



Side-by-Side Version

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.¹ Sample clinical tools and measurement resources are available for quality improvement purposes at 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)
1. Transition Policy <ul style="list-style-type: none"> • Develop a transition policy/statement with input from youth and families that describes the practice's approach to transition, including privacy and consent information. • Educate all staff about the practice's approach to transition, the policy/statement, the <i>Six Core Elements</i>, 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. 	1. Transition Policy <ul style="list-style-type: none"> • 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 <i>Six Core Elements</i>, 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 youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care. 	1. Young Adult Transition and Care Policy <ul style="list-style-type: none"> • 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 <i>Six Core Elements</i> and distinct roles of the young adult, family, and pediatric and adult 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 <ul style="list-style-type: none"> • Establish criteria and process for identifying transitioning youth and enter their data into a registry. • Utilize individual flow sheet or registry to track youth's transition progress with the <i>Six Core Elements</i>. • Incorporate the <i>Six Core Elements</i> into clinical care process, using EHR if possible. 	2. Transition Tracking and Monitoring <ul style="list-style-type: none"> • 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/young adults' transition progress with the <i>Six Core Elements</i>. • Incorporate the <i>Six Core Elements</i> into clinical care process, using EHR if possible. 	2. Young Adult Tracking and Monitoring <ul style="list-style-type: none"> • 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 <i>Six Core Elements</i>. • Incorporate the <i>Six Core Elements</i> into clinical care process, using EHR if possible.
3. Transition Readiness <ul style="list-style-type: none"> • 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. 	3. Transition Readiness <ul style="list-style-type: none"> • 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. 	3. Transition Readiness/Orientation to Adult Practice <ul style="list-style-type: none"> • 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.

¹ American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2011; 128:182.

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Side-by-Side Version (continued)

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<p>4. Transition Planning</p> <ul style="list-style-type: none"> • 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. • 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. • Determine level of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources. • Plan with youth/parent/caregiver for optimal timing of transfer. If both primary and subspecialty care are involved, discuss optimal timing for each. • 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. 	<p>4. Transition Planning/Integration into Adult Approach to Care</p> <ul style="list-style-type: none"> • 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. • 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. • Determine of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources. • Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult specialty care • Obtain consent from youth/guardian for release of medical information. • Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports. 	<p>4. Transition Planning/Integration into Adult Practice</p> <ul style="list-style-type: none"> • Communicate with young adult's pediatric provider(s) and arrange for consultation assistance, if needed. • 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.) • Make pre-visit appointment reminder call welcoming new young adult and identifying any special needs and preferences. • Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.
<p>5. Transfer of Care</p> <ul style="list-style-type: none"> • Confirm date of first adult provider appointment. • Transfer young adult when his/her condition is stable. • 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. • Prepare letter with transfer package, send to adult practice, and confirm adult practice's receipt of transfer package. • Confirm with adult provider the pediatric provider's responsibility for care until young adult is seen in adult setting. 	<p>5. Transfer to Adult Approach to Care</p> <ul style="list-style-type: none"> • 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. • Conduct self-care assessment (transition readiness assessment) if not recently completed and discuss needed self-care skills. • Review young adult's health priorities as part of ongoing plan of care. • Continue to update and share portable medical summary and emergency care plan. 	<p>5. Transfer of Care/Initial Visit</p> <ul style="list-style-type: none"> • Prepare for initial visit by reviewing transfer package with appropriate team members. • 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. • Conduct self-care assessment (transition readiness assessment) if not recently completed and discuss the young adult's needs and goals in self-care. • Review young adult's health priorities as part of their plan of care. • Update and share portable medical summary and emergency care plan.
<p>6. Transfer Completion</p> <ul style="list-style-type: none"> • 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. • Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed. • Build ongoing and collaborative partnerships with adult primary and specialty care providers. 	<p>6. Transfer Completion/Ongoing Care</p> <ul style="list-style-type: none"> • Assist young adult to connect with adult specialists and other support services, as needed. • Continue with ongoing care management tailored to each young adult. • Elicit feedback from young adult to assess experience with adult health care. • Build ongoing and collaborative partnerships with specialty care providers. 	<p>6. Transfer Completion/Ongoing Care</p> <ul style="list-style-type: none"> • Communicate with pediatric practice confirming transfer into adult practice and consult with pediatric provider(s), as needed. • Assist young adult to connect with adult specialists and other support services, as needed. • Continue with ongoing care management tailored to each young adult. • Elicit feedback from young adult to assess experience with adult health care. • Build ongoing and collaborative partnerships with pediatric primary and specialty care providers.