Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Transitioning to an Adult Approach to Health Care Without Changing Clinicians

Core Element 1 - Transition and Care Policy/Guide

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I. Purpose, Objectives, and Considerations

Purpose

A written transition and care policy/guide is the first element in the Six Core Elements of Health Care Transition™ (HCT). The transition and care policy/guide is intended to be shared with youth/young adults and parents/caregivers early in adolescence and periodically repeated. Developed by your practice or health system, with input from youth/young adults, parents/caregivers, and staff, the policy/guide formalizes the practice/system approach to HCT. It represents a consensus among the practice staff and youth/young adults and parents/caregivers about the HCT approach involved. It can also represent structure for evaluation. It should be at the appropriate reading level, offered in languages common among your clinic population, and concise (no more than one page). *See sample transition and care policies/guides in Section III.*

Objectives

Develop a transition and care policy/guide with input from youth/young adults and parents/caregivers that describes the practice's approach to transition and an adult approach to care in terms of privacy and consent.

Educate all staff about the practice's approach to transition and the distinct roles that youth/young adult, parent/caregiver, and health care team play in the transition process, taking into account cultural preferences.

Display the transition and care policy/guide somewhere accessible in practice space, discuss and share with youth/young adult and parent/caregiver, beginning at age 12 to 14, and regularly review as part of ongoing care.

Considerations

CONTENT

What should be included in the transition and care policy/guide?

Below are some questions and ideas to think about.

- *At what age will your practice start the HCT planning process?*
- *What will your practice offer youth/young adults and parents/caregivers to assist them in transition—e.g., a readiness assessment for youth and parents/caregivers or self-care skills assessment once they are young adults, plan of care that includes transition, medical summary, referral of young adults to adult subspecialists?*
- *What will your practice do to prepare youth for changes in privacy and consent that happen at age 18?*
- *Will your practice have them sign a HIPAA form to allow others to be present in their visit or see their health records?*
- *What does your practice offer to assist youth/young adults and parents/caregivers to consider if there is a need for supported decision-making and how to begin the legal process, if needed? For more information about resources, see the National Resource Center for Supported Decision-Making and The Arc.*
- *Does your practice have information for youth/young adults and parents/caregivers on sensitive services available for youth/young adults in your state?*
- *Does your practice have information for parents/caregivers to let them know when they no longer have legal access to their youth's electronic medical records on the practice's portal?*

PROCESS

What is the process to develop the transition and care policy/guide?

Below are some questions and ideas to think about.

- *Does it describe the practice's approach to transition, including privacy and consent information?*
- *Does it describe the practice's approach to practicing an adult model of care after age 18?*
- *Is the reading level appropriate for your youth/young adults and parents/caregivers?*
- *Test the policy/guide with 1-3 youth/young adults and parents/caregivers and consider asking:*
    - *Are there any words you do not understand?*
    - *What does this policy/guide mean to you?*
    - *How could the policy/guide be clearer?*
- *Create a written document to describe the clinic approach to implement the process outlined above.*
- *Educate all team members/staff about the process.*

What is the process to implement the transition and care policy/guide?

Below are some questions and ideas to think about.

- *Whose job is it to share and discuss the HCT policy/guide with the youth/young adult and parent/caregiver?*
- *Whose job is it to ask if the youth/young adult and parent/caregiver have any questions?*
- *How do we inform all staff about the practice's approach to transition and practicing an adult model of care for young adults?*
- *How do we inform all staff about the practice's expectations for youth/young adult, parent/caregiver, and the health care team during the transition process?*
- *How do we discuss with all staff the different ways the practice is taking cultural preferences of their youth/young adults/parents/caregivers into account throughout the transition process?*
- *How often will your practice share the policy/guide during the transition process?*
- *Regularly review the policy/guide as part of ongoing care.*
- *Create a written document to describe the clinic approach to implement the process outlined above.*
- *Educate all team members/staff about the process.*

Examples of Process

1. Mail the transition and care policy/guide to all 12 to 14-year-olds and their parents/caregivers annually. Mail the policy again to all 18-year-olds to remind them of the practice's adult approach to care.
2. Have the front desk hand out the transition and care policy/guide when all 12 to 14-year-olds and their parents/caregivers check in for their appointment, or when they are waiting in the exam room at their annual preventive visit.
3. Display the policy/guide on the practice website and on the patient portal or make it a poster to be displayed in the clinic.
4. Include the transition and care policy/guide as part of the after-visit summary in the electronic medical record (EMR).
5. Discuss your practice's approach to transition during a Lunch and Learn or during a staff meeting.

