Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Integrating Young Adults Into Adult Health Care

got transition®

How to Implement the Six Core Elements of Health Care Transition™ 3.0

Introduction

The Six Core Elements of Health Care Transition™ (HCT) offer a structured approach for pediatric-to-adult transitional care recommended by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) Clinical Report on HCT.[1] This approach incorporates a set of steps and sample tools for transition planning in pediatric care, transfer to adult care, and integration into adult care. Having a structured HCT process has been shown to significantly improve population health, patient experience, and health care utilization[2] and has been successfully incorporated into many different health care settings for youth and young adults with and without chronic physical, developmental, and behavioral health conditions.[1]

The goal of the Six Core Elements approach is to guide systems of care and health care professionals and clinicians in improving the ability of youth and young adults to manage their own health and safely and effectively use health care as they transition to an adult approach to care and/or to an adult clinician, all while partnering with youth, young adults, and their families in the process. To implement the Six Core Elements, quality improvement (QI) methods are recommended. The Model for Improvement, developed by the Associates in Process Improvement, is one such framework (www.IHI.org), which is used in this implementation guide. This guide can be used as a resource for payers, managed care organizations, health care systems, public health professionals, and individual clinicians as they implement a structured HCT improvement process.

How to Use This Implementation Guide

There are three Six Core Element packages:

- ***Transitioning Youth to an Adult Health Care Clinician*** for use by pediatric, family medicine, and med-peds clinicians
- ***Transitioning to an Adult Approach to Health Care Without Changing Clinicians*** for use by family medicine and med-peds clinicians
- ***Integrating Young Adults into Adult Health Care*** for use by clinicians caring for adults, including family medicine and med-peds clinicians

This guide is a supplement to the *Integrating Young Adults into Adult Health Care* package and is organized into nine steps a health care delivery system or individual practice can consider when implementing a QI process for HCT. To access guides for the other two packages, click here.

Systems/clinicians can draw on the practical ideas presented in this guide when developing a HCT implementation plan, when experiencing challenges, or when the way forward seems unclear. The plan should be customized to fit the system/practice resources, patient population, health care setting and the local context. For example, the scope of Pediatrics/ Internal Medicine/Family Medicine/General Practice is different in different countries and thus the transition process needs to be locally adapted.

Note: The term "practice" will be used generically throughout the guide, and some of the points in each of the steps need to be interpreted in light of the size of your practice/health care delivery or public health system/program.

The implementation steps are outlined below with suggested strategies and tips and include:

Step 1: Secure Senior Leadership Support

Step 2: Form the HCT Quality Improvement Team

Step 3: Develop an HCT Improvement Plan

Step 4: Raise Awareness About HCT Activities

Step 5: Implement the Six Core Elements of HCT

Step 6: Plan for Sustainability

Step 7: Plan for Spread

Step 8: Communicate Successes

Step 9: Tips for Success

Step 1: Secure Senior Leadership Support

Obtaining senior leadership support within your system or practice before your HCT QI project starts, or shortly thereafter when you have identified the key HCT gap areas in your system/practice to focus on, is essential. To gain their support, align your HCT priorities with existing practice, departmental, or health system priorities – e.g., discuss how investing in HCT will help with retention of young adult patients, improve patient satisfaction, meet criteria for medical home certification, and increase adolescent and young adult primary care access and preventive care use. In addition, provide data on the need for HCT, such as the number of youth who will need transition services over the next 5 years in your system/state/practice or the percentage of youth not receiving HCT services from health care providers in your state from the National Survey of Children's Health. Make leadership aware of the evidence that population health, satisfaction, and utilization outcomes are improved with a structured HCT approach. Further, have the practice/system of services fill out Got Transition's Current Assessment of HCT Activities to show where the practice/system of services is in implementing the evidence-informed Six Core Elements approach. Be sure to share any data about HCT gaps in your practice/system of services in a clear, concise manner. Personal stories about youth/young adults/parents/caregivers experience with HCT are useful as well.

Gaining explicit support of key senior leader(s) who are in a position to develop long-range goals means they are willing to:

- Back the project publicly and actively
- Align with other strategic activities
- Ensure dedicated time for both administrative support and the clinical transition improvement team to pilot incorporating the Six Core Element approach into the clinic process including utilizing appropriate billing codes[3]
- Ensure availability of resources, such as health information technology
- Endorse/guide expansion from pilot to full implementation
- Communicate with other senior leader counterparts when needed (e.g., between pediatric and adult institutions or settings)

Step 2: Form the HCT Quality Improvement Team

Implementing and sustaining changes in your practice requires strong, effective partnerships. These partnerships should not only be within your practice but also with adult partners and community-based organizations. You will need a dedicated team. This team should be led by a practice employee who is vested with the authority to coordinate the team's efforts and implement practice changes. The most effective teams include representatives from clinical and administrative staff, and families, youth, and young adults.

A. Identify Team Members

Choose an energized and empowered team leader

The team leader must have both enthusiasm for QI and the clout to spearhead practice change. If the team leader is not part of the practice's senior leadership, senior leadership must make it clear that the team leader has the authority to lead. In addition, the team leader should be able to facilitate input from all team members, including families and youth/young adults.

Involve key stakeholders

Key stakeholders include, but are not limited to, pediatric care champion(s), adult care champion(s), care coordinators, parents/caregivers, and youth/young adults. Having a youth/young adult patient and/or parent/caregiver on the team is essential. These team members can provide invaluable first-hand insight on what they experience and how systems and communication can be improved. To identify youth/young adults and parents/caregivers consider the following:

- Ask for volunteers – including current youth or former young adult patients or parents/caregivers of transition-aged youth who are typical of your patient population – to join the HCT improvement team.
- Connect with a family based organization, such as the Family-to-Family Health Information Center in your area/state or other entity that could connect with/find youth/young adults and parents/caregivers.
- Provide compensation unless they are paid staff members.
- Be flexible about meeting times and modalities (phone, Skype) to accommodate participation.
- Consider recruiting more than one youth/young adult and parent/caregiver so their views and opinions are always represented.
- Articulate roles and provide training, if needed (including from other consumers who have taken leadership roles in the practice)

Include at least one motivated and respected representative from each area of your practice/system

In small practices, it often works best to include most or all of your clinical and administrative staff members. In large practices, it is important to include at least one representative from each area of your practice. Team members may include but are not limited to:

- Clinician
- Nurse
- Social worker
- Medical assistant
- Practice manager
- Front office staff
- Billing staff/payers
- Community-based organization that, for example, can assist in providing services in your transition process such as patient education.
- Public health programs that, for example, can assist by raising awareness around HCT needs and improving services
- Others (as part of the team or to participate on *ad hoc* basis) such as epidemiologists, care coordinator/key support staff, clinic support staff from both pediatric and adult practices/clinics, electronic medical record (EMR) representative, data administrator who can pull system/practice data to support the initiation and evaluation of the process, senior leader, or payer. While a data person and an EMR analyst don't need to attend all the meetings, they are critical as the process evolves, so plan on and budget their involvement early.

Tip: If you've done QI work before, build on former or existing teams to populate your HCT team.

Keep the size of your team manageable
A team with more than 12 members can make it hard to get things done.

B. Bring Team Members Together

- Have an initial meeting to introduce the topic and educate your team, introduce the Six Core Elements package and its sample tools, and review the goals of implementing HCT in your practice.
- Ask at least one or two team members to review the full Six Core Elements package carefully to become familiar with its contents.

C. Have Subsequent Meetings and Establish Routine Reporting

- Schedule regular team meetings. Frequent meetings may be needed at the outset (e.g., twice a month). Meetings can take place less frequently once your implementation activities are underway.
- Early on and throughout the process, it is important to clarify each team member's role and responsibilities.
- Report progress on a monthly basis in a templated format, including data, to the practice's senior leadership to maintain accountability and team engagement.

Step 3: Develop an HCT Improvement Plan

Prior to beginning your HCT improvement plan, assess your practice's current implementation of the Six Core Elements using Got Transition's Current Assessment of HCT Activities or HCT Process Measurement Tool (see *here*) to obtain a baseline. This will help your practice identify current strengths and areas for improvement. Once you assess your practice using either the

Current Assessment or HCT Process Measurement Tool, prioritize your area of focus. For example, you may decide to start with Core Element 1 and progress through each of the Six Core Elements, or your assessment may indicate you need a different prioritization. You do not need to focus on all of the Six Core Elements at the outset, nor do you have to aim to reach the highest score for each of the core elements you prioritize (e.g., Level 4 in the Current Assessment of HCT). It is important to develop goals that are realistic and achievable for your practice.

During the plan development process, keeping an eye on where the youth will transfer is important. Develop a strategy to maintain a database of interested adult providers, and who will curate it and how often. This will help all involved in the process.

To start the HCT improvement plan, use a known improvement methodology. The Model for Improvement has been adopted by many health care organizations for its simple but robust model (see *QI Primer* for more detail). Consider practice/system strategies or initiatives that can help to push the project forward.

Include an overall aim, specifying the following (see *QI Primer* for more detail)**:**

- Scope (single clinic, primary care, specialty care, institution-wide)
- Population – e.g., all youth vs. youth with special health care needs vs. youth with selected conditions vs. all young adults 20 and over
- Timeline for improvement activities (what you need to do and how it will get done)
- Measurement plan (what data are needed to show improvement?) (see *here* for more information)
  Note: The Current Assessment of HCT or HCT Process Measurement Tool can be used as part of that measurement plan to assess process improvements over time and fidelity to the Six Core Elements. Other measures could include an HCT experience survey, using for example Got Transition's HCT Feedback Survey, that could be anonymously given out after the initial visit to the adult practice.

Step 4: Raise Awareness about HCT Activities

Plan and conduct educational activities to help the members of your practice and youth, young adults, and parents/caregivers become more aware about transitioning youth to adult care, why it is important, how it affects your patients, and how you can work together to make transition improvements.

For example:

- Hold learning sessions over lunch or other already scheduled times to introduce professional recommendations and build buy-in for this work.
- Use the results from your baseline assessment of the practice's implementation of the Six Core Elements to demonstrate the need.
- Try quick reminders to help your practice develop knowledge and skills in a particular area of transition. For example, some reminders could be having a list of potential adult providers or a laminated card that shows which specialists transition when.

- Discuss at practice team meetings, huddles, and other opportunities to teach and reinforce HCT strategies.
- Make information and resources readily available and visible to keep practice staff members and youth, young adults, and parents/caregivers engaged in transition work.
- Publicly display information (e.g., in the waiting room) and share resources to raise awareness of the importance of HCT to youth, young adults, and parents/caregivers.
- Find a bright spot – a youth who has made the transition and can help inform what worked and what were barriers.

Step 5: Implement the Six Core Elements of HCT

Start by reviewing each of the Six Core Elements in light of what your assessment reveals and your decision about what areas to prioritize. Be sure the tools for each of the Six Core Elements go through a QI process, such as a plan/do/study/act (PDSA) cycle (see *QI Primer* for more detail), to ensure the staff, youth, and parents/caregivers have a chance to review, "try out," make changes, and approve. Decide how to incorporate tools into clinic work flow and test in a similar PDSA cycle process so that if the clinician champion is not there, the transition process still moves forward.

The Implementation Guide for each of the Six Core Elements is organized into the following sections:

I. Purpose, Objectives, and Considerations
II. Quality Improvement Considerations, Tools, and Measurement
III. Sample Tools
IV. Additional Resources

Implementation guides for each of the Six Core Elements can be accessed here.

In addition, the QI Primer contains additional examples and materials. It further outlines how to use improvement science to improve your transition process.

The QI Primer has the following sections:

I. What is Quality Improvement?
II. Selecting Improvement Projects
III. Successful Teams
IV. The Model for Improvement
V. Measuring for Improvement
VI. Tools for Improvement
VII. Sustaining Improvement
VIII. Spreading Improvement
IX. Health Literacy
X. Co-Production
XI. Resources and References
Appendix

Step 6: Plan for Sustainability

Once your data shows that you have reached the goal you set for six months you should think about sustaining your work. If not, it is common for processes to erode and in one or two years find yourself starting over.

There are five key strategies to support sustainability:

1. Assign a process lead. This person can be someone on the original team or another member in the practice. They are responsible for calling team meetings when needed, monitoring the data for any slippage, and planning any new tests that may need to be completed.
2. Hardwire the process into the practice. Make sure people are trained and know what to do and ensure training for new staff. Crosstrain critical steps of your process so success does not depend on one person. Encourage people to build generic tools that can be used across divisions.
3. Continue to measure but less frequently, eventually only twice a year.
4. Update your leadership periodically to keep the work visible. Finally, use the sustainability checklist found in the QI Primer.
5. Consider the financial aspects of transition in creating your sustainability plan, e.g. better coding, the financial model used at your site (fee-for-service, accountable care, or value-based payment, etc.).

Step 7: Plan for Spread

Depending on how you implemented the core elements, you may need to plan for spread. Do you need to spread to other physicians, other practices, other specialties, or throughout a health care system? Create a plan for spread. Who is the target for the spread? Identify your opinion leaders, messengers, and allies. Is there both senior leadership and front line leadership for spread? Is improvement methodology understood by the target areas? Allow testing of any generic tools you've created and allow further adapting to the spread practices. You can spread one element at a time, or all six simultaneously. Identify a spread champion who can help the other providers and/or practices throughout the process. If possible, target your early adopter providers or practices first. Find your opinion leaders or influencers to help. Engage both front line leadership and formal leadership for resources. Identify what measures are needed to demonstrate successful spread. They may be the original measures, and/or any additional measures (see *here* for more information). Use the spread checklist found in the QI Primer.

Step 8: Communicate Successes

There is a saying in improvement work: communicate five ways five times. Communication is critical in all aspects of the work. During testing, raise awareness so other practice members and patients are aware of the work. Use your run charts in breakrooms, on posters, etc. Honor those who are doing the front-line work. During implementation, communicate the wins and the progress within the practice. During sustaining, communicate the data, any new modifications, and continued wins. And finally during spread, communicate the timing, the

plan, the deliverables, and the specific changes to be spread. Find ways to communicate your success: post run charts, send newsletters to youth/young adults and parents/caregivers, apply to institutional quality events, consider publishing or presenting at regional or national programs, etc. If you have access, include public relations and marketing departments. Consider working with your state Title V program to communicate and disseminate your successes.

