. Transition Planning/Integration into Adult Practice</b>   |          |          |          |          |          |           |        |
| Updating and sharing medical summary and emergency care plan regularly  |          |          |          |          |          | 0 to 5    |        |
| Updating and sharing plan of care including readiness assessment findings, goals, and prioritized actions regularly |          |          |          |          |          | 0 to 5    |        |
| <b>Transition Planning Dissemination Subtotal:</b>  |          |          |          |          |          | <b>10</b> |        |
| <b>5. Transfer of Care/Initial Visit</b>  |          |          |          |          |          |           |        |
| Administering self-care assessment tool   |          |          |          |          |          | 0 to 5    |        |
| Updating and sharing medical summary and emergency care plan  |          |          |          |          |          | 0 to 5    |        |
| Updating and sharing plan of care including self-care assessment findings, goals, and prioritized actions           |          |          |          |          |          | 0 to 5    |        |
| <b>Transfer of Care Dissemination Subtotal:</b>   |          |          |          |          |          | <b>15</b> |        |
| <b>6. Transfer Completion/Ongoing Care</b>  |          |          |          |          |          |           |        |
| Eliciting feedback from new young adult patients six months after the first visit                                   |          |          |          |          |          | 0 to 5    |        |
| Communicating with pediatric practices to confirm transfer or care responsibilities                                 |          |          |          |          |          | 0 to 5    |        |
| <b>Transfer Completion Dissemination Subtotal:</b>  |          |          |          |          |          | <b>10</b> |        |
| <b>DISSEMINATION SUBTOTAL:</b>  |          |          |          |          |          | <b>50</b> |        |

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## Health Care Transition Process Measurement Tool for Integrating Young Adults into Adult Health Care (continued)

Six Core Elements of Health Care Transition 2.0

The table below can be used to total the number of points that your practice obtained in implementation of the *Six Core Elements*, young adult engagement, and dissemination.

|   | 1. Transition Policy |       | 2. Tracking & Monitoring |       | 3. Transition Readiness/ Orientation |       | 4. Transition Planning/ Integration |       | 5. Transfer of Care/ Initial Visit |       | 6. Transfer Completion/ Ongoing Care |       | Total Score |       |
|---|----------------------|-------|--------------------------|-------|--------------------------------------|-------|-------------------------------------|-------|------------------------------------|-------|--------------------------------------|-------|-------------|-------|
|   | Possible             | Score | Possible                 | Score | Possible                             | Score | Possible                            | Score | Possible                           | Score | Possible                             | Score | Possible    | Score |
| <b>Implementation in Practice/Network</b>       | 14                   |       | 7                        |       | 4                                    |       | 4                                   |       | 9                                  |       | 3                                    |       | 41          |       |
| <b>Youth and Family Feedback and Leadership</b> | —                    | —     | —                        | —     | —                                    | —     | —                                   | —     | —                                  | —     | —                                    | —     | 9           |       |
| <b>Dissemination in Practice/Network</b>        | 5                    |       | 5                        |       | 5                                    |       | 10                                  |       | 15                                 |       | 10                                   |       | 50          |       |
| <b>Total</b>                                    | <b>19</b>            |       | <b>12</b>                |       | <b>9</b>                             |       | <b>14</b>                           |       | <b>24</b>                          |       | <b>13</b>                            |       | <b>100</b>  |       |