Clinician Information Packet: Transition from Pediatric to Adult Care

This packet contains information about:

- Processes for planning, transferring and integrating patients into adult care
- How to incorporate health care transition into your practice
- Resources available to support patient transition

Health Care Transition

- **Goals**
  - To improve the ability of youth and young adults to manage their own health and effectively use health services
  - To ensure an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care and integration into adult-centered care

- **TRANSITION ≠ TRANSFER**

- **Transition is an explicit process** and includes:
  - Planning
  - Transfer
  - Integration into adult health care
Why Do Adolescents Need a Structured Health Care Transition Process?

- Evidence of need for transition services
  - 2016 National Survey of Children's Health shows that, nationally, only 16.5% of youth with special health care needs, and 14.2% without special health care needs, received the services necessary to make transitions to adult care.
  - Florida is below national average: 7.5% of youth with special health care needs, and 7.0% without special health care needs, received the necessary services.

- Evidence of improved outcomes with a structured approach
  - Evaluation studies indicate improvement in population health (adherence to care, perceived health and quality of life, self-care); increased patient and family satisfaction; decreased barriers to care; improved utilization of ambulatory care in adult settings; reduced hospitalizations.

Gabriel et al. J Pediatr 2017 Sep;188:263-269

AAP/AAFP/ACP Clinical Report on Health Care Transition*

- In 2011, Clinical Report on Transition published as joint policy by AAP/AAFP/ACP.
- Targets all youth, beginning at age 12.
- Algorithmic structure with:
  - Branching for youth with special health care needs.
  - Application to primary and specialty practices.
- Extends through transfer of care to adult medical home and adult specialists.
- CR reaffirmed by AAP in 2016; updated CR currently in approval process in AAP, AAFP, ACP.

Age 12: Youth and family aware of transition policy.
Age 14: Health care transition planning initiated.
Age 16: Preparation of youth/parents for adult approach to care; 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)*
Six Core Elements Approach to Health Care Transition

1. Transition Policy
   - Discuss Transition Policy (Ages 12-14)
   - Transition Tracking and Monitoring (Ages 14-18)
   - Transition Readiness (Ages 14-18)
   - Transition Planning (Ages 14-18)
   - Transfer/Integration into Adult-Centered Care (Ages 18-21)
   - Transition Completion and Ongoing Care (Ages 18-26)

Six Core Elements Process Approach and Tools

- Based on the 2011 AAP/AAFP/ACP Clinical Report
  - QI learning collaboratives in DC*, MA, NH, WI, MN, CO using IHI breakthrough approach
- Six Core Elements in three packages with sample tools for each core element
  - Includes measurement options
  - Can be used by all members of the health care team
- 7th grade reading level, Spanish translation available
- FREE (download from www.gottransition.org)
- CUSTOMIZABLE tools and process
  - Use what works for your clinical setting
  - Use your own logos on the tools
- Many models (clinics, programs, consultative services) have incorporated the 6 Core Element Process

Six Core Elements Packages
See www.gottransition.org

Transitioning Youth to Adult Health Care Providers
(Pediatric, Family Medicine and Med-Peds Providers)

Transitioning to an Adult Approach to Health Care Without Changing Providers
(Family Medicine and Med-Peds Providers)

Integrating Young Adults into Adult Health Care
(Internal Medicine, Family Medicine and Med-Peds Providers)

What Steps Can You Take to Prepare Adolescents and their Families for the Change?