II. Quality Improvement Considerations, Tools, and Measurement

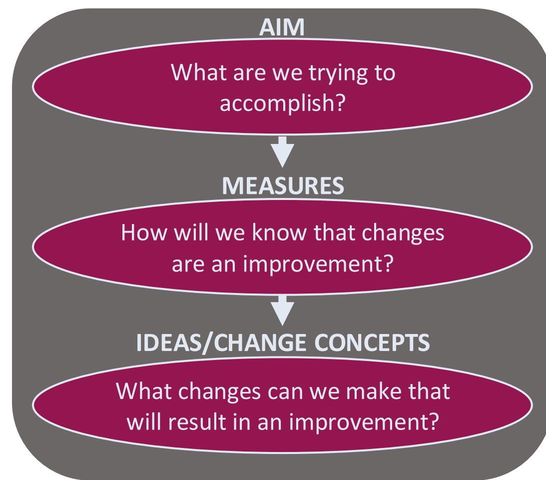
Quality Improvement Considerations

What should be thought about when forming a team? (See *Successful Teams* in the *QI Primer*)

- Include a representative from all areas of your practice
- Include a youth/young adult/parent/caregiver whenever possible
- Depending on what you are aiming to improve, consider any ad hoc members you might need (e.g., information services, lab, pharmacy, supply distribution, etc.)
- Schedule meetings or huddles

What is the Model for Improvement?

The Model for Improvement (see *Model for Improvement* in the *QI Primer*) is an approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes. The figure here illustrates the three questions that make up the Model for Improvement. This is a simple but robust model widely used for improvement in many industries, including health care.



Adapted from Langley GL, et al. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, 2nd ed. San Francisco: Jossey-Bass Publishers, 2009.

As you continue to work through this document and the Six Core Elements, you will find that the QI tools and other items below have been customized to each Element for each kind of practice. However, you will find the basic team considerations described above remain the same for most if not all of your QI work.

Quality Improvement Tools

The most important QI tools to guide a team's improvement work include ***Tools 1-5*** listed below. Using these tools in the following order will increase your chances of success, but teams can make modifications as needed. For more information and examples, see *Tools for Improvement* in the *QI Primer*.

- ***Tool 1: An aim statement*** is a fundamental element of this model and answers the question of what you are trying to accomplish.
- ***Tool 2: Key driver diagrams*** allow teams to visualize the relationship between the project aim and contributing factors, helping them determine key actions necessary to meet this aim.
- ***Tool 3: Process flow maps*** can help you visualize the steps in your change process.
- ***Tool 4: The simplified failure mode and effects analysis*** form helps teams recognize what problems might arise in each step of the process and think of possible solutions.
- ***Tool 5: Plan-Do-Study-Act (PDSA) cycles*** allow teams to trial and learn from their process changes. Using Tools 1-4 before initiating a PDSA cycle helps teams assess root causes before jumping to solutions.

