



# Incorporating Pediatric-To-Adult Transition into NCQA Patient-Centered Medical Home Recognition

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**Introduction:** This practice resource is intended to facilitate the easy application of nationally recognized transition tools to address specific Patient-Centered Medical Home (PCMH) criteria, developed by the National Committee for Quality Assurance (NCQA) in their 2017 PCMH standards. Got Transition, the federally funded national health care transition resource center, developed the Six Core Elements of Health Care Transition (HCT), which define the basic components of pediatric-to-adult transition for youth and young adults ages 12-26 and include free, customizable tools for implementation and measurement. The Six Core Elements align with the Transition Clinical Report, published by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) to improve health care transition within the medical home.<sup>1</sup>

Evidence suggests that adopting PCMH criteria improves delivery and coordination of care in primary care practices and uniquely positions such practices to address transition from pediatric to adult care for all youth and young adults. The need to establish an organized process in both pediatric and adult medical home settings is critical to facilitate transition preparation, transfer of care, and integration to adult-centered care. While transition from pediatric to adult care is only one part of seeking PCMH recognition, it is a crucial aspect of care for all adolescents and young adults.

The Six Core Elements offer an easy-to-use, customizable set of transition tools that can be adapted to specific criteria for PCMH recognition. Got Transition has received helpful feedback based on key informant interviews with clinicians who have used the Six Core Elements in meeting PCMH requirements for their academic health system, community health center networks, and family practice group. The customizable transition tools in the Six Core Elements are “extremely useful” in meeting PCMH requirements. “They gave me a guide...something to start with.” Key informants noted that it is important to review each of the tools and decide which ones to prioritize. “Tackle these, with feedback, then return to the others.” Also, it is important to consider which age groups should be targeted and to include both pediatric and adult clinicians in the quality improvement process.

Key informants also commented that to make transition changes engrained in any system, it is very helpful to have a champion, especially with continuous resident and staff turnover. Also, noted was the need to have “all providers on board, saying that they are going to tackle this as a group and not as individual providers.” Repeatedly, key informants noted the need for greater functionality with electronic medical records.

In response to popular requests for use of the Six Core Elements for PCMH recognition, Got Transition developed this tip sheet. Using the NCQA PCMH 2017 standards, the following chart displays all six NCQA PCMH concepts.<sup>2</sup> Within each concept, we identified the relevant NCQA criteria and guidance related to transition and linked them to existing Six Core Elements tools.

It is important to note that the Six Core Elements tools may contribute to the NCQA criteria they are cross-walked to, but they are not by themselves sufficient. The exception is for the Care Coordination and Care Transitions criteria – CC 20 – where the sample tools would fully meet NCQA requirements.

For further information about PCMH recognition, please visit NCQA’s website ([www.ncqa.org](http://www.ncqa.org)). To obtain free, customizable copies of the three following Six Core Elements packages, please visit <http://gottransition.org/providers/index.cfm>:

- 1) Transitioning Youth to Adult Providers
- 2) Transitioning to an Adult Approach to Care Without Changing Providers
- 3) Integrating Young Adults into Adult Care

Got Transition’s website has additional transition resources for clinicians, youth and families, plans and payers, and policymakers and researchers.

## References

1. American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Cooley, WC, Sagerman, P and Transitions Clinical Report Authoring Group. [Supporting the health care transition from adolescence to adulthood in the medical home](#). *Pediatrics*. 2011;128(1):182-200.
2. National Committee for Quality Assurance. NCQA PCMH Standards and Guidelines. Available at <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/getting-recognized/documents>. 2017; Version 1. Accessed April 4, 2017.

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**2017 NCQA PCMH CRITERIA AND LINKED TRANSITION RESOURCES**

How to use this table: NCQA criteria and guidance are cross-walked with relevant Six Core Elements sample tools available in the following packages:

- 1) Pediatrics (Peds): “Transitioning Youth to an Adult Health Care Provider”
- 2) Family Medicine and Med-Peds (FM/Med-Peds): “Transitioning to an Adult Approach to Health Care Without Changing Providers”
- 3) Internal Medicine (IM): “Integrating Young Adults into Adult Health Care” (This package is relevant to FM/Med-Peds accepting new young adult patients)