Adopt an office transition policy
Assess the youth transition readiness skills
Jointly develop a transition plan and medical summary and emergency care plan
Review and update transition plan
Implement an adult health care model at age 18
Ask for a transfer package and that your pediatric and adult clinicians communicate before transfer

STEPS
Pediatric Core Element #1: POLICY

- **Purpose**
  - Formalize practice’s approach, reduce clinician variability, offer a transparent explicit approach to youth/young adults and families
  - Voted most important element by youth and families

- **Content**
  - Define practice approach and recommended ages for transition preparation for adult-focused care, transfer and integration into adult care
  - **Key point**: Clarify and practice an adult approach to care at age 18 (including legal changes)
  - Include youth/young adult and family input
  - Reading level should be appropriate

- **Post**
  - Communicate it to all involved early in the process

---

Youth and Parent Transition Readiness Assessments

- Many validated tools are available, such as Got Transition and the TRAQ
- There are also readiness tools for youth with ID/DD and their families at [www.gottransition.org/resources/index.cfm#developmentaldisabilitiesandtransition](http://www.gottransition.org/resources/index.cfm#developmentaldisabilitiesandtransition)
How Can You Engage Your Patients and Parents/Caregivers in the Transition Process?

- Initiate discussion with youth and caregiver regarding the importance of transition.
- Initiate having time alone with youth that increases as they become older.
- Administer assessment to the youth to gauge their knowledge of their own personal health and about which areas they may need to know more.
- Administer assessment to caregiver to gauge their knowledge of what their youth may already know and what areas caregiver feels youth may need to know more about.
- Add transition skills to be acquired by youth, parent/caregiver to assist with self-management into the care plan.

Transition Planning Activities

**Planning tasks**

- Develop and regularly update the plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents. Documents could also be utilized by client/caregiver to create their own medical binder.
- Prepare youth and parent/caregiver for adult approach to care at age 18, including changes in decision-making and privacy and consent, self-advocacy, and access to information.
- Determine level of need for decision-making supports for youth with intellectual challenges; make referrals to legal resources.
- Plan with youth/guardian for optimal timing of transfer.
- Obtain consent from youth/guardian for release of medical information.
- Assist youth in identifying an adult provider and communicate with selected provider about pending transfer of care.
- Provide linkages to insurance resources, self-care management information and culturally appropriate community supports.
How Can You Ensure a Smooth Transition to the New Adult Care Provider?

One of the most effective transition tools is physician-to-physician communication.

Sample Transfer Letter

Dear [Adult Provider],

[Patient Name] is an [age] year-old patient of our pediatric practice who will be transitioning to your care on [date] of this year. [Patient Name]’s primary chronic condition is [condition], and [condition] are secondary conditions that are [condition]. [Patient Name] related medications and specialists are outlined in the enclosed transfer package that includes [list of items].

[Patient Name] medical summary and emergency care plans, sites of care, and transition readiness assessment. [Patient Name] acts as [guardian’s name] guardian, and is insured under [insurance provider] until [date].

I have had [Patient Name] as a patient since [date] and am very familiar with [Patient Name]’s health condition, medical history, and specialists. I would be happy to provide any consultation assistance to you during the initial phases of [Patient Name]’s transition to adult healthcare. Please do not hesitate to contact me by phone or email if you have further questions.

Thank you very much for your willingness to assume the care of this young [Patient Name].

Sincerely,
Is There a Way to Bill for Transition Services?

- Got Transition and the American Academy of Pediatrics developed a transition payment tip sheet to support the delivery of recommended transition services in pediatric and adult primary and specialty care settings.

- The 2017 tip sheet provides a comprehensive listing of transition-related CPT codes, corresponding Medicare fees and several clinical vignettes.


Patient-Centered Medical Home Recognition

- In response to popular requests for use of the Six Core Elements for PCMH certification, Got Transition completed a series of key informant interviews with clinical and administrative leaders in the health field and developed a tip sheet.

- This resource includes an easy-to-use chart displaying specific NCQA criteria and guidance with links to related Six Core Elements tools.

http://gottransition.org/resourceGet.cfm?id=444
Starting a Health Care Transition Improvement Process

This resource includes a step approach to starting a health care transition process in a practice/health care delivery system. It was developed with input from the integrated health care delivery systems who have incorporated the Six Core Elements into their practice processes.

