Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Integrating Young Adults into Adult Health Care

Core Element 4 – Integration Into Adult Practice

got transition®

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

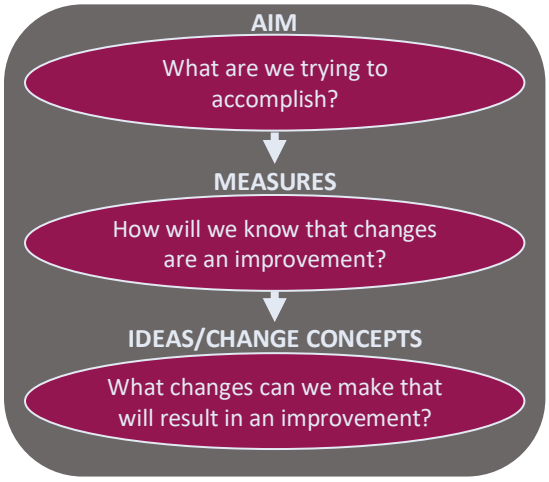
Quality Improvement Considerations

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.



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

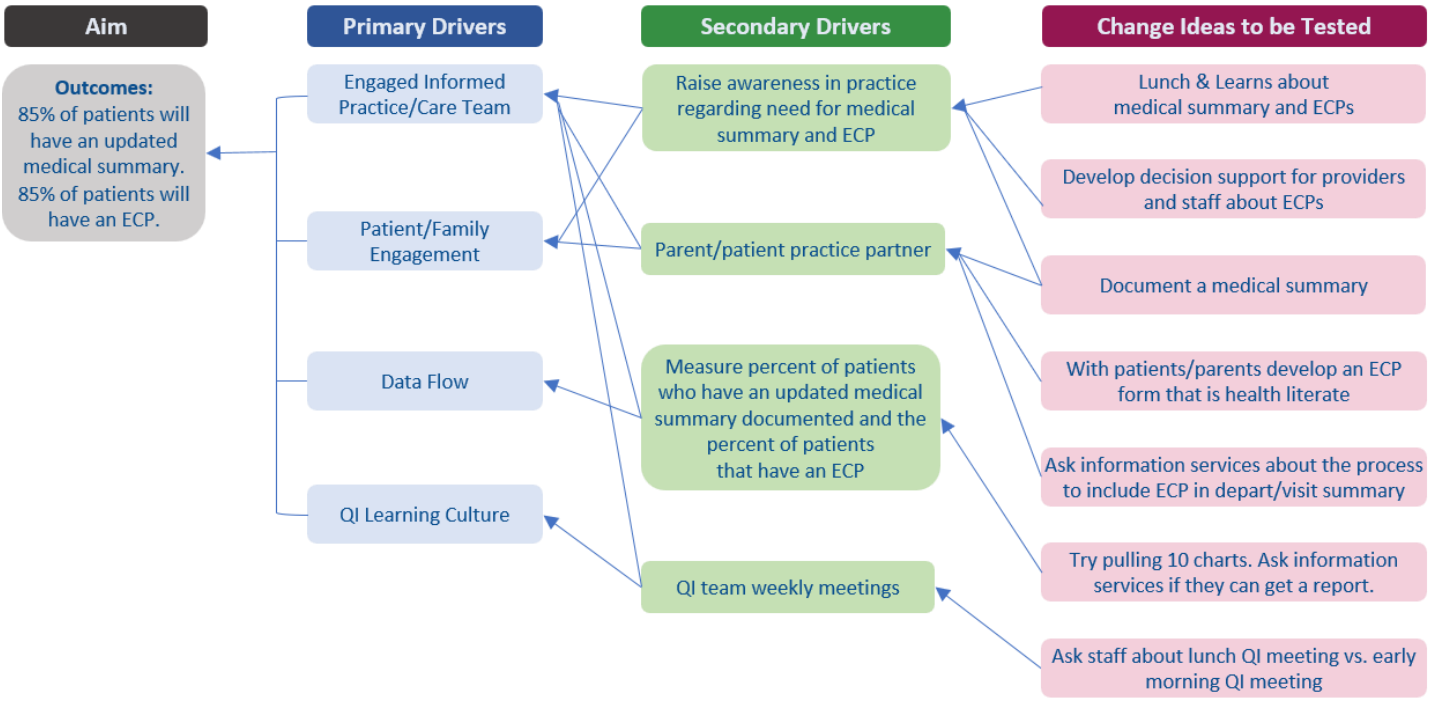
The aim statement is a written statement that describes the improvement effort and includes the rationale for doing the work, the target population, the time period of the work, and measurable numeric goals. For more information and examples, see *Model for Improvement* in the *QI Primer*.