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	Guidance	
<b>1. Team-Based Care and Practice Organization (TC)</b>		
<i>TC 09 (Core):</i> Has a process for informing patients, families, caregivers about the role of the medical home and provides patients, families, caregivers materials that contain the information.	<i>Guidance:</i> The documented process includes providing patients, families, caregivers with information about the role and responsibilities of the medical home. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. The information that the practice provides should at minimum include information on after-hours access, practice scope of services, evidence-based care, availability of education and self-management support and practice points of contact. As a medical home, the practice helps patients understand the importance of having comprehensive information about all their healthcare activity and how and where to access the care they need coordinated by their personal clinician and care team.	<ul style="list-style-type: none"> <li>• Sample Transition Policy                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• <a href="#">Sample Welcome and Orientation of New Young Adults</a></li> </ul>
<b>2. Knowing and Managing Your Patients (KM)</b>		
<i>KM 08 (1 Credit):</i> Evaluates patient population demographics, communication preferences, health literacy to tailor development and distribution of patient materials.	<i>Guidance:</i> The practice demonstrates an understanding of the patients’ communication needs by utilizing materials and media that are easy for their patient population to understand and use. The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population. The practice may consider how its patients like to receive information (i.e., paper brochure, phone app, text message, e-mail), in addition to the readability of materials (e.g., general literacy and health literacy). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and establish processes that address health literacy to improve patient health behaviors and safety in the practice setting. Reducing barriers to the patient’s ability to access, understand and absorb health information supports their ability to comply with their care.	<ul style="list-style-type: none"> <li>• Sample Transition Readiness/Self-Care Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• For those with intellectual/developmental disabilities                             <ul style="list-style-type: none"> <li>○ Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers) all found <a href="#">here</a></li> </ul> </li> <li>• Sample Transition Registry                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> </ul>

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<p><i>KM 22 (1 Credit):</i> Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.</p>	<p><i>Guidance:</i> Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients.</p> <ul style="list-style-type: none"> <li>Educational programs and resources may include information about a medical condition or about the patient’s role in managing the condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups).</li> <li>Self-management tools enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings.</li> </ul> <p>The practice provides or shares available health education classes, which may include alternative approaches such as peer-led discussion groups or shared medical appointments (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multi-disciplinary care team and facilitate patients to interact with and learn from each other.</p>	<ul style="list-style-type: none"> <li><a href="#">Talking with Your Child’s Doctor about Transition to Adult Health Care</a></li> <li><a href="#">How to Ask Your Doctor about Transitioning to Adult Primary Health Care</a></li> <li><a href="#">Youth and Family Frequently Asked Questions</a></li> <li><a href="#">Transition Resources</a></li> </ul>
<b>3. Patient-Centered Access and Continuity (AC)</b>		
<p><i>AC 10 (Core):</i> Helps patients/families/ caregivers select or change a personal clinician.</p>	<p><i>Guidance:</i> Giving patients/families/caregivers a choice of practitioner emphasizes the importance of the ongoing patient-clinician relationship. The practice documents patients’ choice of clinician, gives patients/families/caregivers information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice may document a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a practice team. Single clinician sites automatically meet this criterion.</p>	<ul style="list-style-type: none"> <li><a href="#">Sample Welcome and Orientation of New Young Adults</a></li> </ul>

2017 NCQA PCMH Standards		Six Core Elements Tools
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<b>4. Care Management and Support (CM)</b>		
<p><i>CM 04 (Core):</i> Establishes a person-centered care plan for patients identified for care management.</p>	<p><i>Guidance:</i> The practice has a process to consistently develop patient care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan’s development, which includes discussions about goals (e.g., patient function/life style, goal feasibility and barriers) and considers patient preferences.</p> <p>The care plan incorporates a problem list, expected outcome/ prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services.</p> <p>The practice updates the care plan at relevant visits. A <b>relevant visit</b> addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.</p>	<ul style="list-style-type: none"> <li>• Sample Plan of Care                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• Sample Transition Readiness/Self-Care Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• For those with intellectual/developmental disabilities                             <ul style="list-style-type: none"> <li>○ Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers) all found <a href="#">here</a></li> </ul> </li> </ul>
<p><i>CM 05 (Core):</i> Provides a written care plan to the patient/family/caregiver for patients identified for care management.</p>	<p><i>Guidance:</i> The practice provides the patient’s written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient’s health literacy and language preference. (i.e., the patient version may use different words or formats from the version used by the practice team).</p>	<ul style="list-style-type: none"> <li>• Sample Plan of Care                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• Sample Transition Readiness/Self-Care Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• For those with intellectual/developmental disabilities                             <ul style="list-style-type: none"> <li>○ Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers) all found <a href="#">here</a></li> </ul> </li> </ul>