www.gotttransition.org/resourceGet.cfm?id=369

### Side-by-Side Version: Six Core Elements of Health Care Transition 2.0

<table>
<thead>
<tr>
<th>Translating Youth to Adult Care Providers (Pediatric, Family Medicine, and Adult Providers)</th>
<th>Translating to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Adult Primary)</th>
<th>Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, and Adult Primary Care)</th>
</tr>
</thead>
</table>
| 1. **Transition Policy**  
   - Develop thorough communication plan with youth and their families that describes transitions to the adult system, including delays and next steps.  
   - Establish clear criteria for transitioning youth and older adults to the adult system.  
   - Utilize feedback from youth and family to track youth’s transition progress with the Six Core Elements.  
   - Incorporate the Six Core Elements into clinical care process, using EHR if possible. | 1. **Transition Policy**  
   - Develop thorough communication plan with young adults who have left their pediatric care system, but still maintain the provider’s approach to transitioning to an adult system for up to age 18, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Utilize feedback from youth and family to track youth’s transition progress with the Six Core Elements.  
   - Incorporate the Six Core Elements into clinical care process, using EHR if possible. | 1. **Young Adult Transition and Care Policy**  
   - Develop a transition plan in collaboration with young adults who have left their pediatric care system to transition to adult care.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Utilize feedback from youth and family to track youth’s transition progress with the Six Core Elements.  
   - Incorporate the Six Core Elements into clinical care process, using EHR if possible. |
| 2. **Transition Tracking and Monitoring**  
   - Establish criteria and process for identifying transitioning youth and older adults to the adult system.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps. | 2. **Transition Tracking and Monitoring**  
   - Establish criteria and process for identifying transitioning youth and older adults to the adult system.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps. | 2. **Young Adult Tracking and Monitoring**  
   - Establish criteria and process for identifying transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps.  
   - Establish clear criteria for transitioning young adults, including delays and next steps. |
| 3. **Transition Readiness**  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools. | 3. **Transition Readiness**  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools. | 3. **Transition Readiness**  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools.  
   - Identify normal transition readiness assessment tools. |
|   |   |   |


Sponsoring the health care transition from adolescence to adulthood through the Transitions Clinical Report.  
Supporting the health care transition from adolescence to adulthood through the Transitions Clinical Report.

© Get Transition!™, a program of The National Alliance to Advance Adolescent Health, supported by RWJF.  
GEH/03/10/13/

Continued on next page...
Florida Health and Transition Services
See www.FloridaHATS.org
FloridaHATS offers many resources for both practitioners and consumers, including a Tool Box and Health Services Directory for Young Adults.

Direct patients and caregivers to the site for downloadable educational materials.
Education and Training Opportunities for Health Care Professionals

- Web-based training is available to everyone; appropriate for clinical support staff, graduate students in health-related fields, medical and nursing school students, etc.
- Up to 4 free continuing education contact hours for Florida physicians, physician assistants, nurses, nurse practitioners, social workers, mental health counselors and allied health professionals are available through the Florida AHEC Network.

www.floridahats.org/education-training-for-health-care-professionals

Thank You!

- The information provided here highlights only a small portion of the resources found on the FloridaHATS (www.floridahats.org) and Got Transition (www.gottransition.org) web sites. We invite you to explore the sites further!

- Please contact for questions or feedback:
  - Dr. Janet Hess, jhess@health.usf.edu, 813-259-8604
  - Joni Hollis, RN, MSN, CNL, Joni.Hollis@flhealth.gov, 850-901-6303
### Six Core Elements of Health Care Transition 2.0

The Six Core Elements of Health Care Transition 2.0 are intended for use by pediatric, family medicine, med-peds, and internal medicine practices to assist youth and young adults as they transition to adult-centered care. They are aligned with the AAP/AAFP/ACP Clinical Report on Transition. Sample clinical tools and measurement resources are available for quality improvement purposes at [www.GotTransition.org](http://www.GotTransition.org).

