PRACTICE RESOURCE
October 2019

Incorporating Pediatric-To-Adult Transition into NCQA Patient-Centered Medical Home Recognition: 2019 Update

Margaret McManus, MHS
Patience White, MD, MA
The National Alliance to Advance Adolescent Health
and
Christina Borden, PCMH, CCE
National Committee for Quality Assurance

INTRODUCTION

This updated 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™, which define the basic components of pediatric-to-adult transition for youth and young adults ages 12-26 and include free tools for implementation and measurement. The Six Core Elements align with the 2018 Transition Clinical Report jointly developed 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.[1]

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, as there is an overlap conceptually in what organization, structure, process, and procedures need to be in place for a practice to be successful. 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, according to these informants, 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."
- It is important to consider which age groups should be targeted and to include both pediatric and adult clinicians in the quality improvement process.
- To make transition changes ingrained in any system, it is very helpful to have a champion, especially with continuous staff and resident 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 and updated this tip sheet. Using the NCQA PCMH 2017 standards, the following chart displays all six NCQA PCMH concepts.[2] 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 enough; additional requirements must be met. The exception is for the Care Coordination and Care Transitions criteria – CC 20 – where the sample tools would fully meet NCQA requirements. Practices should follow the PCMH Standards and Guidelines for detailed information on how to meet PCMH criteria, which are intended to be applied to all patients, unless otherwise specified.

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

1) Transitioning Youth to Adult Providers (Pediatrics)
2) Transitioning to an Adult Approach to Care Without Changing Providers (Family Medicine, Med-Peds)
3) Integrating Young Adults into Adult Care (Internal Medicine)

Got Transition's website (GotTransition.org) has additional transition resources for clinicians, youth and families, plans and payers, and policymakers and researchers.

REFERENCES

1. White PH, Cooley WC, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018;142(5).
2. National Committee for Quality Assurance. NCQA PCMH Standards and Guidelines. Available at www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/getting-recognized/documents. 2017; Version 1. Accessed July 10, 2019.

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**	
1. Team-Based Care and Practice Organization (TC)		
TC 09 (Core): Medical Home Information: 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.	*Guidance*: 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.	• Sample Transition Policy: - Peds - FM/Med-Peds - IM • Sample Welcome and Orientation of New Young Adults
2. Knowing and Managing Your Patients (KM)		
KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.	*Guidance:* Up-to-date means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician, or by querying the patient—are added to the problem list. The report shows that the practice updates patients' problem lists at least annually. The patient's active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient's current care. Implementing KM 01 is a foundation for understanding health risks.	• Sample Medical Summary and Emergency Care Plan

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
KM 08 (1 Credit) Patient Materials: Evaluates patient population demographics, communication preferences, health literacy to tailor development and distribution of patient materials.	*Guidance:* 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, email), 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.	• Sample Transition Readiness/ Self-Care Assessment: - Peds: For youth or for parents/ caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers - IM: For young adults • For those with intellectual/ developmental disabilities: - Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers). All samples found here. • Sample Transition Registry: - Peds - FM/Med-Peds - IM
KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	*Guidance:* 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. • 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). • 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. • 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.	• Talking with Your Child's Doctor about Transition to Adult Health Care • How to Ask Your Doctor about Transitioning to Adult Primary Health Care • Youth and Family Frequently Asked Questions • Transition Resources

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
3. Patient-Centered Access and Continuity (AC)		
AC 10 (Core) Personal Clinician Selection: Helps patients/families/caregivers select or change a personal clinician.	*Guidance:* 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.	• Sample Welcome and Orientation of New Young Adults
4. Care Management and Support (CM)		
CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for patients identified for care management. (*Note*: Care management patients should include patients identified using at least 3 of the following criteria from CM 01: A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations, practice staff, etc.)	*Guidance:* 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. 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. The practice updates the care plan at relevant visits. A relevant visit addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	• Sample Plan of Care: - Peds - FM/Med-Peds - IM • Sample Transition Readiness/ Self-Care Assessment: - Peds: For youth or for parents/ caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers - IM: For young adults • For those with intellectual/ developmental disabilities: - Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers). All samples found here.