Step 9: Tips for Success

- Make sure there is a champion for transition improvement in the practice.
- Select which of the Six Core Elements to use based on your practice's needs and capacities.
- Do not try to do too much too quickly. Practices that try to implement too many changes at once risk doing none of them well. Do not lose sight of the fact that your long-term goal is to redesign your systems to improve patient care, which takes longer than making incremental changes.
- Develop a registry so the team can keep track of the activities being offered to which youth/young adults.
- Connect with other transition improvement efforts regionally and/or nationally to learn and share best practices.
- Do not forget to measure and track progress for each core element. This step is critical to help you implement successful transition changes in your practice.
- Linking implementation activities for two or more of the Six Core Elements can foster efficiencies and bring about added clarity and connectedness for your practice staff.
- Choose Core Elements that can build on or complement other QI and/or practice transformation efforts, such as Patient-Centered Medical Home certification. Connecting these efforts can help staff to see transition work as a logical extension to existing efforts.
- Communicate progress regularly. Ways to do this include updates at staff and team meetings, posters in the waiting room explaining the project, participation in a learning collaborative, or direct reporting to a practice improvement committee. These activities can help build and support for this work.
- Plan a process that starts early (ages 12-14), but also plan a fast track process for "20-21 year olds" still in the pediatric system who need to transfer within the next year.
- It is important to have early wins to test the process. Consider not beginning with youth/young adults with complex conditions as the initial pilot population as they often require multiple transfers.

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[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):e20182587.

[2] Schmidt A, Ilango SM, McManus MA, Rogers KK, White PH. Outcomes of pediatric to adult health care transition interventions: An updated systematic review. *Journal of Pediatric Nursing*. 2020;51:92-107.

[3] McManus M, White P, Schmidt A, Kanter D, Salus T. *2020 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care.* Washington, DC: Got Transition and American Academy of Pediatrics, March 2020.

Integrating Young Adults into Adult Health Care

Core Element 1 - Transition and Care Policy/Guide

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 young adults at their first visit and be publicly posted. Developed by your practice or health system, with input from young adults, the policy provides consensus among the practice staff, mutual understanding of the welcoming process involved, and a 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 young adults that describes the practice's approach to transition, accepting and partnering with new young adult patients, and an adult approach to care in terms of privacy and consent.

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

Display transition and care policy/guide somewhere accessible in practice space, discuss and share with young adult at first visit, 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.

- *What will your practice offer young adults to assist them in learning how to manage their health and health care—e.g., a self-care skills assessment, developing or updating a plan of care that includes transition goals and action steps, an updated medical summary and emergency care plan, and referrals to adult subspecialists as needed?*
- *What will your practice do to discuss/remind young adults about the 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 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.*

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 welcoming young adults into the practice, including privacy and consent information?*
- *Is the reading level appropriate for your young adults?*
- *Test the policy/guide with 1-3 young adults 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 young adult?*
- *Whose job is it to ask if the young adult has any questions?*
- *How do we inform all staff about the practice's approach to welcoming new young adults into your practice?*
- *How do we inform all staff about the practice's expectations for new young adult patients, and pediatric and adult health care teams during the transition process?*
- *How do we discuss with all staff the different ways the practice is taking cultural preferences of their new young adult patients into account throughout the transition process?*
- *How often will your practice share the policy/guide during the transition planning 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 new young adults who are joining the practice.
2. Have the front desk hand out the transition and care policy/guide when all young adults check in for their appointment, or when they are waiting in the exam room at their annual preventive visit.
3. Display the transition and care 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 welcoming new young adults into the practice during a lunch and learn or during a staff meeting.

II. Quality Improvement Considerations, Tools, and Measurement

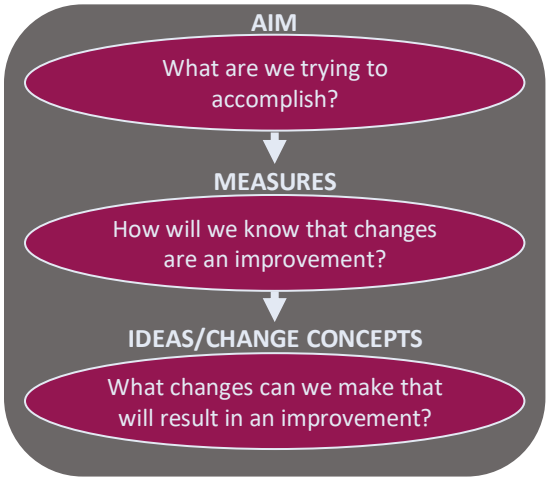
Quality Improvement Considerations

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 young adult 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

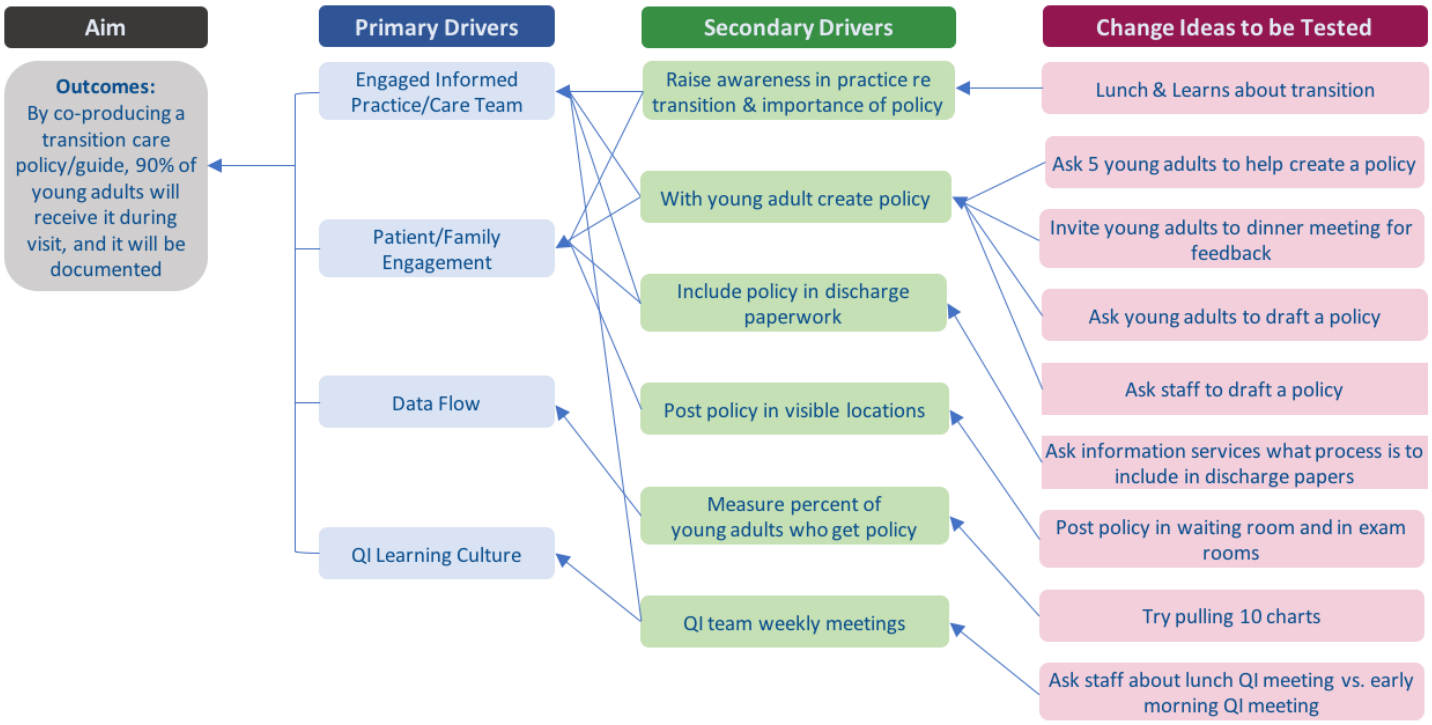
We aim to inform our new young adult patients about the practice's welcoming approach by ensuring they receive our current transition and care policy/guide. By [insert date], 85% of new young adult patients will be given the transition and care policy/guide and have this documented in their medical record.

Example Aim Statement 2

Having young adults feel welcome is important to our practice. By [insert date], we will co-produce (with young adults) a transition and care policy/guide, and 90% of 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*.



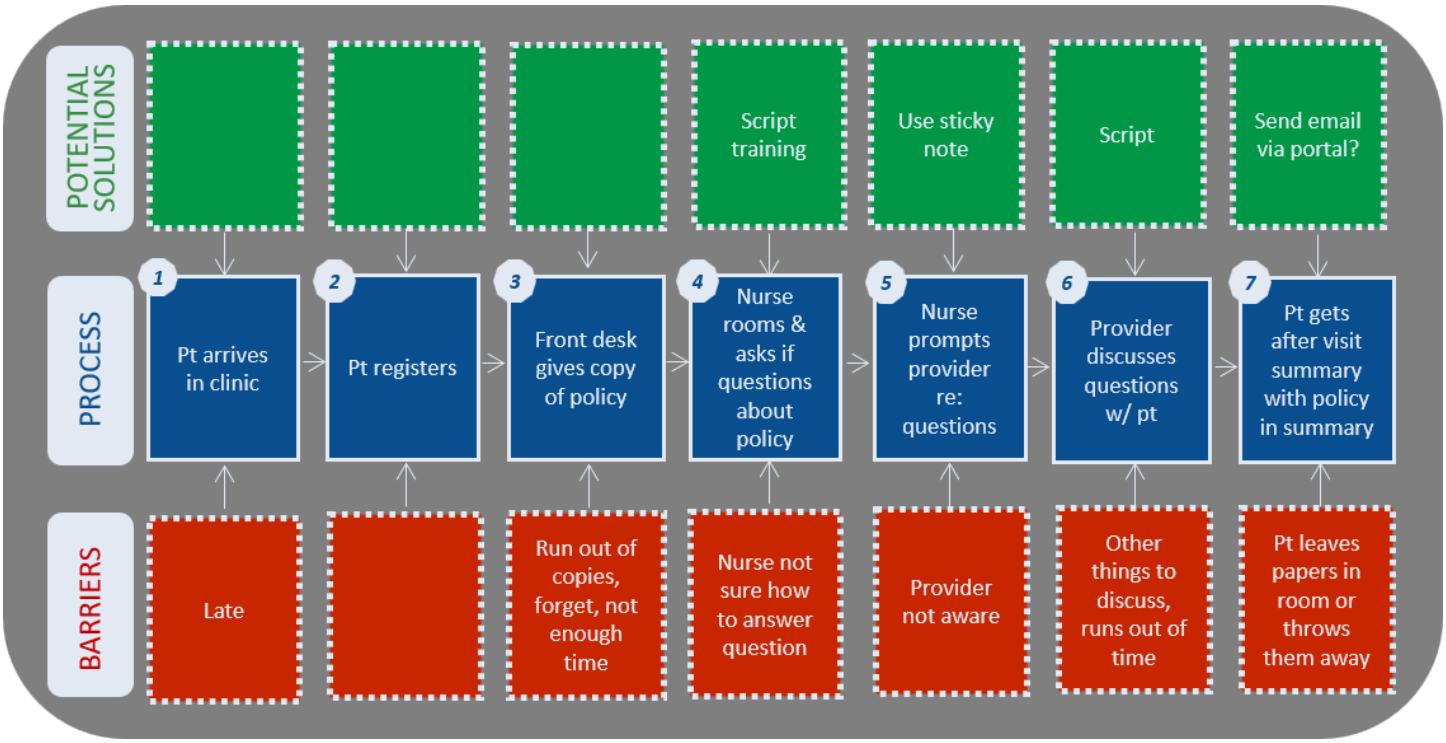
Adapted from ST3P UP, a collaborative sponsored by Patient Centered Outcomes Research Institute® (PCORI) Award MCSC-1608-35861 Titled A Comparative Effectiveness of Peer Mentoring Versus Structured Education Based Transition Programming For The Management Of Care Transitions In Emerging Adults With Sickle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

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.

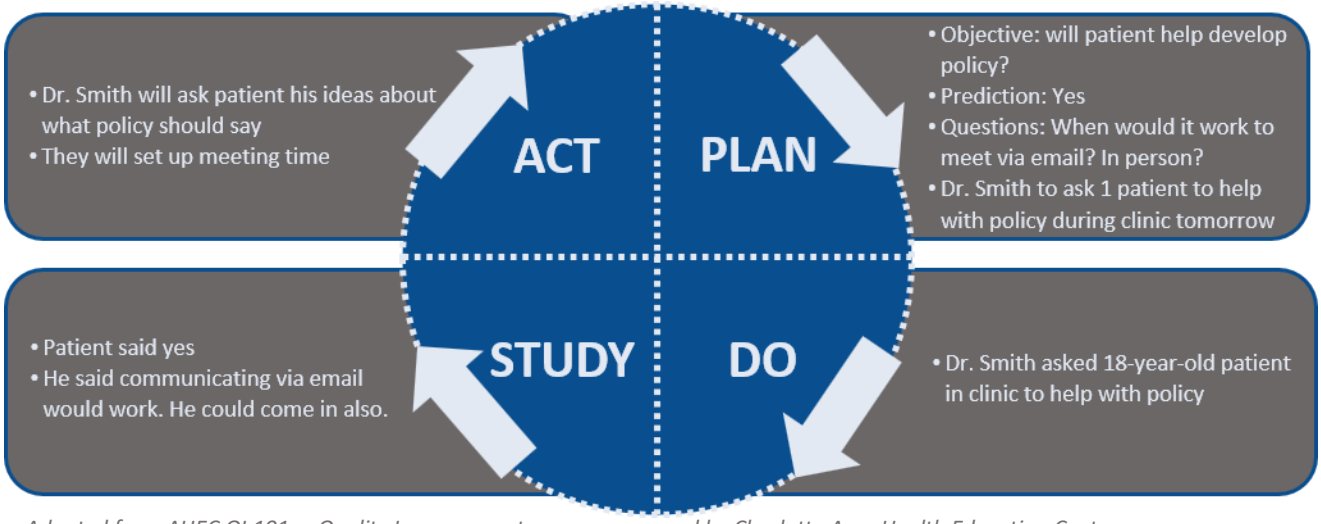
Tool 5: PDSA Cycles

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 young adults
- 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

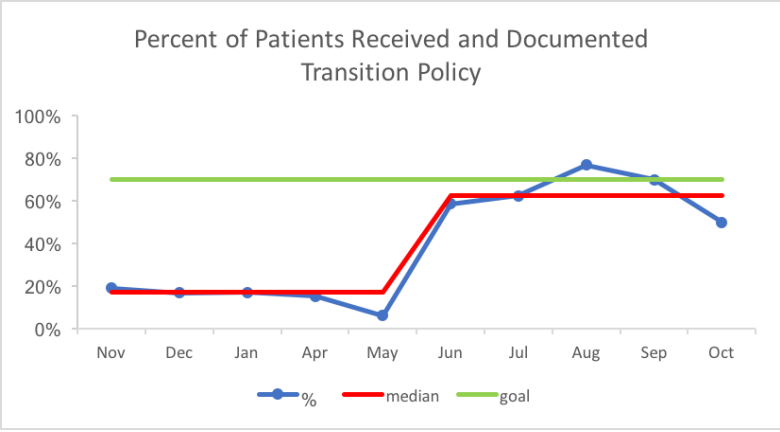
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of 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 young adults received it.
- ☐ For one week, track how many were found in the trash or left behind in the room.
- ☐ Track how many 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 young adults and their families.