Example Aim Statement

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*.



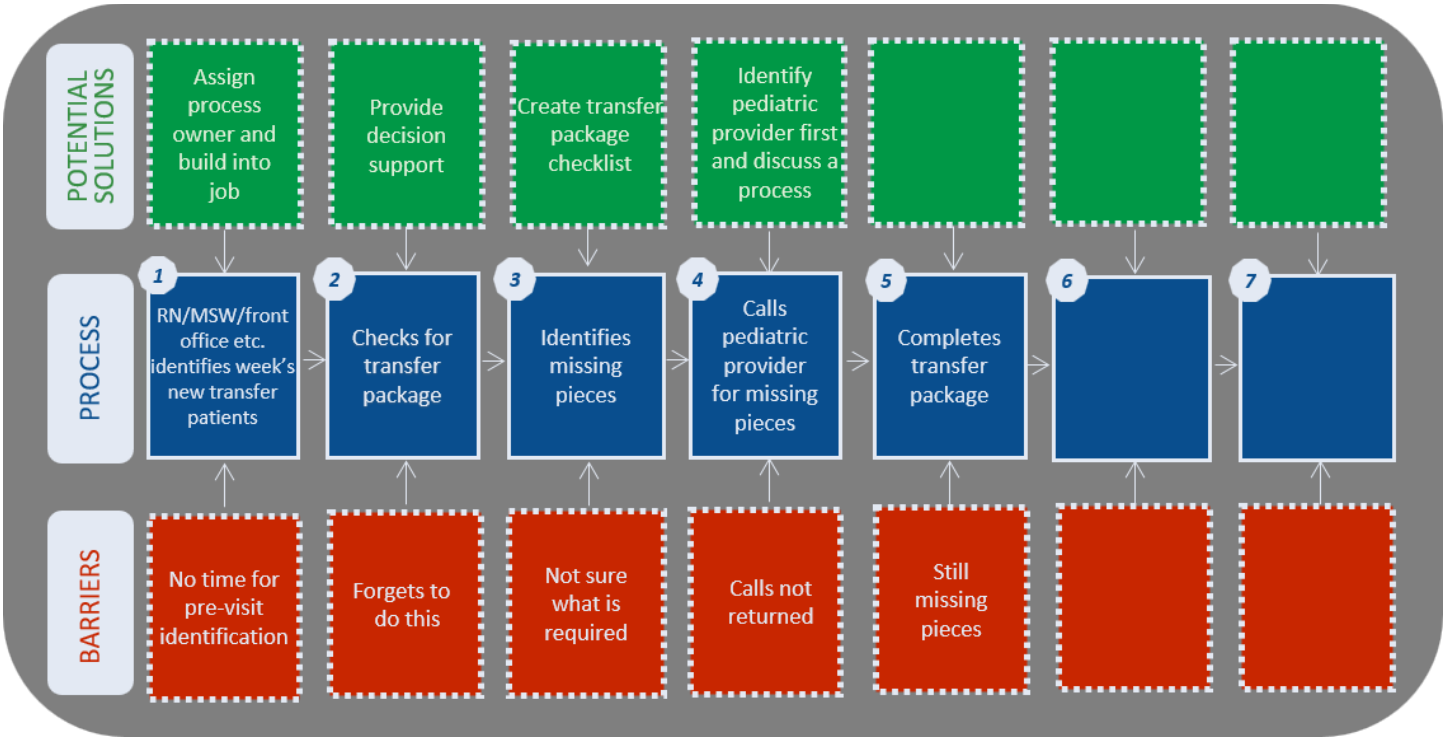
Adapted from ST3P UP, a collaborative sponsored by Patient Centered Outcomes Research Institute® (PCORI) Award MCSC-1608-35861 Titled A Comparative Effectiveness of Peer Mentoring Versus Structured Education Based Transition Programming For The Management Of Care Transitions In Emerging Adults With Sickle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