Tool 1: Aim Statement

The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement 1

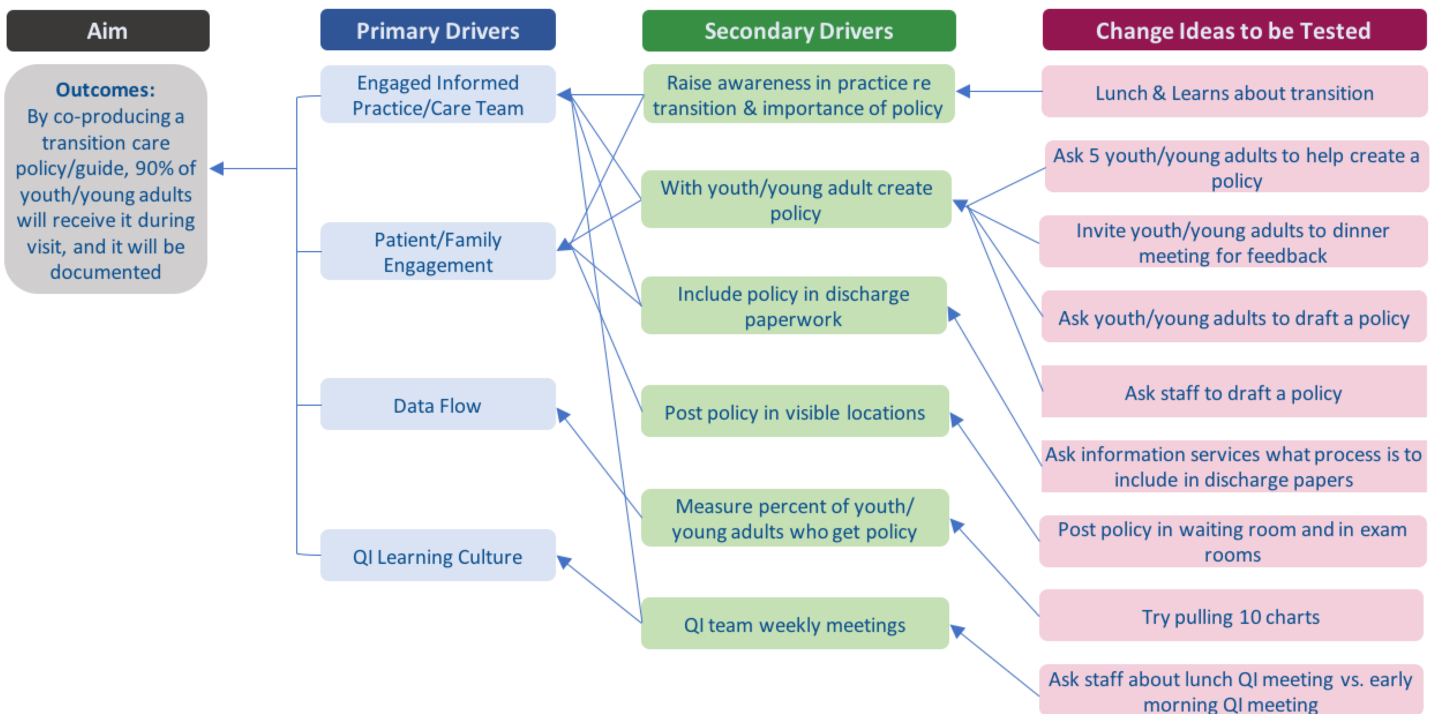
We aim to inform our youth/young adults and parents/caregivers about the practice's HCT approach by ensuring they receive our current transition and care policy/guide. By [insert date], 85% of 14-year-old patients and their parents/caregivers will be given the transition and care policy/guide and have this documented in their medical record.

Example Aim Statement 2

Understanding when to transition from pediatric to adult care is important for parents/caregivers. By [insert date], we will co-produce (with youth/young adults and parents/caregivers) a transition and care policy/guide, and 90% of youth/young adults will receive it during their preventive care visit, which will be documented in their medical record.

Tool 2: Key Driver Diagram

Key driver diagrams (KDDs) require teams to identify their theories or "key drivers" which lead to outcomes. They help teams see relationships and organize work, especially in complex systems. They are frequently used for analysis, organization, and communication to direct improvement work. For more information and examples, see *Tools for Improvement* in the *QI Primer*.



Adapted from ST3P UP, a collaborative sponsored by Patient Centered Outcomes Research Institute® (PCORI) Award MCSC-1608-35861 Titled A Comparative Effectiveness of Peer Mentoring Versus Structured Education Based Transition Programming For The Management Of Care Transitions In Emerging Adults With Sickle Cell Disease.

