Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Transitioning Youth to an Adult Health Care Clinician

Core Element 5 – Transfer of Care

got transition®

I. Purpose, Objectives, and Considerations

Purpose

Transfer of care is the fifth element in the Six Core Elements of Health Care Transition™ (HCT). Establishing a systematic method for transfer to an adult clinician ensures that key tasks are accomplished; that youth, young adults, and parents/caregivers are informed of and involved in the hand-off of care and current medical information; and that communication and coordination between pediatric and adult clinicians takes place. For youth and young adults with special health care needs, transfer of care often requires coordination among multiple clinicians to ensure a safe and continuous process. Transfer to an adult clinician is recommended before the age of 22. *See sample transfer of care checklists and transfer letters in Section III*.

Objectives

Complete 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.

Confirm date of first adult clinician appointment.

Prepare letter with transfer package, send to adult clinician, and confirm adult clinician's receipt of transfer package.

Communicate with selected adult clinician about pending transfer of care.

Confirm the pediatric clinician's responsibility for care until youth/young adult is seen by an adult clinician.

Transfer youth/young adult when their condition is as stable as possible.

Considerations

CONTENT

What information should be shared during the transfer of care?

Below are some questions and ideas to think about.

- *What should be communicated to youth/young adults and parents/caregivers about the differences between pediatric and adult care? (See Got Transition's System Differences Between Pediatric and Adult Health Care and Planning to Move from Pediatric to Adult Care? Here's How They Can Differ in Section IV).*
- *Create a checklist of items to include in the transfer package. What will be included in the transfer package for the adult clinician? A transfer checklist can help the practice be sure all the components of the transfer package are done for those youth/young adults leaving the practice (see sample transfer checklists in Section III).*
- *Prepare a transfer of care letter to the adult clinician.*
    - *What will be included in the transfer letter to the adult clinician? The amount of medical history detail included depends on if the letter is taking the place of a medical summary. This might happen, for example, if the youth/young adult has had no major medical problems; the letter could include only basic medical information such as immunization and key family history.*

Continued on next page

- *Decide if you will include in the letter the roles of the pediatric clinicians during the time between the last pediatric and first adult appointment. For example, who is responsible for refilling medications needed once the young adult has left the pediatric practice but not yet seen their new adult clinician?*
- *Decide if you will include in the letter whether the pediatric practice is willing to be available to the adult clinician for consultation throughout the transfer process.*

PROCESS

What is the process to implement a standardized transfer of care by developing a checklist, package and letter?

Below are some questions and ideas to think about.

- *When transfers to many clinicians are involved, it is easier if the transfer to the new adult clinicians (both primary and subspecialty clinicians) does not happen at the same time. Consider starting with transferring to an adult primary care clinician first who can assist the pediatric practice, youth/young adult and parent/caregiver with identifying other adult clinicians (e.g., subspecialists) as needed.*
- *If possible, it is better to transfer the youth/young adult into the adult health care system while they still have health insurance so the youth/young adult does not have to find both health insurance and a new clinician at the same time.*
- *How and when might the pediatric practice communicate with youth/young adults and parents/ caregivers about the differences between pediatric and adult care? Who in the practice might be the one to discuss it?*
- *Transfer checklist and package*
  - *How will you create a process to develop a transfer checklist and package?*
  - *How will you gain youth/young adult/parent/caregiver input into the transfer package?*
  - *What is the process to gather the appropriate up-to-date information for the transfer package?*
  - *Who is responsible for gathering the transfer package materials?*
  - *Who will create the letter of transfer?*
  - *Who obtains the legal approval from the youth/young adult/parent/caregiver to share the medical records in the transfer package?*
  - *Who is responsible for getting the transfer package to the selected adult primary care and, if needed, subspecialty care clinician(s)?*
  - *Who is responsible for confirming that the adult clinicians received the transfer package?*
  - *Who communicates to the youth/young adult/parent/caregiver and adult clinician the role of the pediatric practice in the care of the youth/young adult between the last pediatric and first adult clinician visit?*
  - *How does the pediatric practice standardize the level of communication needed by the pediatric practice with the adult practice for different levels of medical and social complexity for youth/young adults transferring their care (e.g., When is just a call or a letter or an email needed?)? If communicating directly with the new clinician(s), consider team meetings or the use of telemedicine including Facetime and ECHO.*
  - *Who is responsible for making the call, using telemedicine, and/or sending the letter or email?*
- *Create a written document to describe the clinic process to implement a standard transfer of care.*
- *Educate all team members/staff about the process.*

