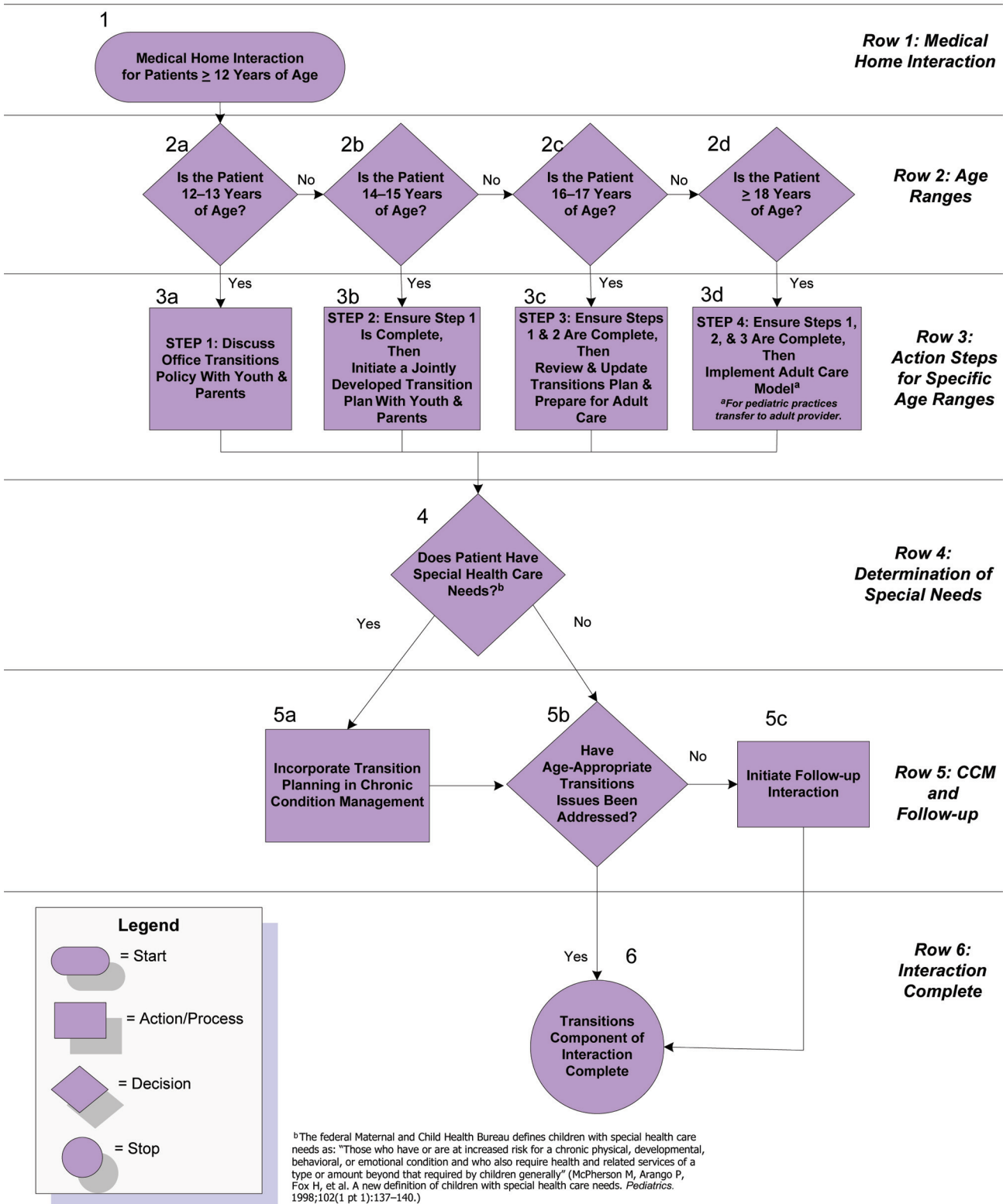


# Health Care Transition Planning Algorithm for All Youth and Young Adults Within a Medical Home Interaction



<p><b>Medical Home Interaction for Patients ≥ 12 Years of Age</b></p>	<p><b>1.</b> Initiate first step in the health care transition planning process at age 12.</p>	
	<p><b>2a, 2b, 2c, 2d. Age Ranges.</b> By age 12, conduct surveillance to assess any special health care needs. Start actual transition planning by age 14. By ages 16-17, transition planning should be well established. At age 18, initiate an adult model of care for most youth, even if there is no transfer of care. If transition planning does not occur on the schedule described by the algorithm, a concentrated effort is required (eg, special visits) to successfully complete the process.</p>	
<p><b>3a.</b> Every practice should have a written transition policy that is prominently displayed and discussed with youth and families. The policy should explicitly state the practice's expectations and care process for the health care transition of their adolescent patients to an adult model of care.</p>	<p><b>STEP 1: Discuss Office Transitions Policy with Youth &amp; Parents</b></p>	
<p><b>STEP 2: Ensure Step 1 Is Complete Then Initiate a Jointly Developed Transition Plan With Youth &amp; Parents</b></p>	<p><b>3b.</b> The practice should utilize a standard transition plan that can be adapted for each patient's needs. This tool should include components to obtain an accurate assessment of the patient's ability to successfully transition. Providers should interview youth and family members to identify needs and to assess the intentions and motivations for youth independence.</p>	
<p><b>3c.</b> Transitions plans must be reviewed regularly and updated as necessary. The provider must also perform surveillance for changes in the youth's medical status and address youth and family concerns that may warrant changes in transition goals. Failure to achieve transition readiness goals warrants reevaluation of the existing plan, and increased frequency of medical home interventions/visits. A "pretransfer" visit to the adult medical home could be conducted during the year before the transfer.</p>	<p><b>STEP 3: Ensure Steps 1 &amp; 2 Are Complete, Then Review &amp; Update Transitions Plan &amp; Prepare for Adult Care</b></p>	