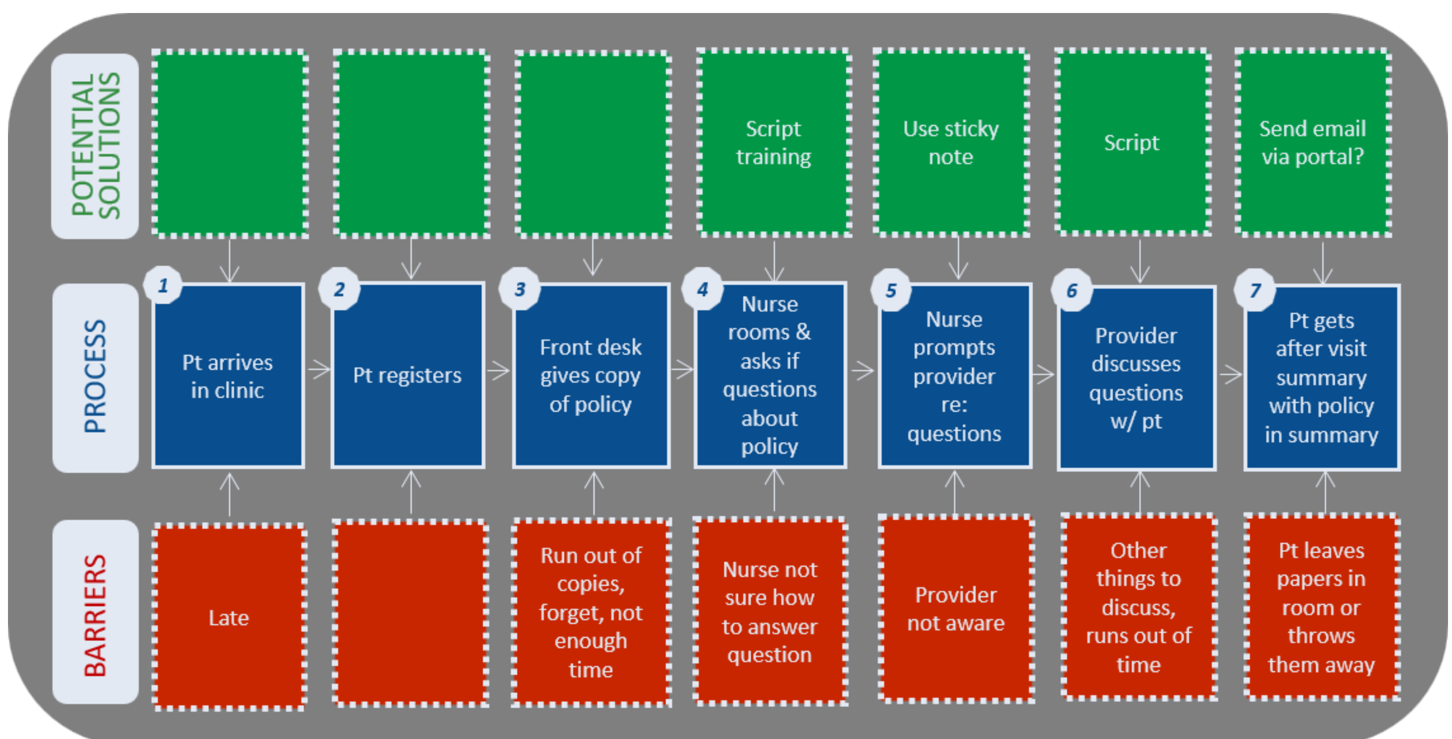
Tool 3: Process Flow Map

A flow map is a visual display of the separate steps in a process placed in sequential order. It is extremely helpful in documenting different views of the same process. It can show the sequence of actions, materials/inputs entering and leaving the process, decision points, and people involved. Flow maps can be used to document steps in the process of either how things are or how things could be. Posting the flow map gives staff an opportunity to clarify the steps in the process and can uncover conflicting understandings. For more information and examples, see *Tools for Improvement* in the [QI Primer].