II. Quality Improvement Considerations, Tools, and Measurement

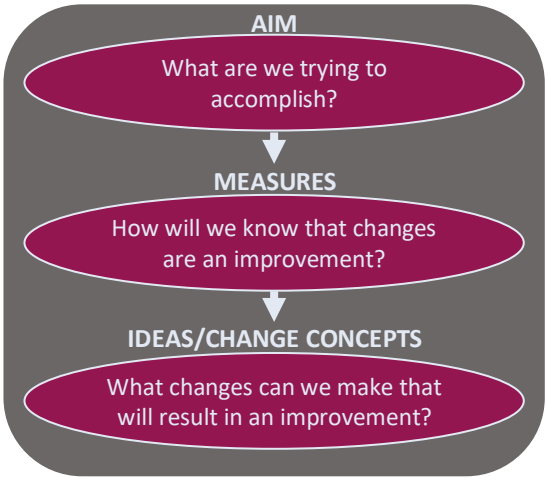
Quality Improvement Considerations

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

What is the Model for Improvement?

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



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

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

Quality Improvement Tools

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

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

Tool 1: Aim Statement

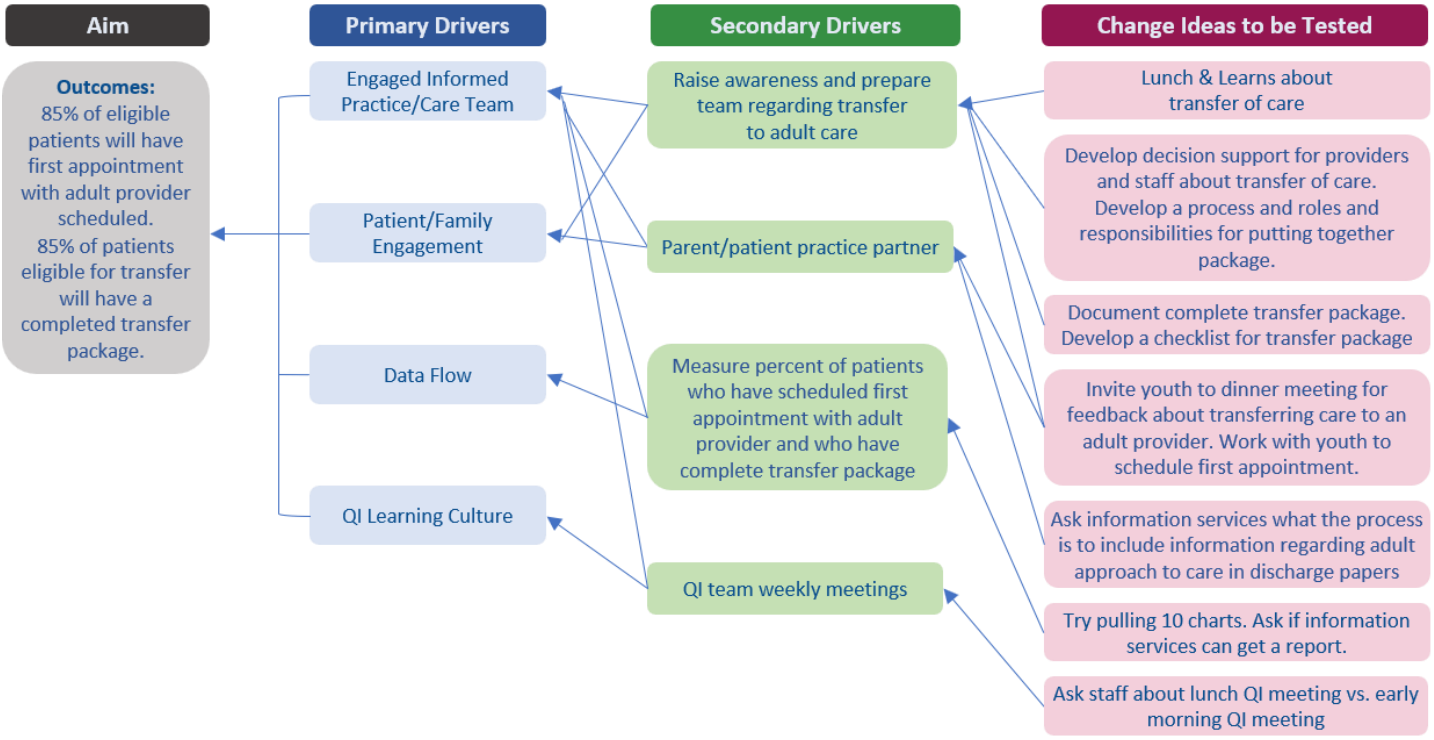
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