<table>
<thead>
<tr>
<th>Transitioning Youth to Adult Health Care Providers</th>
<th>Transitioning to an Adult Approach to Health Care Without Changing Providers</th>
<th>Integrating Young Adults into Adult Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Pediatric, Family Medicine, and Med-Peds Providers)</td>
<td>(Family Medicine and Med-Peds Providers)</td>
<td>(Internal Medicine, Family Medicine, and Med-Peds Providers)</td>
</tr>
<tr>
<td><strong>1. Transition Policy</strong></td>
<td><strong>1. Transition Policy</strong></td>
<td><strong>1. Young Adult Transition and Care Policy</strong></td>
</tr>
</tbody>
</table>
| • Develop a transition policy/statement with input from youth and families that describes the practice’s approach to transition, including privacy and consent information. | • Develop a transition policy/statement with input from youth/young adults and families that describes the practice’s approach to transitioning to an adult approach to care at 18, including privacy and consent information.
• Educate all staff about the practice’s approach to transition, the policy/statement, the Six Core Elements, and distinct roles of the youth, family, and pediatric and adult health care team in the transition process, taking into account cultural preferences.
• Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care. | • Develop a transition policy/statement with input from young adults that describes the practice’s approach to accepting and partnering with new young adults, including privacy and consent information.
• Educate all staff about the practice’s approach to transition, the policy/statement, the Six Core Elements, and distinct roles of the youth, family, and health care team in the transition process, taking into account cultural preferences.
• Post policy and share/discuss with young adults at first visit and regularly review as part of ongoing care. |
| **2. Transition Tracking and Monitoring**          | **2. Transition Tracking and Monitoring**                                | **2. Young Adult Tracking and Monitoring**    |
| • Establish criteria and process for identifying transitioning youth and enter their data into a registry. | • Establish criteria and process for identifying transitioning youth/young adults and enter their data into a registry.
• Utilize individual flow sheet or registry to track youth’s transition progress with the Six Core Elements.
• Incorporate the Six Core Elements into clinical care process, using EHR if possible. | • Establish criteria and process for identifying transitioning young adults until age 26 and enter their data into a registry.
• Utilize individual flow sheet or registry to track young adults’ completion of the Six Core Elements.
• Incorporate the Six Core Elements into clinical care process, using EHR if possible. |
| **3. Transition Readiness**                        | **3. Transition Readiness**                                              | **3. Transition Readiness/Orientation to Adult Practice** |
| • Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care. | • Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care.
• Jointly develop goals and prioritized actions with youth and parent/caregiver, and document regularly in a plan of care. | • Identify and list adult providers within your practice interested in caring for young adults.
• Establish a process to welcome and orient new young adults into practice, including a description of available services.
• Provide youth-friendly online or written information about the practice and offer a "get-acquainted" appointment, if feasible. |

---


© GotTransition™/Center for Health Care Transition Improvement, 01/2014 | GotTransition™ is a program of The National Alliance to Advance Adolescent Health supported by U39MC25729 HRSA/MCHB | [www.GotTransition.org](http://www.GotTransition.org)
### Transitioning Youth to Adult Health Care Providers
(Pediatric, Family Medicine, and Med-Peds Providers)

<table>
<thead>
<tr>
<th>4. Transition Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop and regularly update the plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents.</td>
</tr>
<tr>
<td>• Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information.</td>
</tr>
<tr>
<td>• Determine level of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources.</td>
</tr>
<tr>
<td>• Plan with youth/parent/caregiver for optimal timing of transfer. If both primary and subspecialty care are involved, discuss optimal timing for each.</td>
</tr>
<tr>
<td>• Obtain consent from youth/guardian for release of medical information.</td>
</tr>
<tr>
<td>• Assist youth in identifying an adult provider and communicate with selected provider about pending transfer of care.</td>
</tr>
<tr>
<td>• Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Transfer of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confirm date of first adult provider appointment.</td>
</tr>
<tr>
<td>• Transfer young adult when his/her condition is stable.</td>
</tr>
<tr>
<td>• Complete transfer package, including final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional provider records.</td>
</tr>
<tr>
<td>• Prepare letter with transfer package, send to adult practice, and confirm adult practice’s receipt of transfer package.</td>
</tr>
<tr>
<td>• Confirm with adult provider the pediatric provider’s responsibility for care until young adult is seen in adult setting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Transfer Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contact young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm transfer of responsibilities to adult practice and elicit feedback on experience with transition process.</td>
</tr>
<tr>
<td>• Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed.</td>
</tr>
<tr>
<td>• Build ongoing and collaborative partnerships with adult primary and specialty care providers.</td>
</tr>
</tbody>
</table>