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

- Sample policy from Got Transition's "Integrating Young Adults into Adult Health Care" *(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 Young Adult Transition and Care Policy from Montefiore Health Centers Sickle Cell Center for Adults *(click here)*

IV. Additional Resources

- Turning 18: What It Means for Your Health (*click here*)
- Setting up the “Medical ID” Feature on Apple's Health App and on Android Phones (*click here*)

Integrating Young Adults into Adult Health Care

Core Element 2 - Tracking and Monitoring

I. Purpose, Objectives, and Considerations

Purpose

Tracking and monitoring receipt of the Six Core Elements of Health Care Transition™ (HCT) is the second element in the Six Core Elements. An individual flow sheet within the electronic medical record (EMR) can be used to track when individual transition-aged young adults receive each core element. Information from the individual flow sheet can be used to populate a registry and help monitor the extent to which transition-aged young adults in the practice/system are receiving recommended HCT services. *See sample transition tracking and monitoring tools in Section III.*

Objectives

Establish criteria for identifying transitioning young adults.

Develop process to track receipt of the Six Core Elements, integrating with electronic medical records (EMR) when possible.

Considerations

CONTENT

What information might be included in tracking and monitoring?

Below are some questions and ideas to think about.

- *Demographic and diagnostic information (e.g., name, date of birth, age, diagnosis).*
- *Medical (e.g., disease complexity including utilization) and social complexity information (e.g., social determinants of health/adverse childhood experiences) information. This information will be helpful to risk stratify your transition-aged population.*[1-3]
- *Date of receipt of each core element, including:*
  - *When the transition and care policy/guide was shared with young adult*
  - *When the self-care skills assessment was administered*
  - *When the self-care skills education was provided*
  - *When the HCT plan of care was shared with young adult*
  - *When the medical summary and emergency care plan were shared with young adult*
  - *When the age 18 privacy and consent changes were discussed*
  - *When supported decision-making (if needed) was discussed*
  - *When the adult clinician subspecialists were identified (if needed)*
  - *When the transfer package was received*
  - *When communication with the referring clinician occurred*
  - *When the first adult appointment was attended*
  - *When feedback was elicited from young adult about the HCT supports received*

PROCESS

What is the process to implement tracking and monitoring?

Below are some questions and ideas to think about.

- *Develop criteria for what young adults will be a part of this transition registry. Will it include all transition-aged young adults or will it include young adults with selected chronic conditions? (See references below.)*
- *Decide at what age the registry will begin to track the young adult's receipt of HCT services.*
- *Decide what patient data should be tracked. Will a complexity score or level be used? If so, will it include a combination of medical and social complexity scores?*
- *Choose the format. Will it be an individual flow sheet or a registry via your EMR, REDCap, or an Excel spreadsheet? (See examples in Section III. Due to the variety and proprietary nature of EMRs, none can be provided as an example.)*
- *Work with your practice/system to decide who will input the data and how progress will be monitored. Will the team or the individual clinician be monitoring if all HCT services were offered? If not, who will be responsible for ensuring all services are provided?*
- *Create a written document to describe the clinic approach to implement the process outlined above.*
- *Educate all team members/staff about the process.*

1. Simon TD, Haaland W, Hawley K, Lambda K, Mangione-Smith R. Development and validation of the Pediatric Medical Complexity Algorithm (PMCA) Version 3.0. *Academic Pediatrics.* 2018;18(5):577-580.
2. Schrager SM, Arthur KC, Nelson J, Edwards AR, Murphy JM, Mangione-Smith R, Chen AY. Development and validation of a method to identify children with social complexity risk factors. *Pediatrics.* 2016;138(3):e20153787.
3. Oregon Health Authority. Health Complexity in Children – Statewide Summary Report. 2018. Available at https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Statewide-Summary-pub-2019-March.pdf.

II. Quality Improvement Considerations, Tools, and Measurement

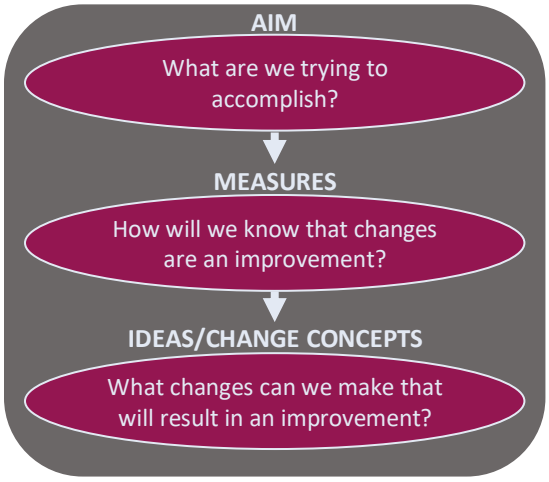
Quality Improvement Considerations

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 young adult 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

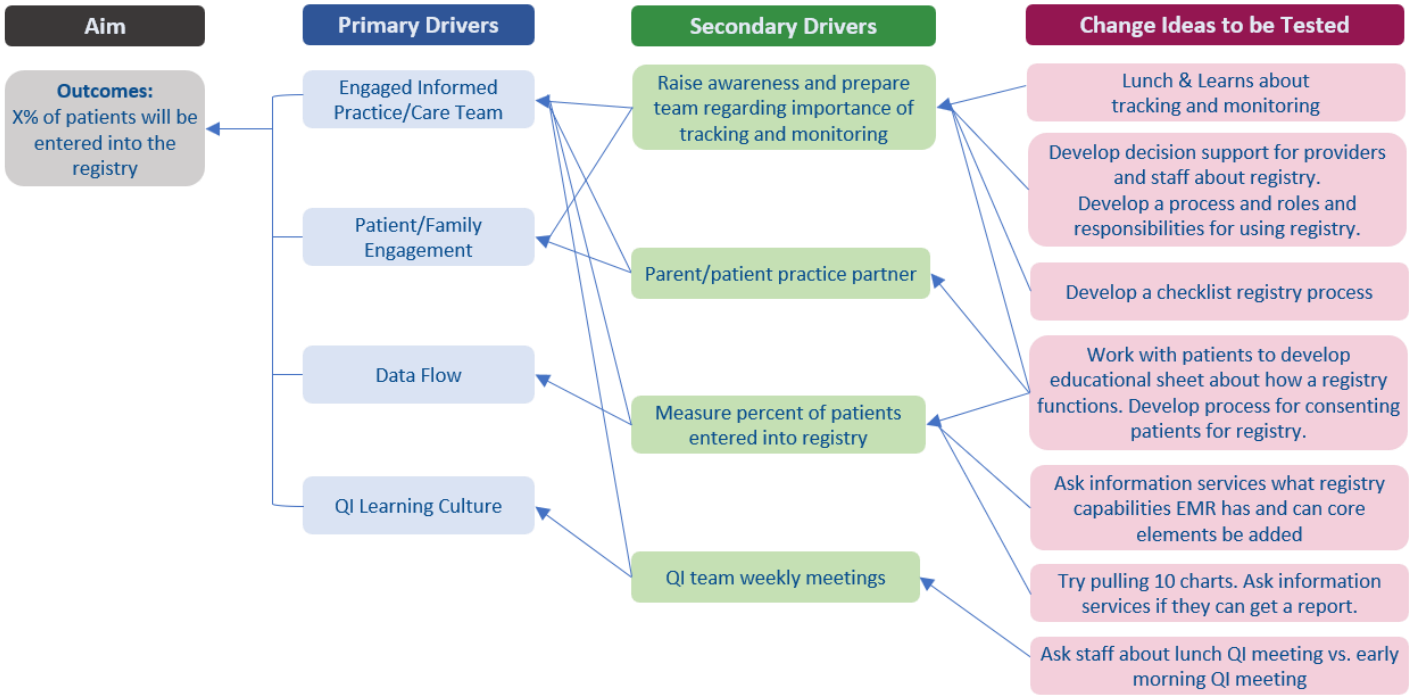
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

We aim to improve care by implementing a tracking and monitoring database. By [insert date], 80% of patients with sickle cell disease will be in the database.

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*.

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.

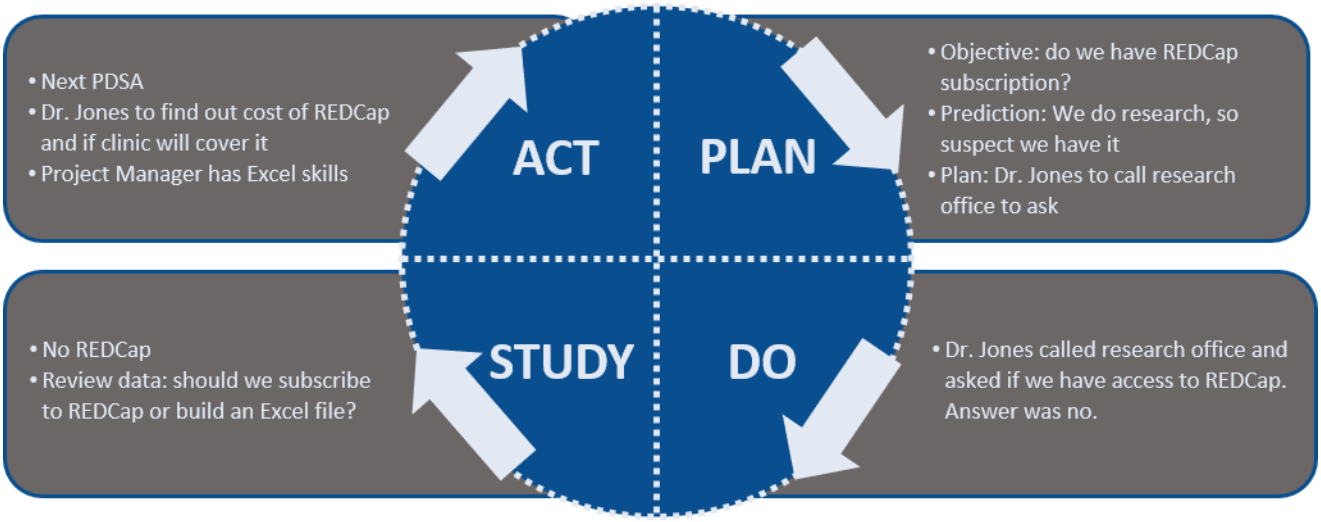
Tool 5: PDSA Cycles

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

- Using Excel vs. REDCap
- Creating a mock database and testing, are there any components missing?



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

Quality Improvement Measurement

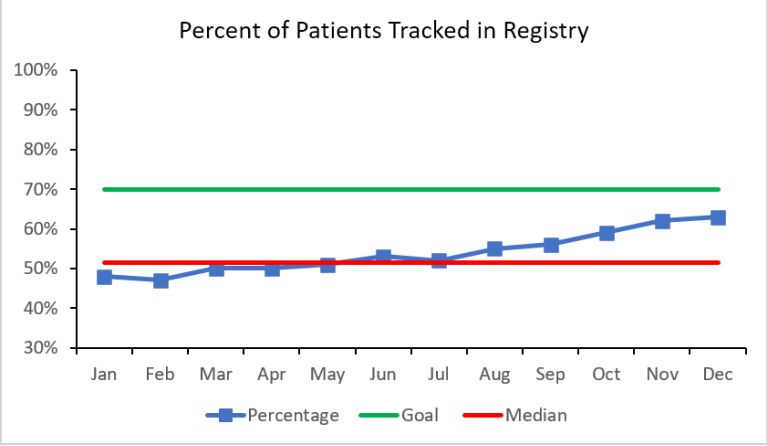
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of 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

- ☐ Track how long it takes to enter the data per patient.
- ☐ Track the number of patients entered for 1 week.
- ☐ Generate reports.
- ☐ Track how the report is used.
- ☐ Once the process is refined, weekly or daily track the percent of patients seen who are entered into the database.
- ☐ Note what is achieved from the reports.

	Mon	Tues	Wed	Thurs	Fri
# pts put in database	||||	||	||||	|	|

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 Tracking and Monitoring Tools

Sample Registry Tool from the Six Core Elements of HCT™

- Sample Excel spreadsheet from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*

Sample Transition Flow Sheet from the Six Core Elements of HCT™

- Sample transition flow sheet from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*

Sample REDCap Tracking and Monitoring System

- *Click here* for information about how to access a customizable REDCap example for a tracking and monitoring system.

Integrating Young Adults into Adult Health Care
Core Element 3 – Orientation to Adult Practice

I. Purpose, Objectives, and Considerations

Purpose

Orientation to adult practice is the third element in the Six Core Elements of Health Care Transition™ (HCT). The adult practice can begin by identifying clinicians in the practice interested in taking care of new young adults. Young adults are relatively new health care consumers, so it is important to offer an orientation to the adult practice and provide young adult-friendly welcome materials that describe confidentiality, services offered, and the logistics of obtaining care. *See sample welcome and orientation tools in Section III.*

Objectives

Identify and list adult clinicians 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 young adult-friendly online or written Frequently Asked Questions about the practice.