We aim to improve care for patients with sickle cell disease by ensuring effective transfer of care. By [insert date], 85% of eligible patients will have had their first appointment and 85% of eligible patients will have a completed transfer package.

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*.



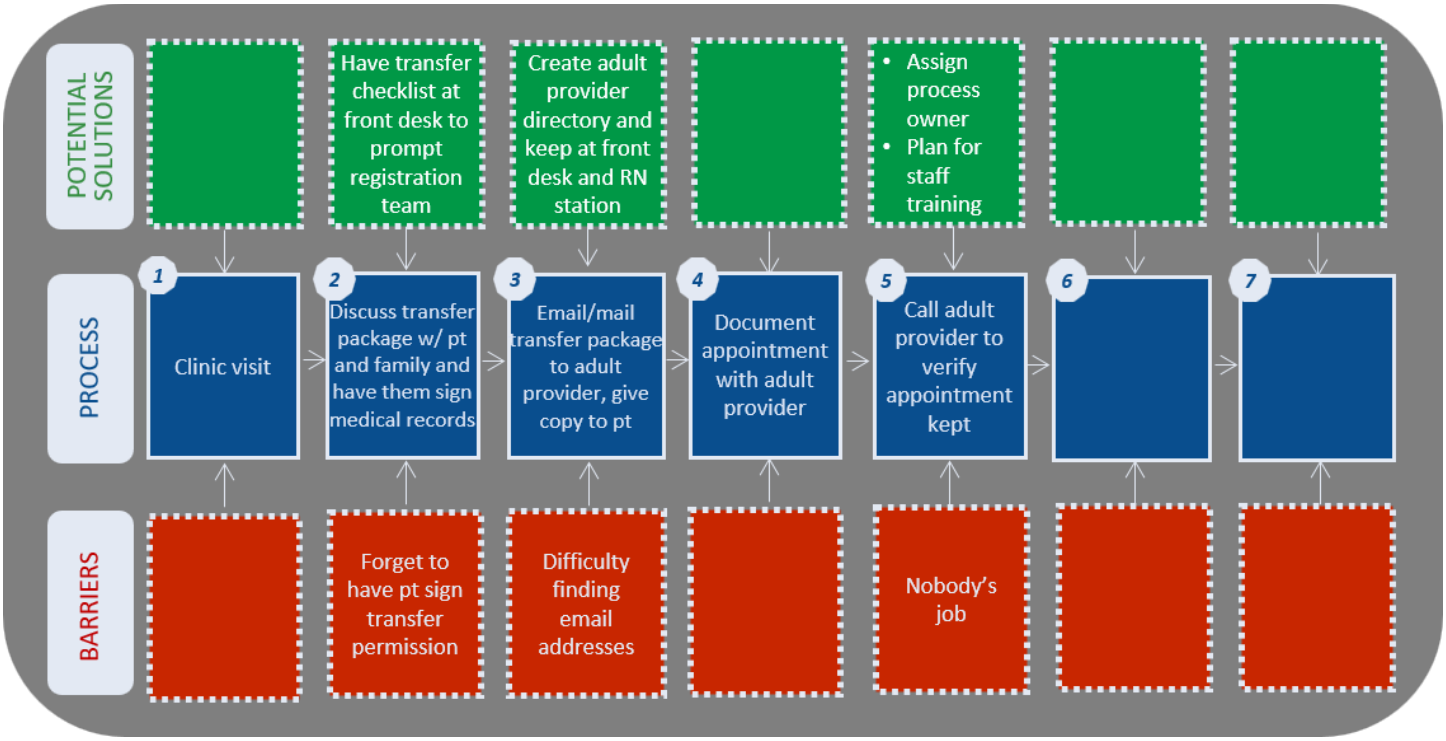
Adapted from ST3P UP, a collaborative sponsored by Patient Centered Outcomes Research Institute® (PCORI) Award MCSC-1608-35861 Titled A Comparative Effectiveness of Peer Mentoring Versus Structured Education Based Transition Programming For The Management Of Care Transitions In Emerging Adults With Sickle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