Y/YA = youth/young adult

Tool 4: Simplified Failure Mode and Effects Analysis (sFMEA)

Simplified Failure Mode and Effects Analysis (sFMEA) is a proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change and help generate ideas to prevent those possible failures. This is a good companion to the flow map – a flow map lets you see the process as it is, and the sFMEA helps you look more closely to identify breakdowns. The example below has a few solutions filled in, to illustrate how teams might start completing an sFMEA. For more information and examples, see *Tools for Improvement* in the [QI Primer].



Adapted from the copyrighted Simplified Failure Mode Effects Analysis Worksheet (sFMEA) from Cincinnati Children's Hospital Medical Center. This version of the sFMEA has been modified and has been reprinted with permission.

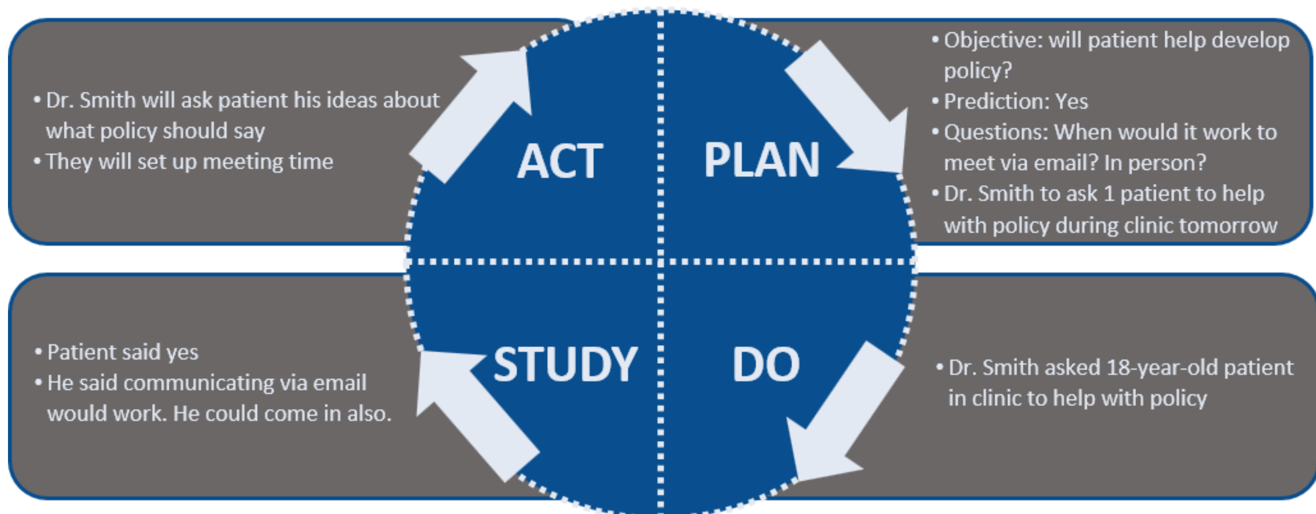
Tool 5: PDSA Cycles

PDSA cycles are a structured test of a process change. These are meant to be done rapidly, for example one patient, one afternoon, with one doctor. To accelerate learning and improvement, small tests with reflection allow for change ideas to be adapted, adopted, or abandoned easily within busy healthcare settings. Learning to do rapid cycle testing is key to keeping the momentum going; it is not necessary to schedule a full separate meeting, just a quick huddle allows teams to plan the next cycle. For more information and examples, see *Model for Improvement* in the *QI Primer*. This effort includes:

- **Plan** the test: who, what, where, when;
- **Do** try the change and observe what happens;
- **Study** reflect on what was learned from the test; and
- **Act** decide next steps based on the reflection.

Examples of Ideas to Test

- Developing the policy/guide with youth/young adults and parents/caregivers
- Posting the policy/guide in the clinic
- Adding the policy/guide to the discharge paperwork



Adapted from AHEC QI 101, a Quality Improvement course sponsored by Charlotte Area Health Education Center.