### Transitioning to an Adult Approach to Health Care Without Changing Providers
(Family Medicine and Med-Peds Providers)

<table>
<thead>
<tr>
<th>4. Transition Planning/Integration into Adult Approach to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop and regularly update a plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents.</td>
</tr>
<tr>
<td>• Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information.</td>
</tr>
<tr>
<td>• Determine need for decision-making supports for youth with intellectual challenges and make referrals to legal resources.</td>
</tr>
<tr>
<td>• Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult specialty care.</td>
</tr>
<tr>
<td>• Obtain consent from youth/guardian for release of medical information.</td>
</tr>
<tr>
<td>• Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Transfer to Adult Approach to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Address any concerns that young adult has about transferring to adult approach to care. Clarify adult approach to care, including shared decision-making, privacy and consent, access to information, adherence to care, and preferred methods of communication, including attending to health literacy needs.</td>
</tr>
<tr>
<td>• Conduct self-care assessment (transition readiness assessment) if not recently completed and discuss needed self-care skills.</td>
</tr>
<tr>
<td>• Review young adult’s health priorities as part of ongoing plan of care.</td>
</tr>
<tr>
<td>• Continue to update and share portable medical summary and emergency care plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Transfer Completion/Ongoing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist young adult to connect with adult specialists and other support services, as needed.</td>
</tr>
<tr>
<td>• Continue with ongoing care management tailored to each young adult.</td>
</tr>
<tr>
<td>• Elicit feedback from young adult to assess experience with adult health care.</td>
</tr>
<tr>
<td>• Build ongoing and collaborative partnerships with specialty care providers.</td>
</tr>
</tbody>
</table>

### Integrating Young Adults into Adult Health Care
(Internal Medicine, Family Medicine, and Med-Peds Providers)

<table>
<thead>
<tr>
<th>4. Transition Planning/Integration into Adult Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Communicate with young adult’s pediatric provider(s) and arrange for consultation assistance, if needed.</td>
</tr>
<tr>
<td>• Prior to first visit, ensure receipt of transfer package (final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional provider records.)</td>
</tr>
<tr>
<td>• Make pre-visit appointment reminder call welcoming new young adult and identifying any special needs and preferences.</td>
</tr>
<tr>
<td>• Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Transfer of Care/Initial Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prepare for initial visit by reviewing transfer package with appropriate team members.</td>
</tr>
<tr>
<td>• Address any concerns that young adult has about transferring to adult approach to care. Clarify approach to adult care, including shared decision-making, privacy and consent, access to information, adherence to care, and preferred methods of communication, including attending to health literacy needs.</td>
</tr>
<tr>
<td>• Conduct self-care assessment (transition readiness assessment) if not recently completed and discuss the young adult’s needs and goals in self-care.</td>
</tr>
<tr>
<td>• Review young adult’s health priorities as part of their plan of care.</td>
</tr>
<tr>
<td>• Update and share portable medical summary and emergency care plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Transfer Completion/Ongoing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Communicate with pediatric practice confirming transfer into adult practice and consult with pediatric provider(s), as needed.</td>
</tr>
<tr>
<td>• Assist young adult to connect with adult specialists and other support services, as needed.</td>
</tr>
<tr>
<td>• Continue with ongoing care management tailored to each young adult.</td>
</tr>
<tr>
<td>• Elicit feedback from young adult to assess experience with adult health care.</td>
</tr>
<tr>
<td>• Build ongoing and collaborative partnerships with pediatric primary and specialty care providers.</td>
</tr>
</tbody>
</table>