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
CM 05 (Core) Written Care Plans: Provides a written care plan to the patient/family/caregiver for patients identified for care management.	*Guidance:* 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 of formats from the version used by the practice team).	• Sample Plan of Care: - Peds - FM/Med-Peds - IM • Sample Transition Readiness/ Self-Care Assessment: - Peds: For youth or for parents/ caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers - IM: For young adults • For those with intellectual/ developmental disabilities: - Transition Readiness Assessment (for youth or for parents/ caregivers) and Self-Care Assessment (for youth or for parents/caregivers). All samples found here.
CM 08 (1 Credit) Self-Management Plans: Includes a self-management plan in individual care plans.	*Guidance:* 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.	• Sample Plan of Care: - Peds - FM/Med-Peds - IM • Sample Transition Readiness/ Self-Care Assessment: - Peds: For youth or for parents/ caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers - IM: For young adults • For those with intellectual/ developmental disabilities: - Transition Readiness Assessment (for youth or for parents/caregivers) and Self-Care Assessment (for youth or for parents/caregivers). All samples found here.

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
5. Care Coordination and Care Transitions (CC)		
CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions: 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).	*Guidance:* 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: • A summary of medical information (e.g., history of hospitalizations, procedures, tests). • A list of providers, medical equipment and medications for patients with special health care needs. • Obstacles to transitioning to an adult care clinician. • Special care needs. • Information provided to the patient about the transition of care. • Arrangements for release and transfer of medical records to the adult care clinician. • Patient response to the transition. • Patient transition plan. **Internal medicine practices** 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. **For family medicine practices** 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.	• Sample Transfer Letter • Sample Medical Summary and Emergency Care Plan • Sample Plan of Care: - Peds - FM/Med-Peds - IM • Sample Transition Readiness Assessment (Peds): - Youth - Parents/Caregivers • Sample Transition Policy (FM/ Med-Peds) • Sample Health Care Transition Feedback Survey: - Peds: For youth or for parents/caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers - IM: For young adults • Sample Welcome and Orientation of New Young Adults

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
CC 21 (Maximum 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries: C. Summary of care record to another provider or care facility for care transitions. (1 Credit)	*Guidance:* 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. Practices can demonstrate this by: C. Making the summary of care record accessible to another provider or care facility for care transitions. 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.	• Sample Transfer Letter • Sample Medical Summary and Emergency Care Plan • Sample Plan of Care: - Peds - FM/Med-Peds - IM • Sample Transition Readiness Assessment (Peds): - Youth - Parents/Caregivers • Sample Transition Policy (FM/Med-Peds) • Sample Health Care Transition Feedback Survey: - Peds: For youth or for parents/caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers) - IM: For young adults • Sample Welcome and Orientation of New Young Adults

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
6. Performance Measurement and Quality Improvement (QI)		
QI 04 (Core) *Patient Experience Feedback:* Monitors patient experience through: A: Quantitative data. Conducts a survey (using any instrument) to evaluate patient/ family/caregiver experiences across at least three dimensions such as: • Access • Communication • Coordination • Whole-person care, self-management support and comprehensiveness B: Qualitative data. Obtains feedback from patients/families/ caregivers through qualitative means	*Guidance:* 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). A. 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: • Access to clinical care (may include routine, urgent and after-hours; ease of getting to the practice, scheduling an appointment or waiting room amenities would not be considered access questions). • Communication with the practice, clinicians and staff (may include "feeling respected and listened to" and "able to get answers to questions"). • Coordination of care (may include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results). • 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). B. 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. The requirement is not met by: • Comments that were collected on surveys to satisfy QI 04, component A, and/or • Feedback collected by a Patient and Family Advisory Committees (PFAC) that represent more than one practice and/or do not depict the entire patient population.	• Sample Health Care Transition Feedback Survey for Youth/Young Adults: - Peds: For youth or for parents/ caregivers - FM/Med-Peds: For youth/young adults or for parents/caregivers - IM: For young adults • Sample Welcome and Orientation of New Young Adults