Quality Improvement Measurement

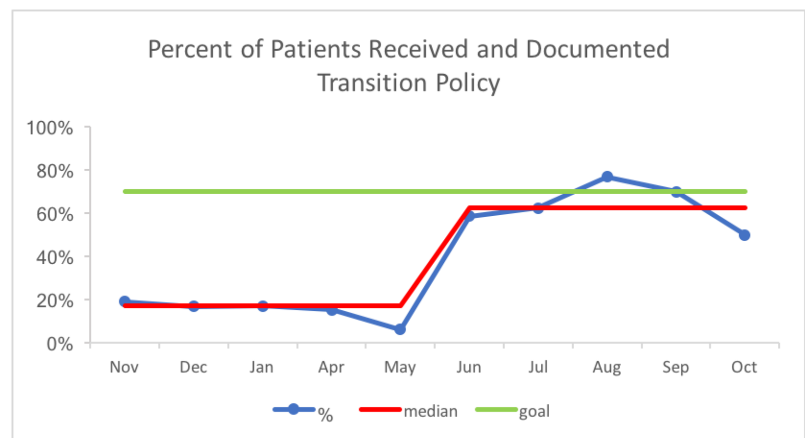
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of HCT Activities or the HCT Process Measurement Tool in the Six Core Elements package can be used by teams to track progress of specific core elements or the overall HCT process. For more information and examples, see *Measuring for Improvement* in the *QI Primer*.

Example Data Collection Check Sheet

- ☐ A few weeks after giving the policy/guide out, track how many youth/young adults received it.
- ☐ For one week, track how many were found in the trash or left behind in the room.
- ☐ Track how many youth/young adults had questions about the policy/guide.
- ☐ Share feedback with the team to help refine the policy/guide and the process.
- ☐ Periodic scoring using Current Assessment of HCT Activities or the HCT Process Measurement Tool in the Six Core Elements package.

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**
Policy/guide given	||	||||	|||	|	||
Left in room or trash		||||			|
Pt questions	|			|	

Data display is important for teams to assess the impact of the changes they are making. In QI, run charts are most often used. Run charts are a dynamic display of data over time. They require no statistical calculations and should be easily understood. Use a clear title. Data points are plotted around a median line. When possible, adding annotations to the chart to explain when certain changes were introduced can make the chart more informative and robust.



Sustain & Spread

For strategies on how to sustain and spread your work, please see Steps 6 and 7 in *How to Implement the Six Core Elements of Health Care Transition*.

III. Sample Transition and Care Policies/Guides

As you develop your transition policy, you should strive for a 6th grade reading level using common words with a concise message, plenty of white space, and an easily readable format. Please see the QI Primer for in depth information about health literacy, including strategies for implementation, which are crucial to creating a transition policy that will be understandable and usable for teenagers, young adults, and their families.

Sample Transition and Care Policies/Guides from the Six Core Elements of HCT™

- Sample policy from Got Transition's "Transitioning to an Adult Approach to Health Care Without Changing Clinicians" *(click here)*

Sample Transition and Care Policies/Guides at Different Reading Levels

- See a policy in the middle of revisions at 8th grade reading level and then see the final version of the policy at 6th grade reading level *(click here)*

Sample Transition and Care Policies/Guides in Different Clinical Settings

- Sample policy from a practice from Weiss Pediatric Care *(click here)*
- Sample policy from a system at Children's Mercy/Henry Ford *(click here)*
- Sample welcome and care policy from a School-Based Health Center *(click here)*

Sample Transition and Care Policies/Guides for Youth/Young Adults with Specific Conditions

- Sample policy from American College of Rheumatology *(click here)*
- Sample sickle cell disease policy from Johns Hopkins All Children's Hospital *(click here)*

Sample Transition and Care Policies/Guides in Video Format

- Sample standard policy from Children's Mercy Kansas City *(click here)*
- Sample policy for youth with intellectual and developmental disabilities from Children's Mercy Kansas City *(click here)*

IV. Additional Resources

- Turning 18: What It Means for Your Health (*click here*)
- Health Care Transition Timeline for Youth and Young Adults (*click here*)
- Health Care Transition Timeline for Parents/Caregivers (*click here*)
- (*click here*)
- (*click here*)
- Add your health information into your smartphone (*click here*)
- Questions for youth/young adults to ask their doctor about transitioning to adult health care (*click here*)
- Questions for parents/caregivers to ask their child’s doctor about transitioning to adult health care (*click here*)

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