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<p><i>CM 08 (1 Credit):</i> Includes a self-management plan in individual care plans.</p>	<p><i>Guidance:</i> The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan. Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers toward meeting care plan goals.</p>	<ul style="list-style-type: none"> <li>• Sample Plan of Care                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• Sample Transition Readiness/Self-Care Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• For those with intellectual/developmental disabilities                             <ul style="list-style-type: none"> <li>○ Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers) all found <a href="#">here</a></li> </ul> </li> </ul>
<p><i>CM 09 (1 Credit):</i> Care plan is integrated and accessible across settings of care.</p>	<p><i>Guidance:</i> Sharing the care plan supports its implementation across all settings that address the patient’s care needs. The practice makes the care plan accessible across external care settings. It may be integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.</p>	<ul style="list-style-type: none"> <li>• Sample Plan of Care                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• Sample Transition Readiness/Self-Care Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• For those with intellectual/developmental disabilities                             <ul style="list-style-type: none"> <li>○ Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers) all found <a href="#">here</a></li> </ul> </li> </ul>

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<b>5. Care Coordination and Care Transitions (CC)</b>		
<p><i>CC 20 (1 Credit):</i> Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).</p>	<p><i>Guidance:</i> The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care. The written care plan may include:</p> <ul style="list-style-type: none"> <li>• A summary of medical information (e.g., history of hospitalizations, procedures, tests).</li> <li>• A list of providers, medical equipment and medications for patients with special health care needs.</li> <li>• Obstacles to transitioning to an adult care clinician.</li> <li>• Special care needs.</li> <li>• Information provided to the patient about the transition of care.</li> <li>• Arrangements for release and transfer of medical records to the adult care clinician.</li> <li>• Patient response to the transition.</li> <li>• Patient transition plan.</li> </ul> <p><b>Internal medicine practices</b> receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices or develop a plan if one is not provided to support a smooth and safe transition.</p> <p><b>For family medicine practices</b> that do not transition patients from pediatric to adult care, should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Sample Transfer Letter</a></li> <li>• <a href="#">Sample Medical Summary and Emergency Care Plan</a></li> <li>• Sample Plan of Care                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• Sample Transition Readiness Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> </ul> </li> <li>• Sample Transition Policy                             <ul style="list-style-type: none"> <li>○ <a href="#">FM/Med-Peds</a></li> </ul> </li> <li>• Sample Health Care Transition Feedback Survey                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• <a href="#">Sample Welcome and Orientation of New Young Adults</a></li> </ul>

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<p><i>CC 21 (Maximum 3 Credits):</i> Demonstrates electronic exchange of information with external entities, agencies and registries (May select one or more):</p> <p>C. Summary of care record to another provider or care facility for care transitions. (1 Credit)</p>	<p><i>Guidance:</i> The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care.</p> <p>Practices can demonstrate this by:</p> <p>C. Making the summary of care record accessible to another provider or care facility for care transitions.</p> <p>Practices may provide the required evidence for each of the criteria options for up to a total of 3 credits. Each option is part of CC 21 but is listed separately in Q-PASS for scoring purposes.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Sample Transfer Letter</a></li> <li>• <a href="#">Sample Medical Summary and Emergency Care Plan</a></li> <li>• Sample Plan of Care                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>• Sample Transition Readiness Assessment                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> </ul> </li> <li>• Sample Transition Policy                             <ul style="list-style-type: none"> <li>○ <a href="#">FM/Med-Peds</a></li> </ul> </li> <li>• Sample Health Care Transition Feedback Survey                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• <a href="#">Sample Welcome and Orientation of New Young Adults</a></li> </ul>
<b>6. Performance Measurement and Quality Improvement (QI)</b>		
<p><i>QI 04 (Core): Monitors patient experience through:</i></p> <p>A: Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:</p> <ul style="list-style-type: none"> <li>• Access.</li> <li>• Communication.</li> <li>• Coordination.</li> <li>• Whole-person care, self-management support and comprehensiveness.</li> </ul> <p>B: Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.</p>	<p><i>Guidance:</i> The practice gathers feedback from patients and provides summarized results to inform quality improvement activities. Patient feedback must represent the practice population (including all relevant subpopulations) and may not be limited to patients of one clinician (of several), or to data from one payer (of several).</p> <ul style="list-style-type: none"> <li>• The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories:                             <ul style="list-style-type: none"> <li>○ Access (may include routine, urgent and after-hours care).</li> <li>○ Communication with the practice, clinicians and staff (may include “feeling respected and listened to” and “able to get answers to questions”).</li> <li>○ Coordination of care (may include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Sample Health Care Transition Feedback Survey for Youth/Young Adults                             <ul style="list-style-type: none"> <li>○ Peds (for <a href="#">youth</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ FM/Med-Peds (for <a href="#">youth/young adults</a> or for <a href="#">parents/caregivers</a>)</li> <li>○ IM (for <a href="#">young adults</a>)</li> </ul> </li> <li>• <a href="#">Sample Welcome and Orientation of New Young Adults</a></li> </ul>