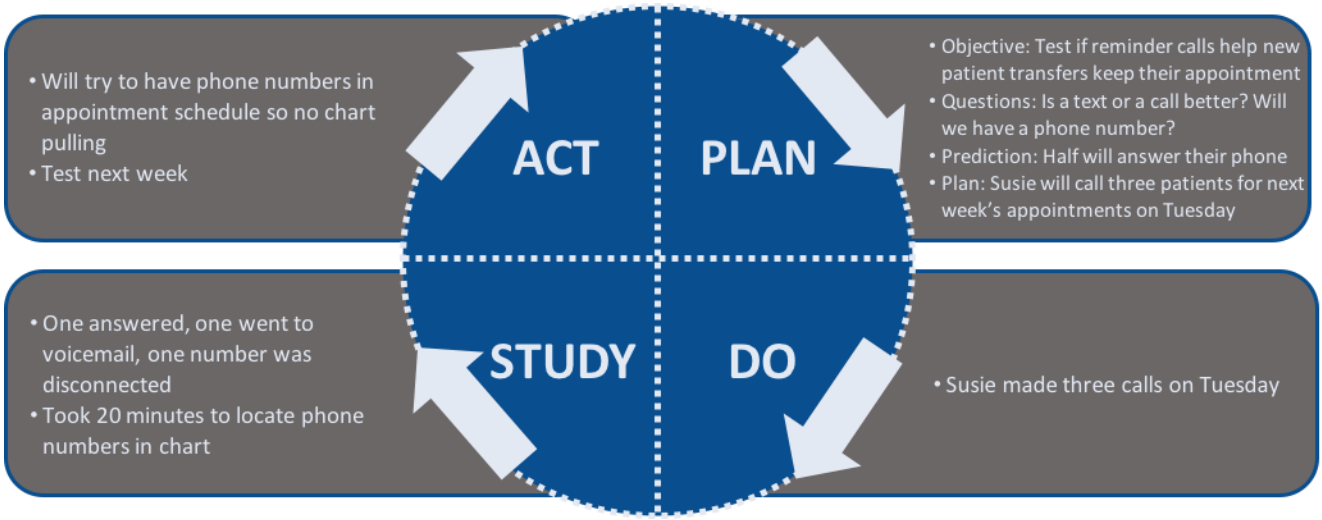
Tool 5: PDSA Cycles

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

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



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

Quality Improvement Measurement

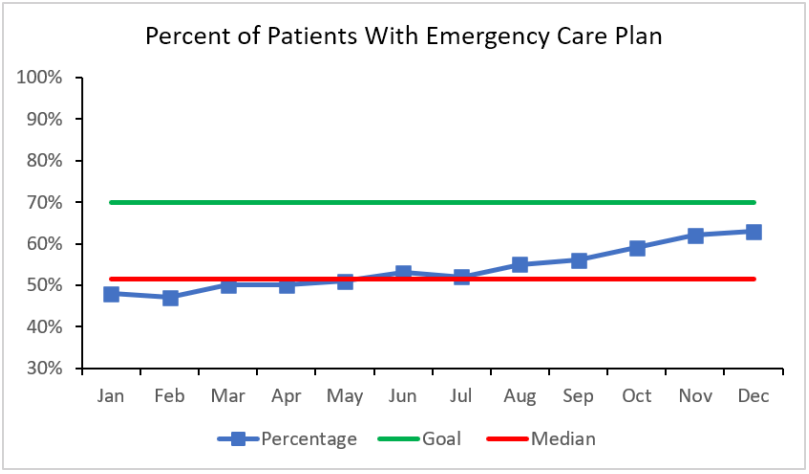
This step will sometimes be informal, while other situations will require a more formal process. Tracking your progress can be as simple as using a check sheet for a short period of time or a more formal use of a run chart which displays improvement over time. Specifically, the Current Assessment of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

- ☐ 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*.

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)*
- Telehealth Toolkit for a Joint Visit with Pediatric and Adult Health Care Clinicians and Transferring Young Adults *(click here)*

IV. Additional Resources

- Turning 18: What It Means for Your Health (*click here*)
- Add your health information into your smartphone (*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)*

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