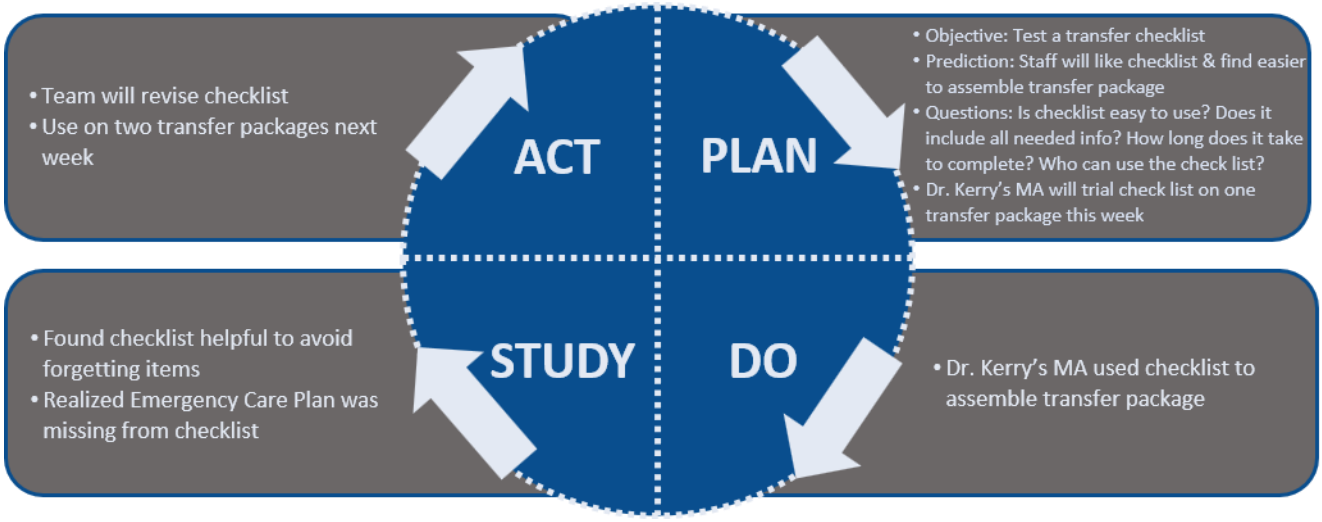
Tool 5: PDSA Cycles

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 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