Considerations

CONTENT

What should be included in a welcome letter for new young adults joining your practice?

Below are some questions and ideas to think about.

- *Does the information describe the practice's approach to welcoming and orienting young adults to the practice?*
- *What information should be included about your practice?*
  - *What can a young adult expect from the practice (e.g., confidential care), and what does the practice expect from the young adult (e.g., arriving to appointments on time)?*
  - *What should be included in a set of Frequently Asked Questions about your practice and available services (e.g., how do I reach my doctor when I have an urgent problem)? See sample welcome and orientation sheet in Section III.*

PROCESS

What is the process to decide and share with young adults which clinicians are interested in caring for young adults?

Below are some questions and ideas to think about.

- *Will clinicians be explicitly asked/surveyed/invited to care for young adults?*
- *Once it is decided which clinicians in the practice are interested in caring for young adults, consider sharing the names of these clinicians with front desk staff for scheduling and also with partnering pediatric practices.*
- *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 develop welcome and orientation information and Frequently Asked Questions about your practice?

Below are some questions and ideas to think about.

- *Is the reading level appropriate for young adults coming to your practice?*
- *Will this information be translated into the common languages in your practice?*
- *Test the welcome and orientation information and Frequently Asked Questions with 1-3 young adults and consider asking:*
  - *Are there any words you do not understand?*
  - *Does this information make you feel welcome in the practice?*
  - *Did it answer your questions about the practice? Are there additional questions that you would like to be included?*
  - *How could the information be clearer?*
  - *When would be the best time to share the welcome and orientation information and Frequently Asked Questions with young adults? Before, during, or after the initial visit?*
- *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 a welcome and orientation process for young adults, which is an integral part of the practice workflow?

Below are some questions and ideas to think about.

- *When will the welcome and orientation information and Frequently Asked Questions be shared with the young adult? Will it be sent via the portal before the visit? If it is written information, will it be sent in the mail before the visit or given during the visit? Will it be included in the after-visit summary?*
- *Who in the practice is responsible for sharing the welcome and orientation information and Frequently Asked Questions with the young adult?*
- *Consider sharing the welcome and orientation information with local pediatric practices to give to their transitioning young adults and parents/caregivers.*
- *Create a written document to describe the clinic approach to implement the processes outlined above.*
- *Educate all team members/staff about the process.*

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 young adult 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

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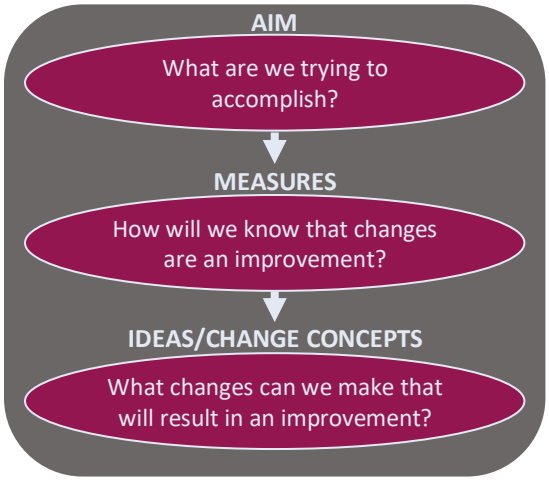

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Tool 1: Aim Statement

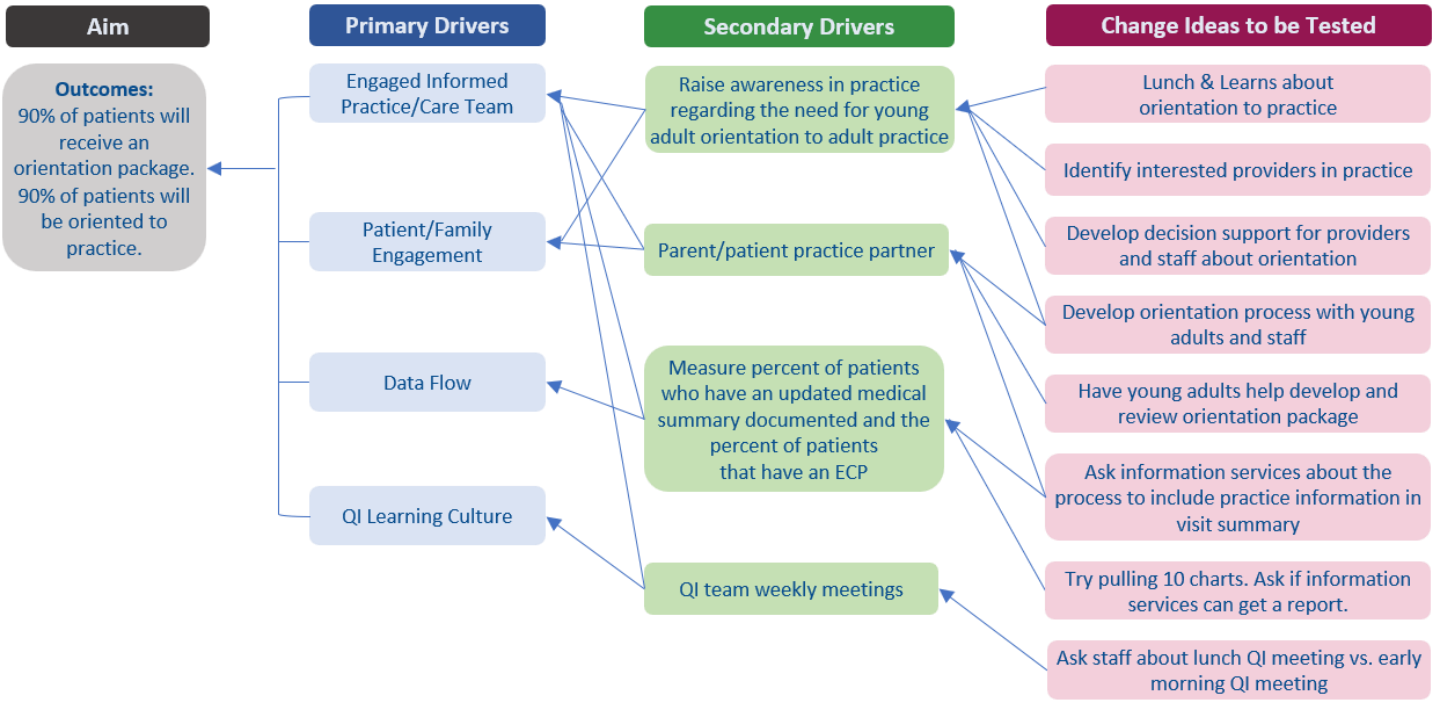
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

We aim to improve care for young adult patients who transition into our practice. We will accomplish this through a patient-centered orientation process. By [insert date], 90% of patients will feel welcomed and oriented to our practice.

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*.



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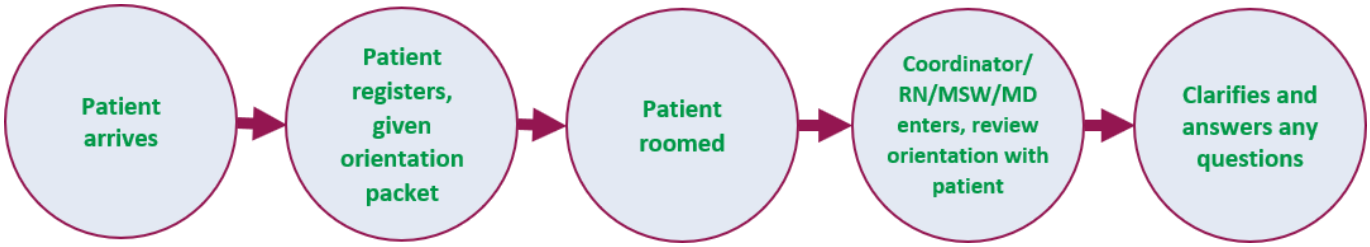
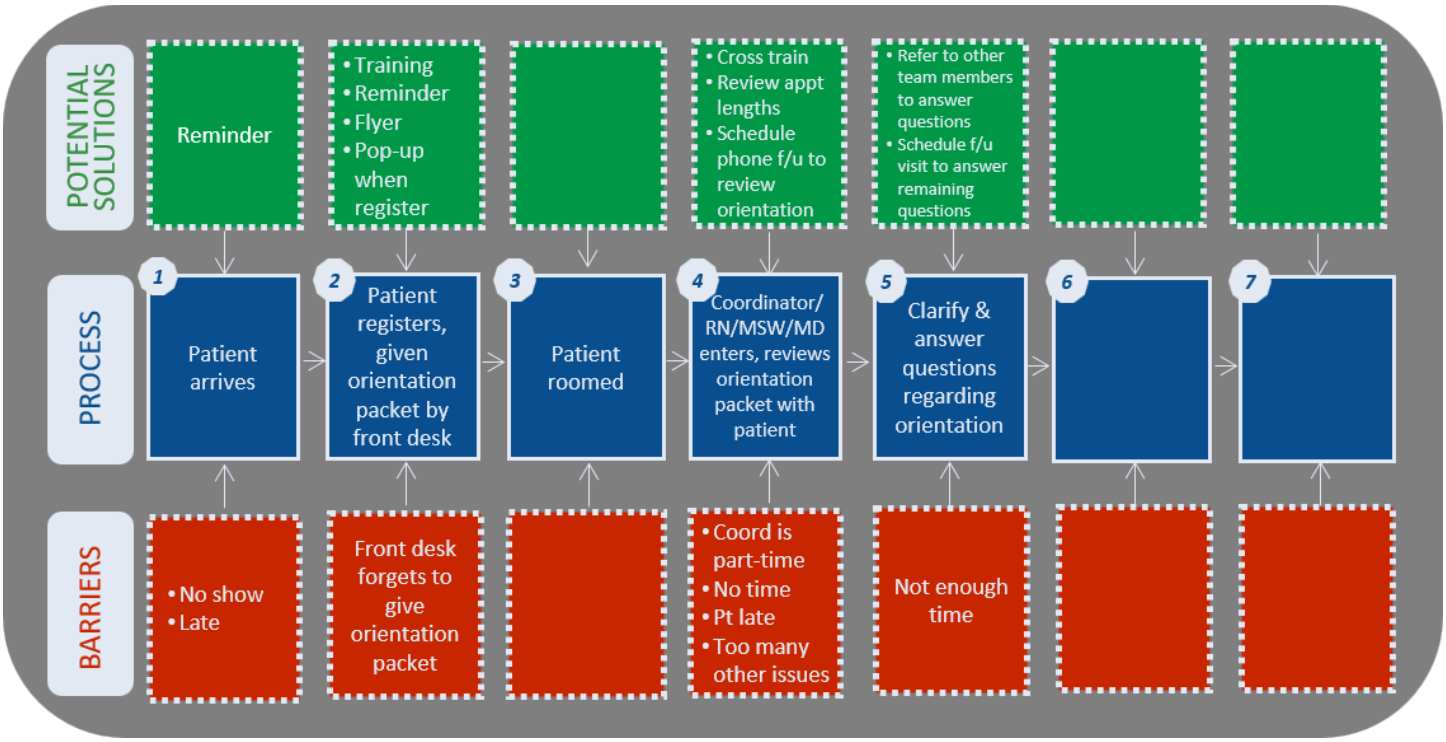
Tool 3: Process Flow Map

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*.



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*.



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Tool 5: PDSA Cycles

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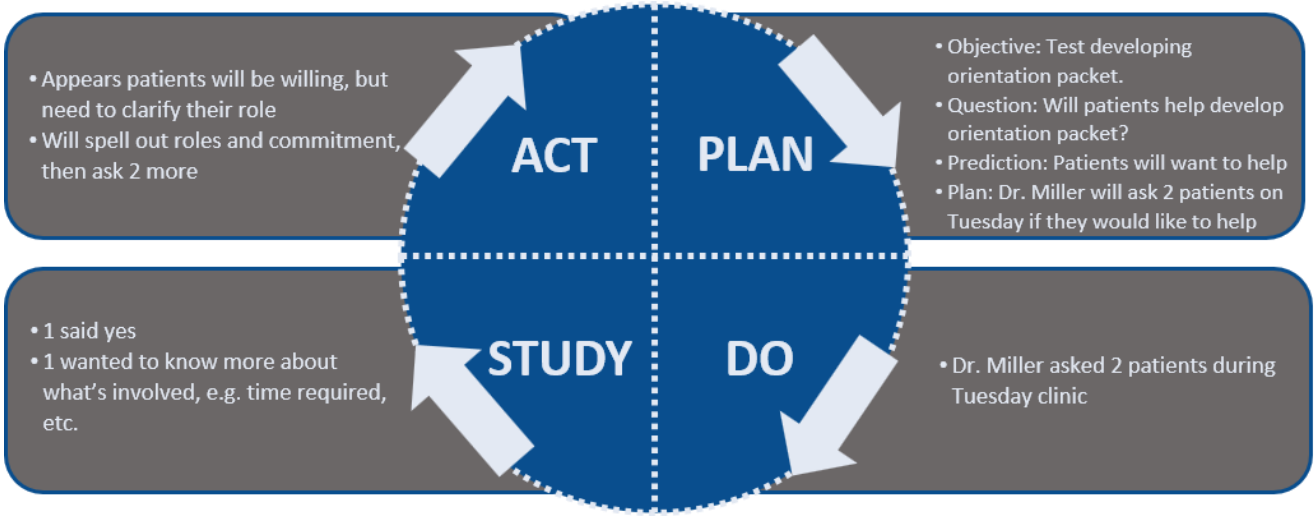
- **Plan** the test: who, what, where, when;
- **Do** try the change and observe what happens;
- **Study** reflect on what was learned from the test; and
- **Act** decide next steps based on the reflection.