2017 NCQA PCMH Standards		Six Core Elements Tools
Criteria	**Guidance**	
QI 15 (Core) Reporting Performance within the Practice: Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.	*Guidance*: The practice provides individual clinician or practice level reports to clinicians and practice staff that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).	• Current Assessment of Health Care Transition Activities: - Peds - FM/Med-Peds - IM • Health Care Transition Process Measurement Tool: - Peds - FM/Med-Peds - IM
QI 17 (2 Credits) Patient/ Family/Caregiver Involvement in Quality Improvement: Involves patient/family/caregiver in quality improvement activities.	*Guidance:* 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. • The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	• Starting a Transition Improvement Process using the Six Core Elements of Health Care Transition

DESCRIPTIONS OF LINKED SIX CORE ELEMENTS TOOLS

SIX CORE ELEMENTS TOOLS	DESCRIPTIONS
Transition Policy	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
Welcome and Orientation of New Young Adults	Welcome letter and frequently asked questions for new young adult patients
Transition Registry	Template for tracking youth/young adult's receipt of the Six Core Elements
Transition Readiness Assessment for Youth and Parents/Caregivers	Youth and parent tools for assessing transition importance and confidence and youth's understanding about own health and using health care
Self-Care Assessment for Young Adults	Young adult tool for assessing transition importance and confidence and young adults' understanding about health and using health care
Plan of Care	Template for establishing priorities and action steps
Medical Summary and Emergency Care Plan	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
Transfer Letter	Cover letter for physicians to send adult provider about transferring youth and young adults
Health Care Transition Feedback Survey for Youth	Survey for youth to provide feedback about transition experience
Health Care Transition Feedback Survey for Parents/Caregivers	Survey for parents/caregivers to provide feedback about transition experience
Health Care Transition Feedback Survey for Young Adults	Survey for young adults to provide feedback about new adult health care provider
Current Assessment for Health Care Transition Activities	Qualitative self-assessment tool for practice to measure implementation of the Six Core Elements
Health Care Transition Process Measurement Tool	Objective scorable tool for practice to measure implementation of the Six Core Elements
Starting a Transition Improvement Process Using the Six Core Elements of Health Care Transition	Practice tip sheet to help providers start a quality improvement effort in implementing the Six Core Elements
Start Talking with Your Child's Doctor about Transition to Adult Health Care	Set of questions for parents to ask their child's doctor about transitioning to adult health care
How to As Your Doctor about Transitioning to Adult Primary Health Care	Set of questions for youth and young adults to ask their doctor about transitioning to adult care

Tools are available here: GotTransition.org/Providers/Index.cfm

The table below outlines the Six Core Transition Elements that support activities associated with NCQA PCMH Criteria. The table also outlines guidance on how the Six Core Elements tools can be used to meet part of the NCQA PCMH Criteria.

NCQA PCMH Criteria	Alignment with Six Core Elements	Six Core Elements	Six Core Elements Tool Guidance
Team-Based Care and Practice Organization (TC)			
Competency A			
TC 01 PCMH Transformation Leads	Partial	1-6	High level alignment – promotes high functioning PCMH that may indicate ability to implement Six Core Elements of Health Care Transition.
TC 02 Structure and Staff Responsibilities	Partial	1-6	High level alignment – promotes high functioning practice. Potential to establish roles and responsibilities of who is responsible for transitions.
TC 04 Patient/Family/Caregiver Involvement in Governance	Partial	1	"Transition Policy" from Core Element 1 calls for practices to have input for the transition policy from the patients/family/caregiver.
TC 05 Certified EHR System	Partial	5,6	High level alignment – promotes high functioning practice/ability to send, receive, collect patient information.
Competency B			
TC 06 Individual Patient Care Meetings/Communication	Partial	1,2	Core Elements 1 & 2 may include structured communication policies/procedures.
Competency C			
TC 09 Medical Home Information	Partial	1-6	Practice can provide information to patients that would meet partial intent of TC 09.
Knowing and Managing Your Patients (KM)			
Competency A			
KM 01 Problem Lists	Partial	3,4	Information that should be sent to new provider and added to transition care plan.
KM 02 Comprehensive Health Assessment	Partial	3,4	Information that should be sent to new provider and added to transition care plan.
KM 08 Patient Materials	Partial	1-6	Transition materials may count as 1 of 3 examples needed, but not for all 3.
Competency D			
KM 14 Medication Reconciliation	Partial	5	Information that should be sent to new provider and added to transition care plan.
KM 15 Medication Lists	Partial	5	Information that should be sent to new provider and added to transition care plan.
Competency F			
KM 22 Access to Educational Resources	Partial	1-6	Transition materials may count as 1 of 3 examples needed, but not for all 3.
KM 24 Shared Decision-Making Aids	Partial	1-3	Helping patients with decisions that occur through the transition process.