- Medical assistant to confirm first adult provider appointment
- Sample letter to adult provider about pending transfer
- Transfer package checklist



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

Quality Improvement Measurement

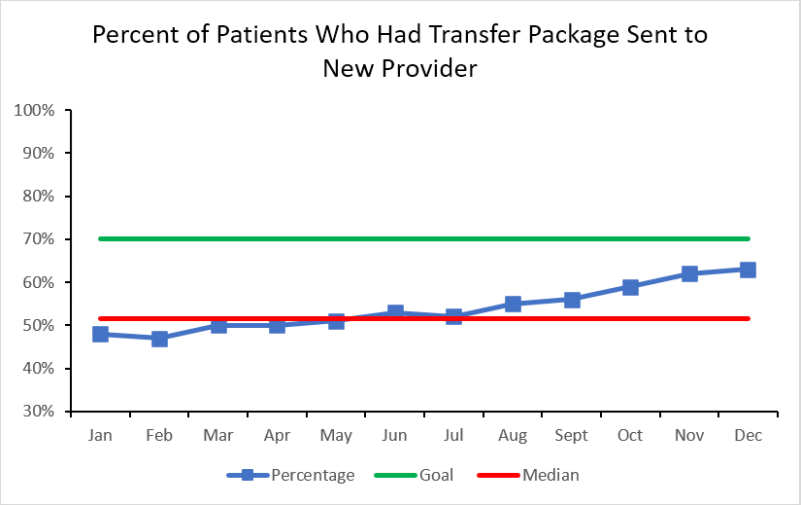
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of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

- ☐ Decide on the elements of the transfer package
- ☐ Track the amount of time it takes to complete the package
- ☐ For 2 weeks, track the number of possible transfers
- ☐ Track the number of patients that had an adult appointment

	Mon	Tues	Wed	Thurs	Fri
# possible transfers	||	||	|||	||||	||
# pts with adult appt		||	|	|	|

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 Transfer of Care Tools

Sample Transfer of Care Tools from the Six Core Elements of HCT™

- Sample transfer checklist from Got Transition's "Transitioning Youth to an Adult Health Care Clinician" *(click here)*
- Sample transfer letter from Got Transition's "Transitioning Youth to an Adult Health Care Clinician" *(click here)*

Sample Transfer of Care Tools for Youth with Specific Conditions

- Transfer letter template for youth with sickle cell disease from University of Louisville Physicians *(click here)*
- Transfer letter template for youth with sickle cell disease from St. Jude Affiliate Clinic at Novant Health Hemby Children's Hospital *(click here)*
- Transfer of care checklist from St. Jude Affiliate Clinic at Novant Health Hemby Children's Hospital *(click here)*
- Transfer of care checklist from Atrium Health Levine Children's *(click here)*
- Sickle cell disease SMART Phrase resource for incorporating a medical summary into a transfer letter (*click here*)

Sample Wellness Plan for School Health Settings

- Sample mental health wellness plan from Mary's Center's school mental health 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)*
- Planning to Move from Pediatric to Adult Care? Here's How They Can Differ *(click here)*

Suggested Citation: White P, Schmidt A, Ilango S, Shorr J, Beck D, McManus M. *Six Core Elements of Health Care Transition™ 3.0: An Implementation Guide.* Washington, DC: Got Transition, The National Alliance to Advance Adolescent Health, July 2020.

The Quality Improvement section was created under the auspices of Atrium Health's Levine Children's Center for Advancing Pediatric Excellence by Laura Noonan, MD and Sarah Mabus, MLA.

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

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

THE NATIONAL ALLIANCE TO ADVANCE ADOLESCENT HEALTH
1615 M Street NW, Suite 290, Washington DC 20036 | 202.223.1500
www.GotTransition.org