Examples of Ideas to Test

- Ask 2 patients to help with the process
- Flow map the ideal process
- Create a list of adult clinicians interested in participating
- Give patients a brief survey asking if they feel welcomed and oriented



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Quality Improvement Measurement

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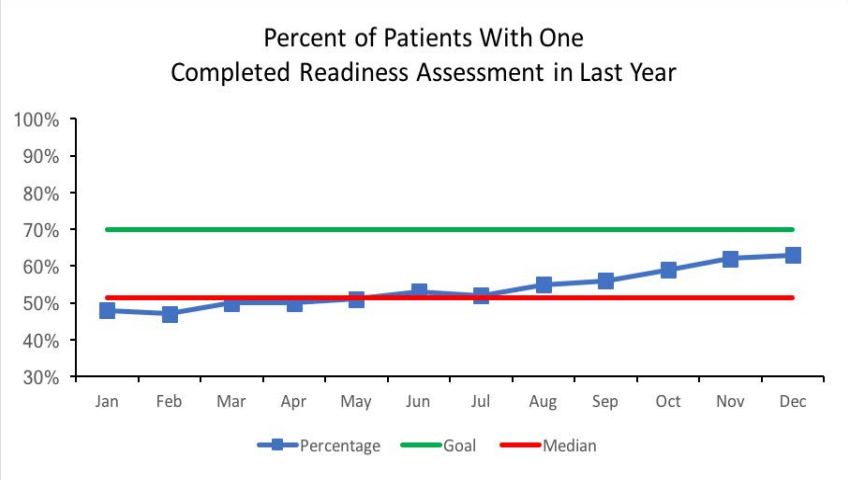
Example Data Collection Check Sheet

- ☐ Assess the need for clarification of orientation packet.
  - Track for 1 week the number of patients who have questions about the packet.
  - Track the areas of orientation package with greatest number of questions.
- ☐ Track the number of patients who are given the packet.
- ☐ Track the percent of patients who felt welcomed and oriented.

	Mon	Tues	Wed	Thurs	Fri
# pts with questions	||	||||	|||	||	||
# pts given packet		|||	||	|	

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 Welcome and Orientation Tools

Sample Welcome and Orientation Tool from the Six Core Elements of HCT™

- Sample welcome and orientation information sheet from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*

Sample Welcome and Orientation Tool for Young Adults with Specific Conditions

- Sample welcome and orientation information materials from Montefiore Sickle Cell Center for Adults *(click here)*
- Sample welcome and orientation transition packet from Atrium Health Sickle Cell Disease Program *(click here)*

IV. Additional Resources

- Turning 18: What It Means for Your Health (*click here*)
- Setting up the “Medical ID” Feature on Apple's Health App and on Android Phones (*click here*)
- System Differences Between Pediatric and Adult Health Care *(click here)*

Integrating Young Adults into Adult Health Care

Core Element 4 – Integration Into Adult Practice

I. Purpose, Objectives, and Considerations

Purpose

Integration into adult practice is the fourth element in the Six Core Elements of Health Care Transition™ (HCT). This includes planning with the pediatric clinician for the young adult's transfer and ensuring receipt of current medical information. Adult practices should receive the young adult's transfer package from the pediatric practice and communicate with the pediatric provider about their residual responsibility for care until the first visit to the adult provider is completed. The adult practice should make a pre-visit contact (call, email, text) to welcome the new young adult, remind them of their upcoming appointment, and identify any special needs or preferences. *See sample integration into adult practice tools in Section III.*

Objectives

Communicate with young adult's pediatric clinician(s) and arrange for consultation assistance, if needed.

Prior to first visit, ensure receipt of transfer package, including final transition readiness assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional clinical records.

Make pre-visit appointment reminder welcoming new young adult and identifying any special needs and preferences.

Considerations

CONTENT

What information does the adult practice want to be shared during the transfer of care?

Below are some questions and ideas to think about.

- *Will your practice communicate with the pediatric practice to ask whether the pediatric practice has communicated with young adults about the differences between pediatric and adult care? (See Got Transition's System Differences Between Pediatric and Adult Health Care, Planning to Move from Pediatric to Adult Care? Here's How They Can Differ, and Turning 18: What It Means for Your Health in Section IV.)*
- *What information about your practice do you want the pediatric practice to give to the transitioning young adult? (See Section III in the implementation guide for Core Element 3 for sample welcome and orientation information.)*
- *Create a checklist of items your practice would like the pediatric practice to include in the transfer package.*
- *Note: A recommended HCT transfer package includes all of these documents: a referral letter, the most recent transition readiness assessment, updated plan of care with transition goals and prioritized actions, medical summary and emergency care plan (ECP), and, if needed, legal documents for supported decision-making, condition fact sheet, and additional clinical records.*

What information could the adult practice ask the young adult before the first visit?

Below are some questions and ideas to think about.

- *Create a list of questions the office staff could ask the young adult. For example, do they have any special needs or preferences for the visit? Do they need directions to the office?*
- *If the young adult does not show up for the initial visit, what process is in place to follow up with them to reschedule? If there are two or more no shows, will the adult practice follow up with the pediatric practice to elicit their assistance in re-connecting the young adult to adult care?*

PROCESS

What is the process of asking for consultation from the pediatric clinician?

Below are some questions and ideas to think about.

- *Does the pediatric practice offer consultation in the transfer letter or on a call to the adult clinician's office during the transfer process? If not, and consultation would be helpful, what is the adult practice's process to obtain consultation?*
- *What is the extent of consultation support that can be made available by the pediatric practice?*
- *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 receiving the transfer package before the young adult's first visit at the adult practice?

Below are some questions and ideas to think about.

- *Once an appointment is made, who follows up with the pediatric practice to obtain the transfer package if it has not been received?*
- *Who checks that the pediatric practice communicated to the young adult about the role of the pediatric practice in the care of the young adult between the last pediatric and first adult clinician visit?*
- *How does the adult practice standardize the type of communication needed with the pediatric practice for the different levels of medical and social complexity of the new young adult (e.g., When is a call or a letter or an email needed?)? If communicating directly with the referring clinician(s), consider team meetings or the use of telemedicine, including FaceTime and ECHO.*
- *Who in the practice checks with the referring pediatric practice if there are immediate needs that should be addressed in the first visit with the young adult, if it is not described in the referral letter?*
- *Who is responsible for making a pre-visit call to the young adult (following any pre-visit questions asked by office staff)?*
- *Create a written document to describe the clinic approach to implement the processes outlined above.*
- *Educate all team members/staff about the process.*

II. Quality Improvement Considerations, Tools, and Measurement

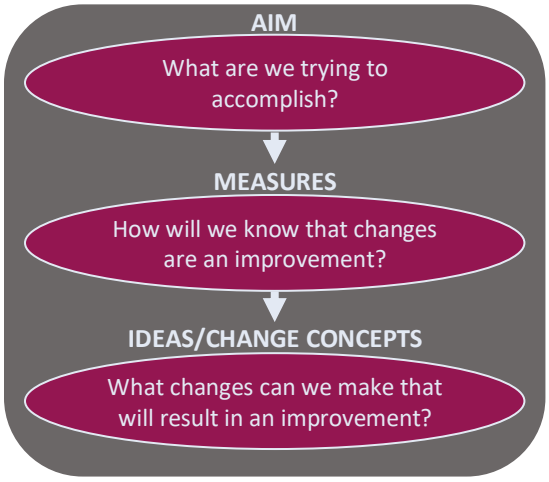
Quality Improvement Considerations

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 young adult 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.



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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

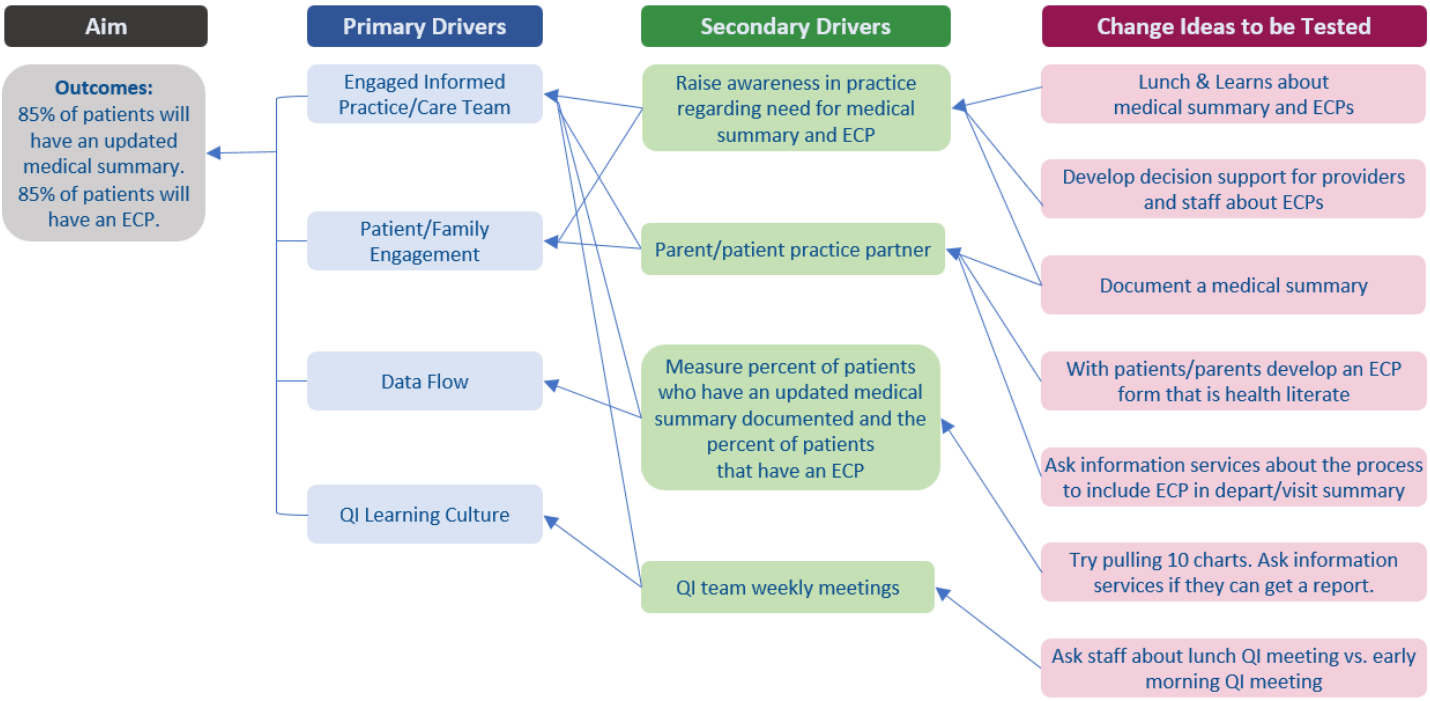
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

Making the transition to an adult practice is difficult for patients and families. Ensuring receipt of transfer materials is key to integrating young adults into our practice. By [insert date] we will create a patient-centered integration process and 90% of patients' transfer packets will be received prior to the first visit.

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*.



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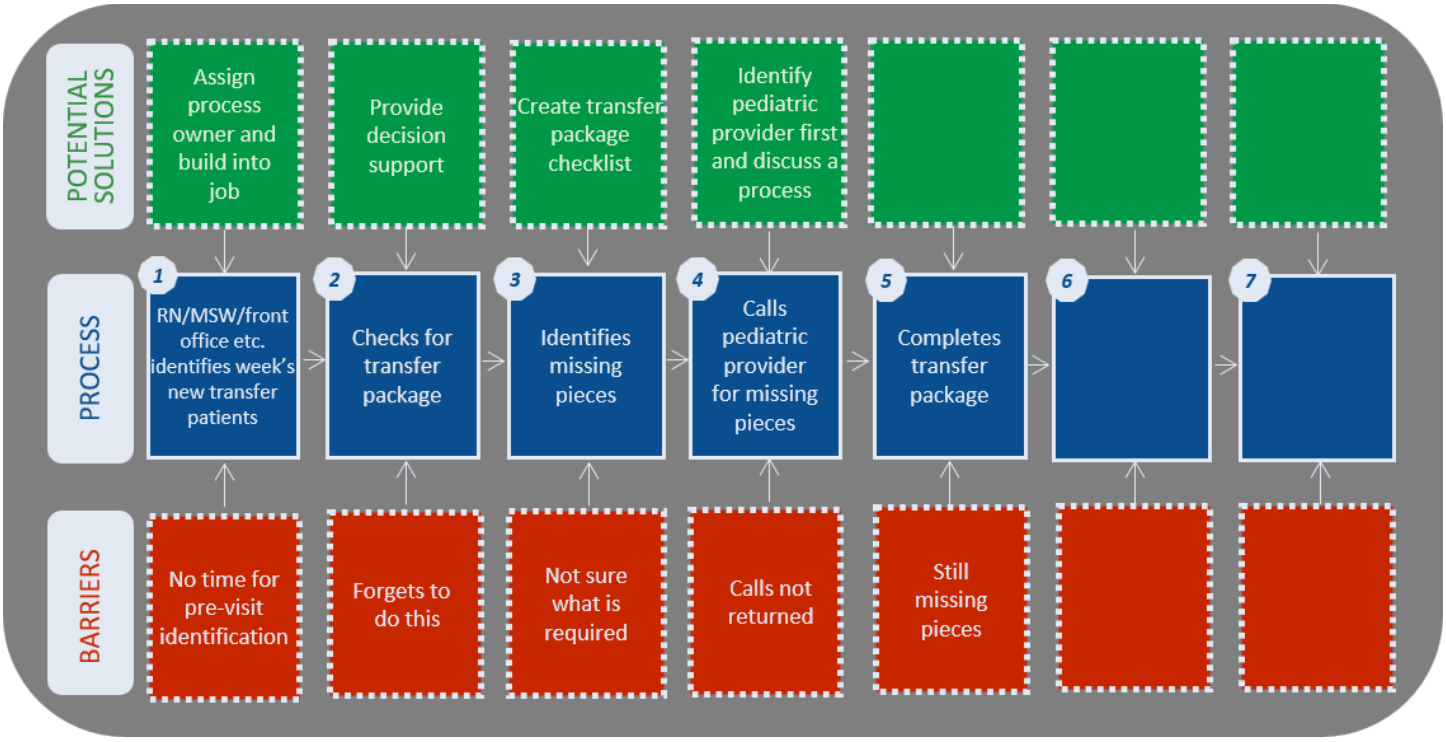
Tool 3: Process Flow Map

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*.

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*.