NCQA PCMH Criteria	Alignment with Six Core Elements	Six Core Elements	Six Core Elements Tool Guidance
Patient-Centered Access and Continuity (AC)			
Competency B			
AC 10 Personal Clinician Selection	Partial	6	Partially aligns because the Six Core Elements only pertain to a subset of the population.
AC 12 Continuity of Medical Record Information	Partial	1-6	Conceptual alignment – sharing care plan, etc. with new provider.
Care Management and Support (CM)			
Competency A			
CM 01 Identifying Patients for Care Management	Partial	1	The practice may be able to use "Transition Registry" tool where practices are asked to identify "Transition Complexity" for *ONE* of the CM categories required for the protocol. However, the practice must have this patient long enough for meaningful care management.
Competency B			
CM 04 Person-Centered Care Plans	Partial	3,4	Transitions care plan partially meets intent for transitioning patients who were identified for CM.
CM 05 Written Care Plans	Partial	3,4	Partially meets for transitioning patients.
CM 06 Patient Preferences and Goals	Partial	3,5	Included in transition care plan.
CM 07 Patient Barriers to Goals	Partial	3,6	Included in transition care plan.
CM 08 Self-Management Plans	Partial	3,7	Included in transition care plan.
CM 09 Care Plan Integration	Partial	1-6	Capability of having care plan integrated across settings.
Care Coordination and Care Transitions (CC)			
Competency C			
CC 15 Sharing Clinical Information	Partial	5,6	Ability of practice to share care plan with new provider.
CC 20 Care Plan Collaboration for Practice Transitions	Direct Alignment	1-6	The only PCMH Criteria that directly aligns with the Six Core Elements.
CC 21 External Electronic Exchange of Information	Partial	5,6	Ability of practice to share care plan with new provider.
Performance Measurement and Quality Improvement (QI)			
Competency A			
QI 02 Resource Stewardship Measures	Partial	1-6	Transition of care can be considered a Care Coordination measure for QI 02A.
QI 04 Patient Experience Feedback	Partial	1-6	If practice has "transition of care" as a component of the patient experience survey.

PRACTICE RESOURCE
October 2019

The authors gratefully acknowledge the useful feedback from several key informants: Suzanne McLaughlin, MD, Lifespan; Rhonda McLean, MBA, Neon Health; Floyd Stephens, MD, Associates in Family Medicine, P.C.; and Tarika James, MD, Long Island Federally Qualified Health Centers. We also appreciate the helpful reviews from Michael Barr, MD, MBA, NCQA; Casey Granack, CCE, NCQA; Christina Boothby, MPA, AAP; Marie Mann, MD, MPH, Maternal and Child Health Bureau (MCHB); and Sarah Beth McLellan, MPH, MCHB.

Got Transition® is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, U1TMC31756. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

For more information about our work and available publications, contact our office at info@GotTransition.org.

THE NATIONAL ALLIANCE TO ADVANCE ADOLESCENT HEALTH
1615 M Street NW, Suite 290, Washington DC 20036
p: 202.223.1500 f: 202.429.3957