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	<ul style="list-style-type: none"> <li>○ Whole-person care/self-management support (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, routine and urgent care, advice, assistance and support for changing health habits and making health care decisions).</li> <li>● Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as “virtual” (e.g., telephone, videoconference) participation. Comments collected on surveys used to satisfy QI 04A do not meet this requirement.</li> </ul>	
<p><i>QI 15 (Core):</i> Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.</p>	<p><i>Guidance:</i> The practice provides individual clinician or practice level reports to clinicians and practice staff. Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan.</p>	<ul style="list-style-type: none"> <li>● Current Assessment of Health Care Transition Activities                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> <li>● Health Care Transition Process Measurement Tool                             <ul style="list-style-type: none"> <li>○ <a href="#">Peds</a></li> <li>○ <a href="#">FM/Med-Peds</a></li> <li>○ <a href="#">IM</a></li> </ul> </li> </ul>
<p><i>QI 17 (2 Credits):</i> Involves patient/family/caregiver in quality improvement activities.</p>	<p><i>Guidance:</i> The practice has a process for involving patients and their families in its quality improvement efforts or on the practice’s patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings.</p> <ul style="list-style-type: none"> <li>● The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.</li> </ul>	<ul style="list-style-type: none"> <li>● <a href="#">Starting a Transition Improvement Process using the Six Core Elements of Health Care Transition</a></li> </ul>

## DESCRIPTIONS OF LINKED SIX CORE ELEMENTS TOOLS

Transition Policy	<i>Peds: Written description of the practice's approach to transition to an adult provider FM/Med-Peds: Written description of the practice's approach to transition to an adult approach to care IM: Written description of the practice's approach to accepting and partnering with new young adults</i>
Welcome and Orientation of New Young Adults	<i>Welcome letter and frequently asked questions for new young adult patients</i>
Transition Registry	<i>Template for tracking youth/young adult's receipt of the Six Core Elements</i>
Transition Readiness Assessment for Youth and Parents/Caregivers	<i>Youth and parent tools for assessing transition importance and confidence and youth's understanding about own health and using health care</i>
Self-Care Assessment for Young Adults	<i>Young adult tool for assessing transition importance and confidence and young adults' understanding about health and using health care</i>
Plan of Care	<i>Template for establishing priorities and action steps</i>
Medical Summary and Emergency Care Plan	<i>Template for a medical summary and emergency care plan, including diagnoses, medications, allergies, emergent presenting problems, providers, past medical history, labs, equipment, and special information the youth/young adult wants provider to know</i>
Transfer Letter	<i>Cover letter for physicians to send adult provider about transferring youth and young adult</i>
Health Care Transition Feedback Survey for Youth	<i>Survey for youth to provide feedback about transition experience</i>
Health Care Transition Feedback Survey for Parents/Caregivers	<i>Survey for parents/caregivers to provide feedback about transition experience</i>
Health Care Transition Feedback Survey for Young Adults	<i>Survey for young adults to provide feedback about new adult health care provider</i>
Current Assessment for Health Care Transition Activities	<i>Qualitative self-assessment tool for practice to measure implementation of the Six Core Elements</i>
Health Care Transition Process Measurement Tool	<i>Objective scorable tool for practice to measure implementation of the Six Core Elements</i>
Starting a Transition Improvement Process Using the Six Core Elements of Health Care Transition	<i>Practice tip sheet to help providers start a quality improvement effort in implementing the Six Core Elements</i>
Start Talking with Your Child's Doctor about Transition to Adult Health care	<i>Set of questions for parents to ask their child's doctor about transitioning to adult health care</i>
How to Ask Your Doctor about Transitioning to Adult Primary Health Care	<i>Set of questions for youth and young adults to ask their doctor about transitioning to adult care</i>

Tools are available here: <http://www.gottransition.org/providers/index.cfm>



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