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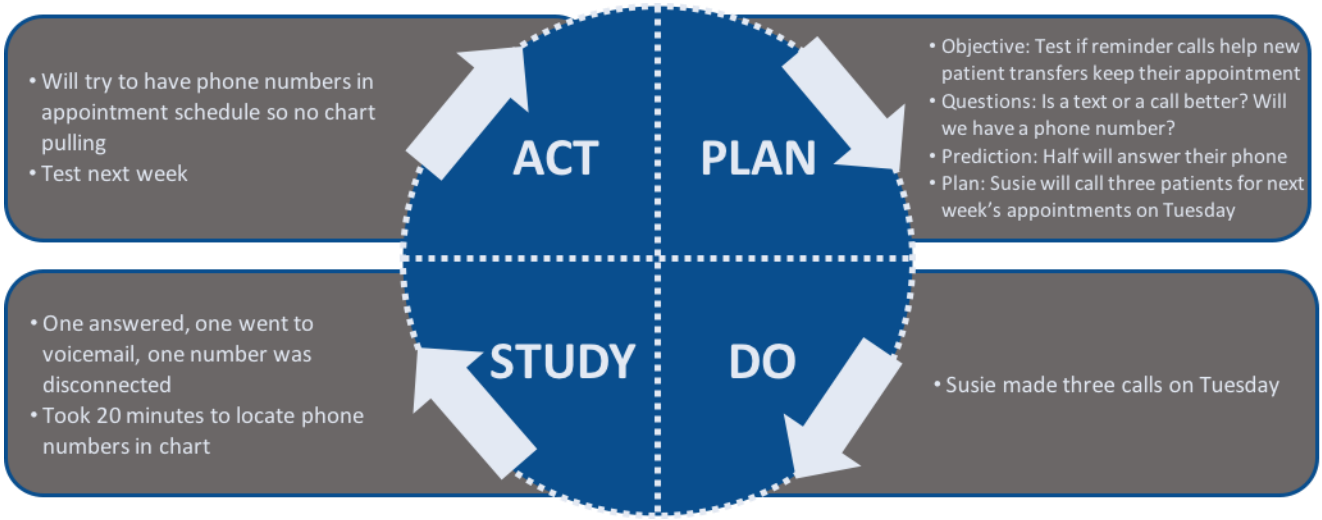
Tool 5: PDSA Cycles

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 detailed explanation and a blank form, 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

- Reminder calls
- Transfer package checklist
- Process to communicate with pediatric provider



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Quality Improvement Measurement

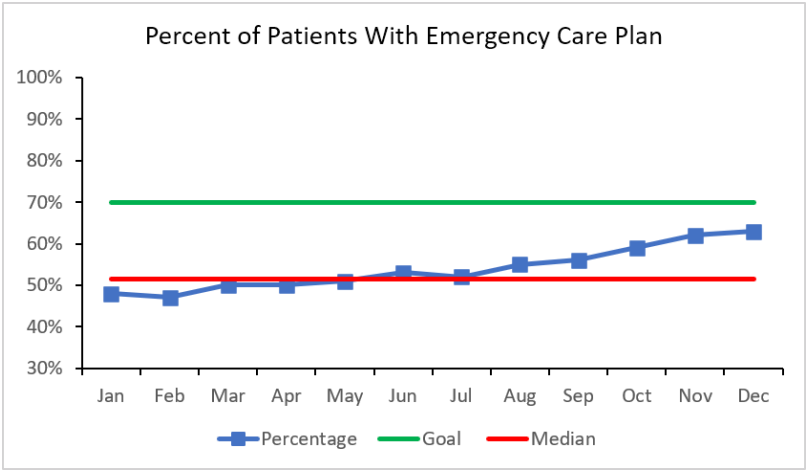
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of 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

- ☐ Track number of complete packets received for 2 weeks.
- ☐ Track how many reminder calls were successful for 2 weeks.
- ☐ Track amount of time spent on calls for 2 weeks.

	Mon	Tues	Wed	Thurs	Fri
# completed packets	||	||||	|||	|	||
# successful reminder calls		|||	|		|

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 Integration Into Adult Practice Tools

Sample Integration Into Adult Practice Tools from the Six Core Elements of HCT™

- Sample plan of care from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*
- Sample medical summary and emergency care plan from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*

IV. Additional Resources

- Turning 18: What It Means for Your Health (*click here*)
- Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones (*click here*)
- System Differences Between Pediatric and Adult Health Care *(click here)*
- Planning to Move from Pediatric to Adult Care? Here's How They Can Differ *(click here)*
- Integrating Young Adults with Autism Spectrum Disorder into Your Practice: Tips for Adult Health Care Clinicians *(click here)*
- Integrating Young Adults with Intellectual and Developmental Disabilities into Your Practice: Tips for Adult Health Care Clinicians *(click here)*

Integrating Young Adults into Adult Health Care

Core Element 5 – Initial Visits

I. Purpose, Objectives, and Considerations

Purpose

Initial visits is the fifth element in the Six Core Elements of Health Care Transition™ (HCT). Following review of the transfer package, the initial appointment should address any concerns that the young adult may have in transferring to a new adult clinician and the distinctions between pediatric and adult care. Specifically, it is important to discuss confidentiality, access to information, and shared decision-making and to learn how to best communicate with the young adult between visits. Over the next few visits, the clinician should work with the young adult to assess and strengthen self-care skills. *See sample initial visit lists and self-care assessments in Section III.*

Objectives

Prepare for initial visit by reviewing transfer package with appropriate team members.

Address any concerns young adult has about transferring to adult care and take into account any cultural preferences.

Clarify an adult approach to care (shared decision-making, privacy and consent, access to information), adherence to care, preferred methods of communication, and health literacy needs.

Conduct self-care skills assessment if not recently completed and discuss their needs for self-care and how to use health care services.

Offer education and resources on needed skills identified through the self-care skills assessment.

Review young adult's health priorities as part of their plan of care.

Update and share with young adult their medical summary and emergency care plan.

Considerations

CONTENT

What information does your practice offer to young adults about an adult approach to care?

Below are some questions and ideas to think about.

- *What should be included in an information sheet or discussion to remind young adults about changes in health care at age 18 and what an adult approach to care means for their involvement in their health and health care (for example, reviewing the changes in privacy and consent)?*
- *What does your practice offer to assist 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 parents/caregivers to remind them that in an adult approach to care they no longer have legal access to their young adult's electronic medical records on the practice's portal, unless there is legal documentation allowing access?*

What information might be considered in assessing self-care skills?

Below are some questions and ideas to think about.

- *Consider the patient population in your practice/system. What HCT skills and knowledge about health care services do they need to learn?*
- *Review existing self-care skills assessments. Decide if you can use an existing self-care skills assessment, if you need to customize one, or if a new self-care skills assessment will need to be developed.*
- *Got Transition's self-care skills assessment contains two motivational interviewing questions. Consider adding them to your selected self-care skills assessment:*
  - *How important is it to you to manage your own health care?*
  - *How confident do you feel about your ability to manage your own health care?*
- *Have the young adult continue to complete the self-care skills assessment several times during the first few years they are in your practice as part of routine preventive or chronic care.*
- *Use the self-care skills assessment both as a discussion tool and to plan for HCT skills-building education.*
- *It is important to note that self-care skills assessments do not predict HCT success.*

PROCESS

What is the process to obtain and review the transfer package from the referring pediatric clinician?

What is the process to welcome a new young adult into your practice/system?

Below are some questions and ideas to think about.

- *Who will explain how an adult approach to care is different than a pediatric approach to care, highlighting the changes in consent and confidentiality?*
- *Will your practice have young adults over age 18 sign a HIPAA form (written at an appropriate reading level) if they wish to allow others to be present in their visit or see their health records?*
- *How will the clinicians in the adult practice decide and agree on the key topics they should discuss with all young adults during their first 1-3 visits (See Got Transition's Sample Content for Initial Visits in Section III.). For example:*
  - *Who will go over the practice information with the young adult and discuss with the young adult the best way the practice can remind them of their upcoming appointment and the importance of staying connected to the practice and care?*
  - *Who will discuss how the young adult can communicate with their clinician/practice about urgent health questions, medication renewals and making and cancelling appointments?*
- *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 self-care skills assessments?

Below are some questions and ideas to think about.

- *If an available self-care skills assessment has been customized or your practice/system has developed its own, check that the reading level is appropriate and do a test with 3-4 young adults in your practice (who will be receiving the self-care skills assessment) of different ages and educational levels to see if they have any difficulty understanding the questions or specific words. If so, make needed changes to the self-care skills assessment and test again.*

Continued on next page

- *Once the self-care skills assessments(s) are ready for use, identify and test the practice's process for conducting it. Below are some questions and ideas to think about.*
  - *Identify eligible young adults needing a self-care skills assessment and decide:*
    - *How often will it be offered? Every year? Every other year?*
    - *Will it be sent to the young adult before the visit via mail, email, or the EMR portal, and will the completed form be brought to the clinic visit?*
    - *Will it be completed in the clinic at the time of the visit? Will it be completed in a paper form? If yes, determine who will incorporate the completed self-care skills assessment into the medical record.*
    - *Who will administer the self-care skills assessment in the clinic? Will it be completed in the waiting room or while waiting for the clinician in the clinic room?*
    - *Who fills out the self-care skills assessment when there is a legal supported decision-making agreement in place?*
  - *Will it be completed via a tablet during the visit, and if so, will the results be incorporated into the EMR? Who will assist the young adult to prioritize needed skills-building education?*
  - *Who will incorporate the needed skills into an HCT plan of care (see below)?*
  - *Who will offer the identified needed education?*
  - *What materials or online resources are available in the practice for education around the needed skills for the young adult?*
  - *Determine how education will be incorporated into follow-up appointments and documented in the medical record.*
- *Create a written document to describe the practice's process that each eligible patient will follow to complete the self-care skills assessment.*
- *Educate all team members/staff about the process.*

What is the process to update and implement a plan of care?

Below are some questions and ideas to think about.

- *Does the practice have a process to create and update a plan of care with HCT goals and prioritized action steps?*
- *As part of the plan of care, how will the young adult's health priorities be elicited and linked with self-care skill needs identified in the self-care assessment?*
- *Who will generate the HCT plan of care goals with the young adult, utilizing the needed skills identified in the self-care skills assessment?*
- *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 update a medical summary and emergency care plan?

Below are some questions and ideas to think about.

- *Who is responsible for updating the medical summary and emergency care plan?*
- *How will the practice share the updated medical summary and emergency care plan with the young adult (i.e., discuss at the visit or send it to the young adult before an annual visit to review during the visit).*
- *Create a written document to describe the clinic approach to implement the process outlined above.*
- *Educate all team members/staff about the process.*

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*)

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- Include a young adult whenever possible
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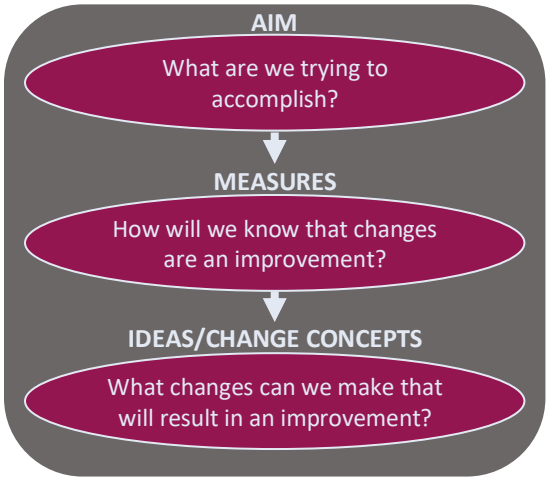

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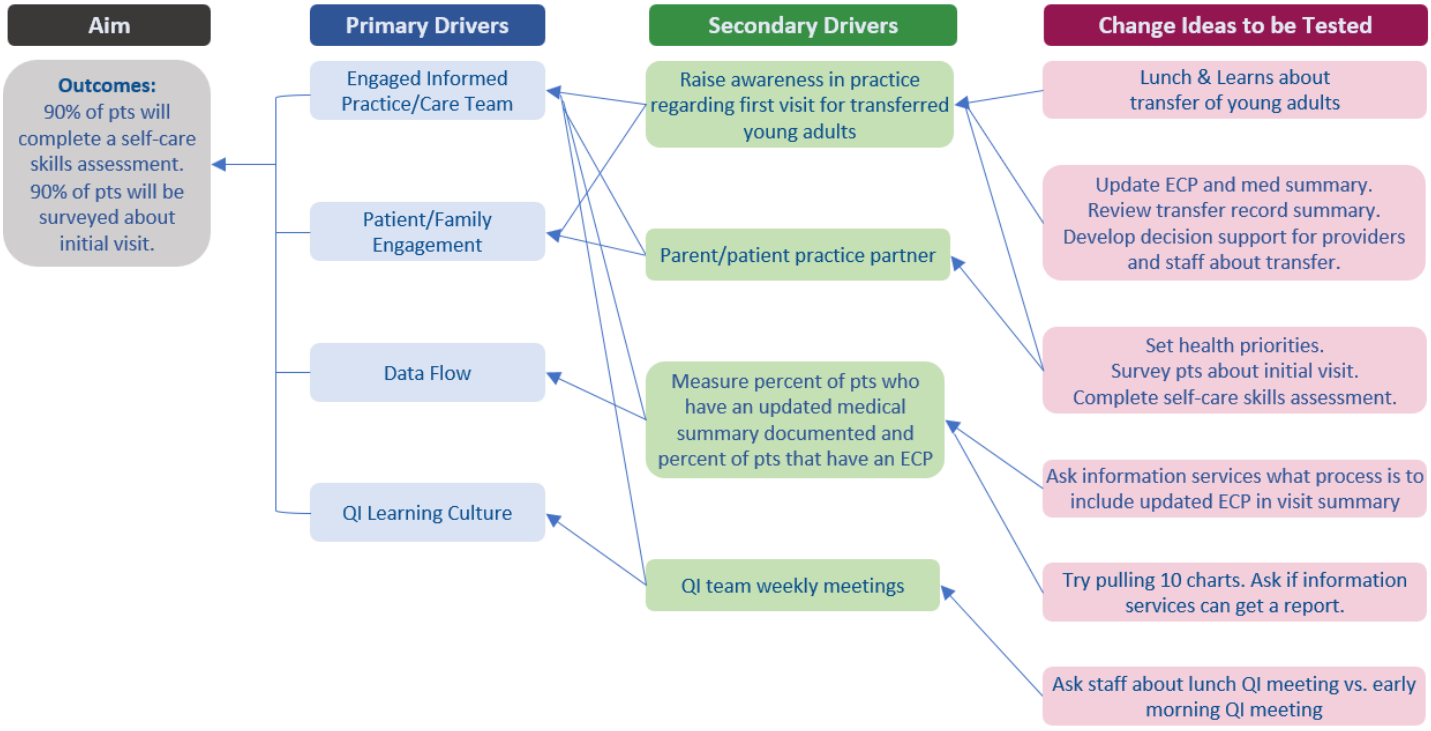
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

Transferring from a pediatric practice to an adult practice is stressful for patients and families. We aim to ease that transfer by having a successful initial visit. By [insert date], 90% of patients will rate their initial visit as satisfactory and 90% of new patients will have a completed self-care skills assessment.

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*.



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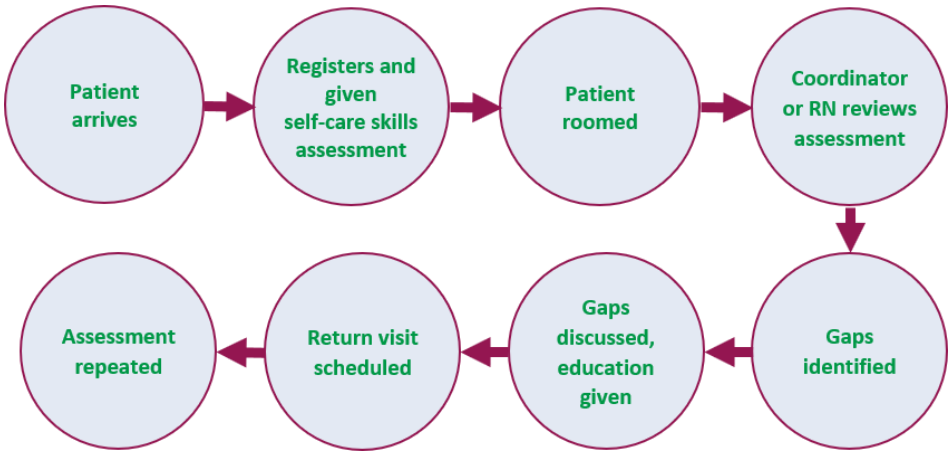

Tool 4: Simplified Failure Mode and Effects Analysis (sFMEA)

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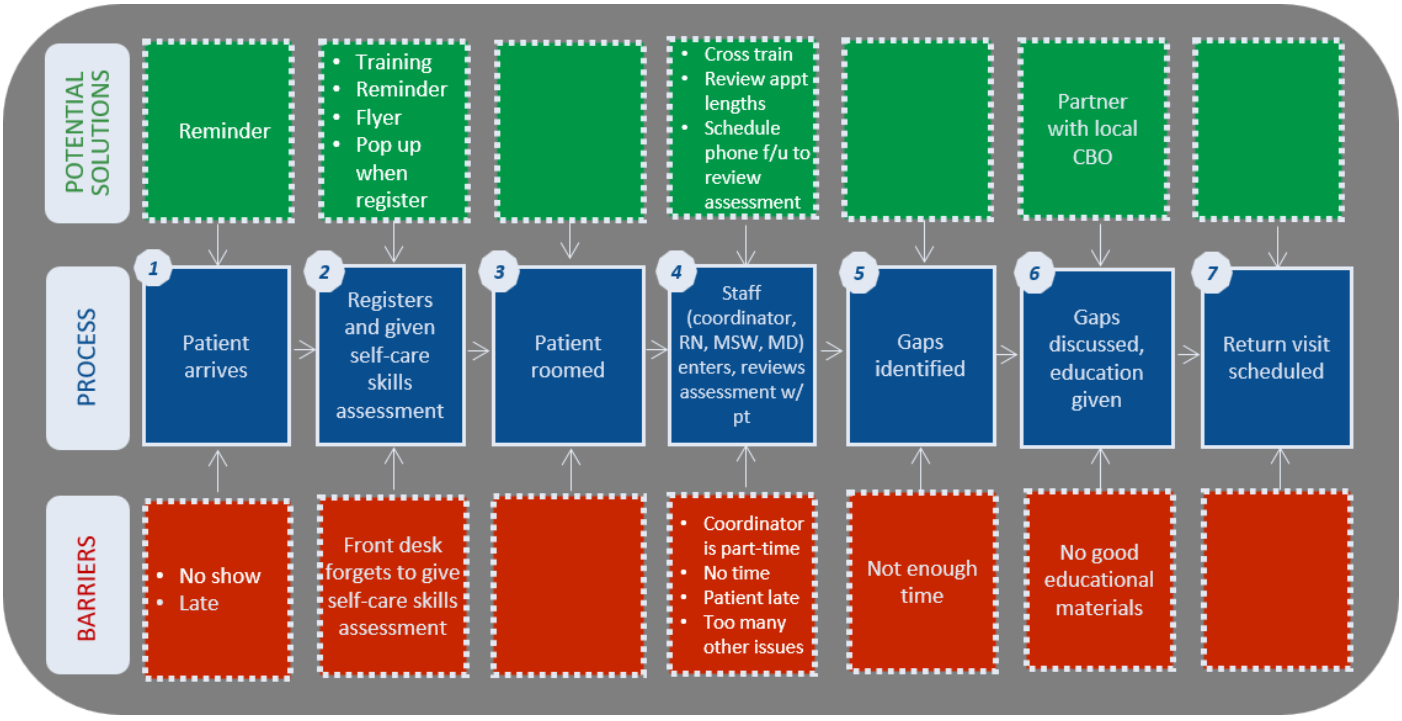

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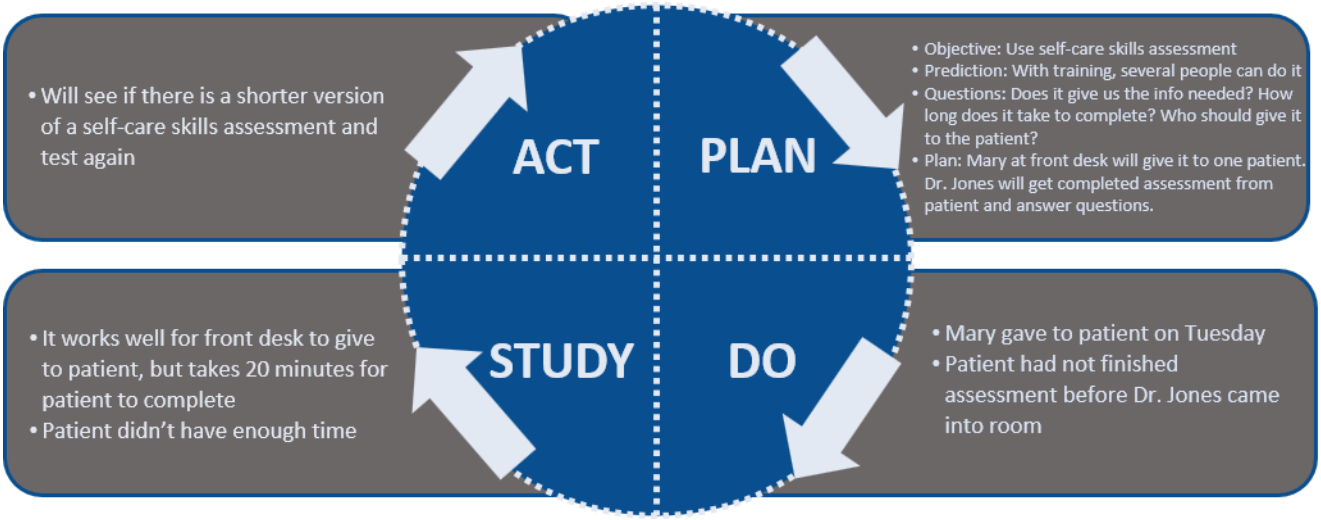
- **Plan** the test: who, what, where, when;
- **Do** try the change and observe what happens;
- **Study** reflect on what was learned from the test; and
- **Act** decide next steps based on the reflection.

Examples of Ideas to Test

- Ask 2 patients to help with the process
- Flow map the ideal process
- Create a list of adult clinicians interested in participating



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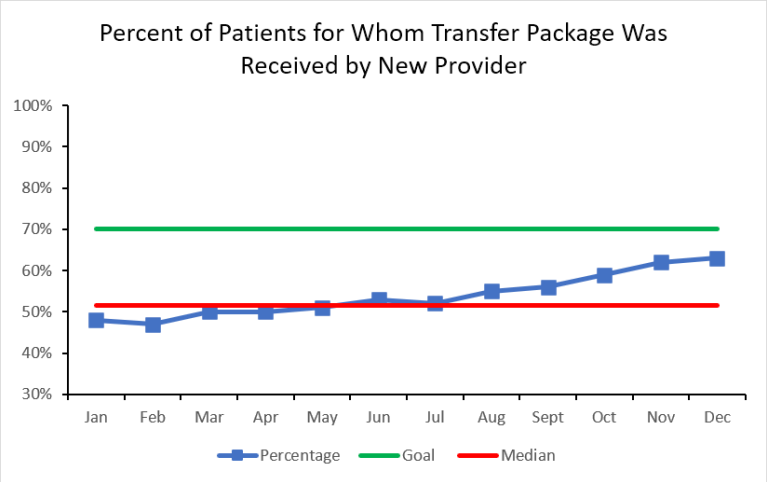
Example Data Collection Check Sheet

- ☐ Assess the need for clarification of self-care skills assessment.
- ☐ Track for 1 week the number of patients who have questions about the assessment.
- ☐ Track the areas of assessment with greatest number of questions.
- ☐ Track the number of patients who are given the self-care skills assessment.

	Mon	Tues	Wed	Thurs	Fri
# pts w/ questions	|||	|||	||||	||	||||
# pts w/ self-care skills assessment	||	||	|||	|	||

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 Tools for Initial Visits

Sample Tools from the Six Core Elements of HCT™

- Sample self-care skills assessment from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*
- Sample content for initial visits from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*

Sample Initial Visits Tools for Young Adults with Specific Conditions

- Sample content for initial visits with young adults with sickle cell disease from PRISMA Health *(click here)*
- Sample content for initial visits with young adults with sickle cell disease from the University of Miami *(click here)*

IV. Additional Resources

- Turning 18: What It Means for Your Health (*click here*)
- Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones (click *here*)
- System Differences Between Pediatric and Adult Health Care *(click here)*

Integrating Young Adults into Adult Health Care
Core Element 6 – Ongoing Care

I. Purpose, Objectives, and Considerations

Purpose

Ongoing Care is the sixth element in the Six Core Elements of Health Care Transition™ (HCT). This includes confirming transfer completion, coordinating referrals to adult specialists, assessing consumer experience with transition, and providing ongoing care management. Confirming with the pediatric practice that the adult clinician has taken on responsibility for the young adult's health care is important, given their high rates of loss to follow-up. Since many young adults transfer to an adult primary care clinician first, helping them to select new adult specialist clinicians may be necessary. In addition, evaluating the success of the HCT process and the young adult's experience with care, with a mechanism to obtain and incorporate the feedback, will improve the practice's approach to integrating young adults into the practice. *See sample feedback surveys in Section III.*

Objectives

Communicate with pediatric practice confirming completion of transfer into adult practice and consult with pediatric clinician(s), as needed.

Assist young adult in connecting with adult specialists, as needed, and provide linkages to insurance resources, self-care management information, and community support services**.**

Obtain consent from young adult for release of medical information.

Continue with ongoing care management tailored to each young adult and their cultural preferences.

Elicit anonymous feedback from young adult on their experience with the transition process.

Build ongoing and collaborative partnerships with other primary and specialty care clinicians.

Considerations

CONTENT

What information might be useful to collect in assessing transition feedback?

Below are some questions and ideas to think about.

- *Does the practice want to gain feedback from young adults on their experience with the practice's welcome process?*
- *Consider the welcome process in your practice/system. Which key components of your HCT welcome process do you want feedback on from young adults?*
- *Does the practice want to use or customize Got Transition's HCT Feedback Survey for Young Adults, which is based on components of the Six Core Elements, or use other existing consumer surveys and add HCT feedback questions?*
- *Does the practice want to obtain feedback from clinicians about the HCT process in the practice/system?*
    - *Consider the HCT process in your practice/system. Which key components of your HCT process do you want to elicit feedback on from clinicians?*
    - *Decide if you want to use or customize Got Transition's Clinician Feedback Survey. Alternatively, you could use other existing clinician feedback surveys and add HCT feedback questions.*

PROCESS

What process do you have in place to notify the referring (pediatric) practice that the young adult has been seen by an adult clinician?

Below are some questions and ideas to think about.

- *Will the practice establish a routine process with the referring (pediatric) practice to notify them when the new young adult comes to their first visit?*
- *Who in the adult practice will be in charge of notifying the referring practice that the young adult has been seen by the adult practice?*
- *What plan does the practice have to work with both the referring practice and the young adult if the young adult does not come to their new adult clinician appointment?*
- *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 ask for consultation from the referring clinician, if needed?

Below is a question to think about.

- *Does the practice have a plan for the best way to communicate with the referring pediatric practice to ask for consultation if advice is needed quickly on the new young adult, especially in the early months after transfer (e.g., if the adult clinician is not familiar with the young adult's childhood-onset disease)?*
- *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 obtain consumer and clinician feedback about your practice's transition process?

Below are some questions and ideas to think about.

- *If an available consumer HCT feedback survey has been customized (e.g., Got Transition's HCT Feedback Survey for Young Adults) or your practice/system has developed its own, is the reading level appropriate? Has it been tested with 3-4 older young adults in your practice (who will be receiving the feedback survey) who have different levels of education to see if they have any difficulty understanding the questions or specific words? If so, make needed changes to the feedback survey and test again.*
- *Once the HCT feedback survey is ready for use, identify and test the process on how it will be completed, ideally 3-6 months after the young adult has joined the practice:*
  - *Identify eligible young adults to complete the HCT feedback survey and decide:*
    - *When will it be offered? After a clinic visit? Will it be sent virtually shortly after the initial visit?*
    - *How will feedback results be kept confidential?*
    - *Will it be completed in a paper form? If yes, determine how often and who will collect the information and collate the results.*

Continued on next page

        - *How will the results be incorporated into an improvement process for the adult practice's HCT welcome process, if needed?*
        - *Will the HCT feedback survey be completed via an online survey (e.g., SurveyMonkey)? Who will review the results? When will they review the results and present them to the adult practice team for review and action if needed?*
    - *Once your HCT clinician feedback survey is ready for use, it is time to identify and test the process for completing it and how the results will be shared so changes can be made if needed. Below are some questions and ideas to think about.*
        - *Who will complete the survey: clinicians, including clinic office staff?*
        - *How will results be kept confidential?*
        - *Test the questions with a few staff to be sure the questions are clear.*
        - *Who will collect the survey?*
        - *Who will collate the results?*
        - *How will the results be incorporated into an improvement process for the pediatric practice's HCT process, if needed?*
    - *Create a written document to describe the practice/system process to obtain feedback on the HCT process. Have this document available for the clinic staff in case there are staff changes.*
    - *Offer education to all team members/staff about the practice's HCT feedback process.*

What is the process your practice uses to tailor ongoing care management to each young adult, keeping in mind their cultural preferences?

What is the process your practice uses to develop collaborative relationships with other primary care and subspecialty care clinicians so there is availability of those clinician services for new young adults in your practice?

II. Quality Improvement Considerations, Tools, and Measurement

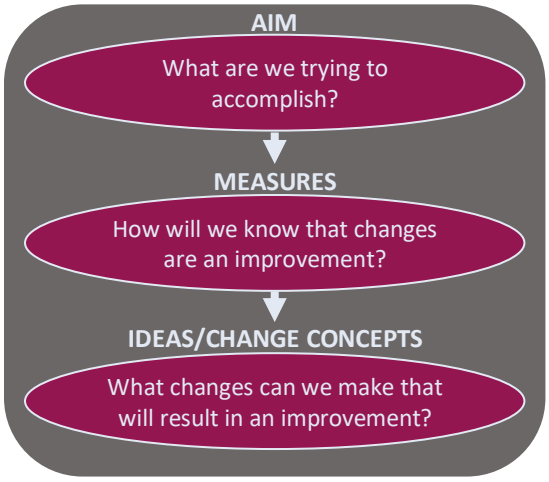
Quality Improvement Considerations

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 young adult 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

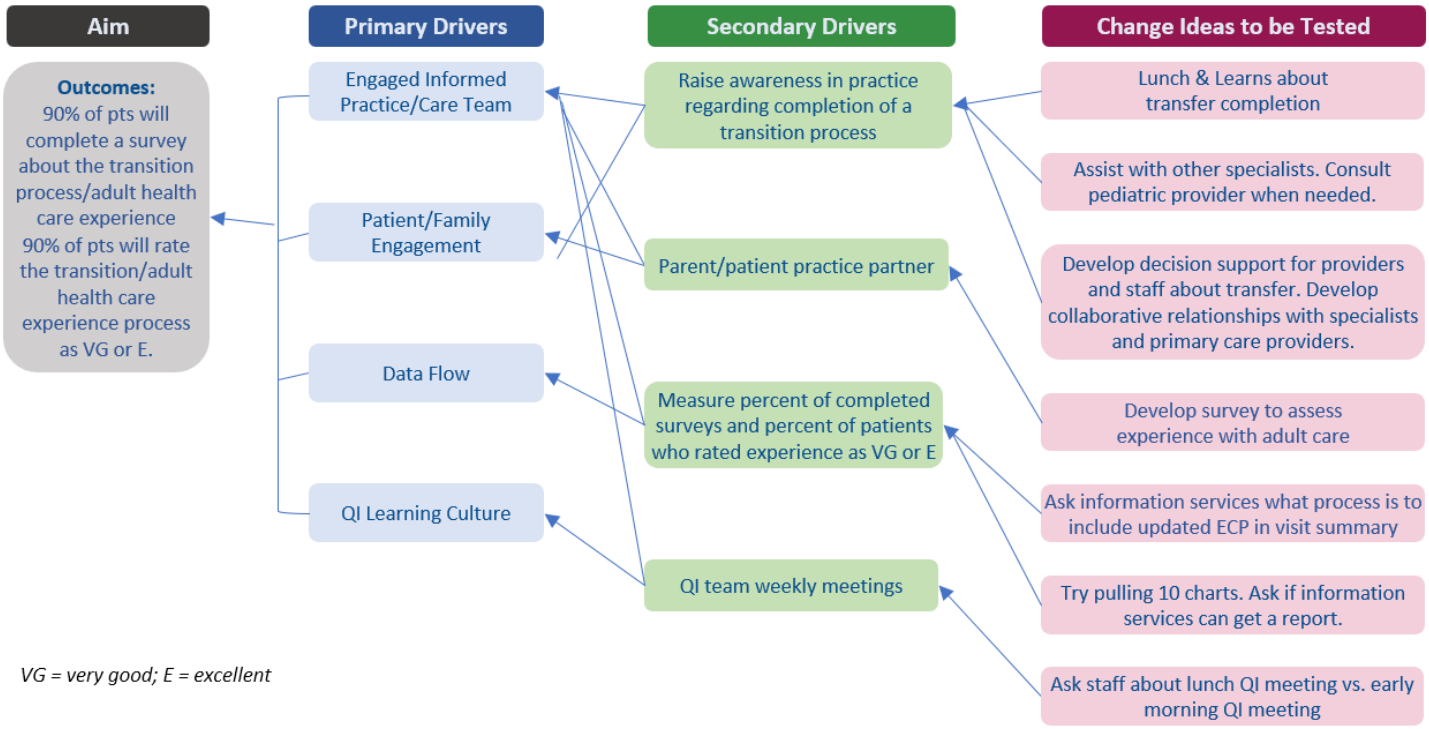
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

Having a successful transition/transfer experience is critical to excellent patient care. By [insert date] 80% of patients will rate their transition/transfer as excellent.

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*.



VG = very good; E = excellent

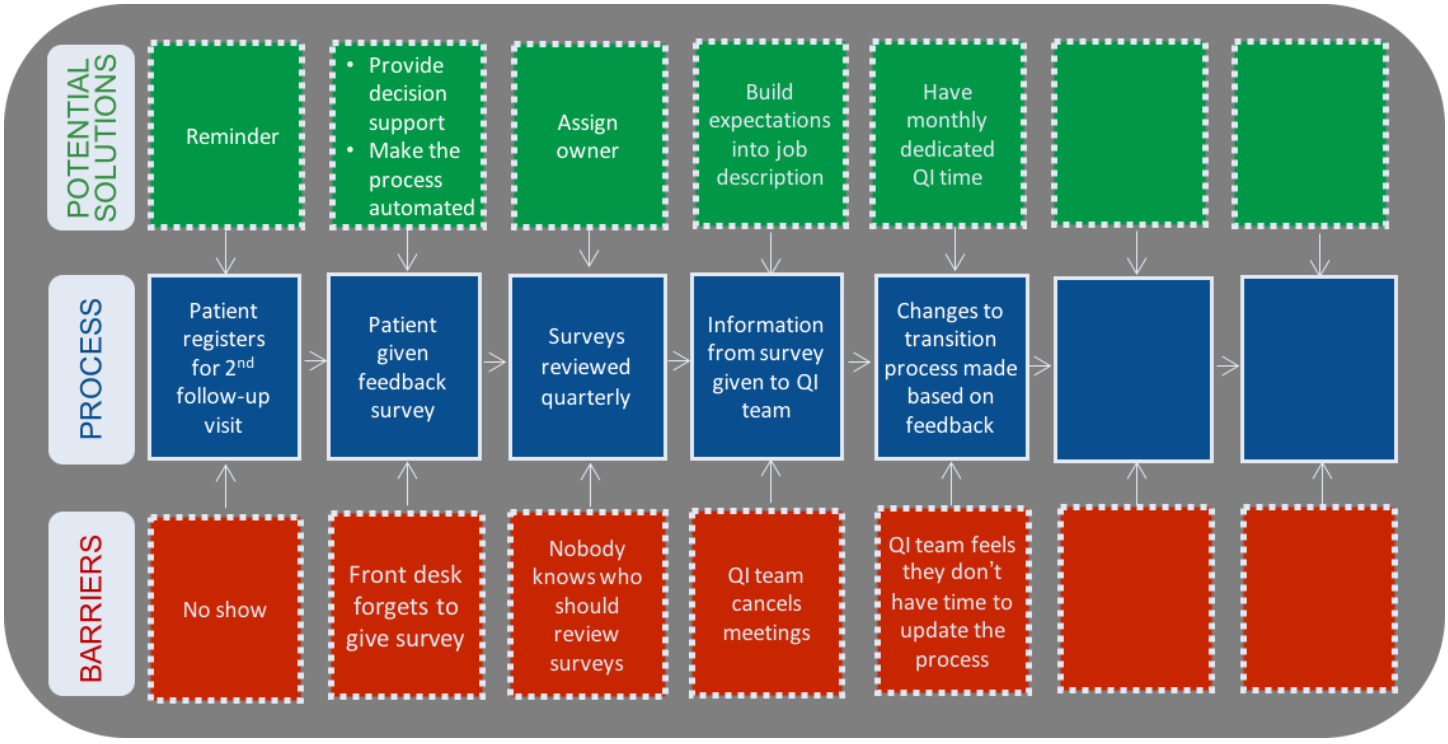
Adapted from ST3P UP, a collaborative sponsored by Patient Centered Outcomes Research Institute® (PCORI) Award MCSC-1608-35861 Titled A Comparative Effectiveness of Peer Mentoring Versus Structured Education Based Transition Programming For The Management Of Care Transitions In Emerging Adults With Sickle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

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.

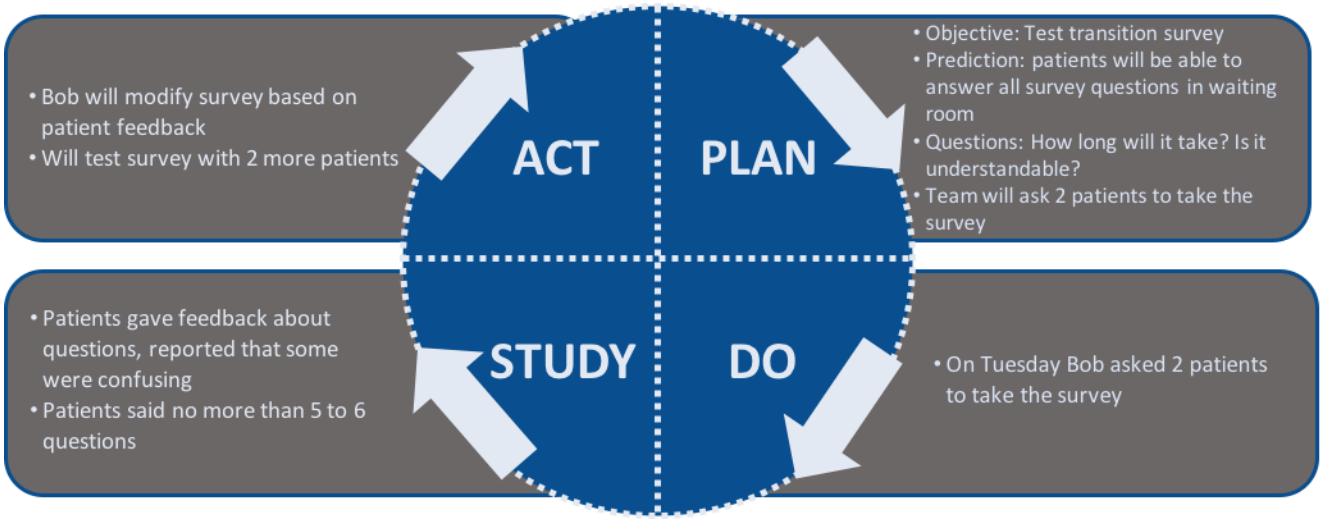
Tool 5: PDSA Cycles

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 detailed explanation and a blank form, 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

- Using the Got Transition toolkit survey
- Using shared decision-making during the visit
- Creating a process to communicate with the pediatric provider



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

Quality Improvement Measurement

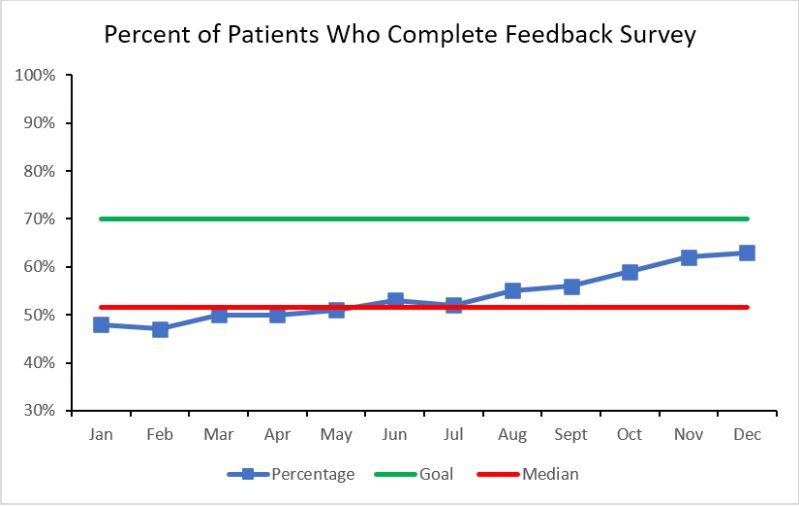
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of 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 survey out, track how many patients received it.
- ☐ For one week, track how many surveys were found in the trash or left behind in the room.
- ☐ Track how many patients had questions about the survey.
- ☐ Share feedback with the team to help refine the survey and the process.
- ☐ Track percent of patients who rate their transition/transfer as excellent.

	Mon	Tues	Wed	Thurs	Fri
# pts received surveys	||||	||||	|||	||	||
# pt surveys left behind	|	|||	|	|	|
# pts with 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 Health Care Transition Feedback Surveys

Sample Health Care Transition Feedback Surveys from the Six Core Elements of HCT™

- Sample feedback survey for young adults from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*
- Sample feedback survey for clinicians from Got Transition's "Integrating Young Adults into Adult Health Care" *(click here)*

IV. Additional Resources

- Health Care Transition Timeline for Youth and Young Adults (*click here*)
- Health Care Transition Timeline for Parents/Caregivers (*click here*)
- Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones (*click here*)

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