<p><b>STEP 4: Ensure Steps 1, 2, &amp; 3 Are Complete, Then Implement Adult Care Model*</b> <small>*For pediatric practices transfer to adult provider</small></p>	<p><b>3d.</b> Transition to an adult model of care occurs appropriate for youth's developmental level. This is followed as appropriate by transfer to an adult medical home. Complete medical records should be delivered to the adult provider, along with a portable summary, which is also provided to the patient or guardian. For children and youth with special health care needs, direct communication between pediatric and adult providers is essential, as adult medical personnel may be unfamiliar with certain pediatric conditions.</p>	
<p><b>4.</b> Transition planning for children and youth with special health care needs should include specific chronic condition management (CCM) activities such as: use of registries; care plans; care coordination; CCM office visits; and comanagement with medical subspecialists. Transition goals must be individualized to account for variations in the complexity of a youth's condition and in the youth's intellectual ability and guardianship status.</p>	<p><b>Does Patient Have Special Health Care Needs?*</b></p>	
<p><b>Incorporate Transition Planning in Chronic Condition Management</b></p>	<p><b>5a.</b> Youth with special health care needs require an expanded transition planning process. Transition planning in CCM includes addressing the exchange of complex health information; competencies for self-care; transfers of specialty care; and issues related to insurance, entitlements, guardianship, and eligibility for adult services. In a medical home, such youth may have a written care plan as part of the medical record. At age 14, this plan should include a section titled "transition plan," which should be expanded and developed as the youth approaches age 18 and beyond.</p>	
<p><b>5b.</b> Use of transition planning tools and readiness checklists facilitate the provider's ability to ensure that all age-appropriate transition issues have been addressed. Each action step must be completed in order, even if this means the provider has to schedule specific visits to initiate and complete steps missed earlier in the process in order to catch up before the next visit.</p>	<p><b>Have Age-Appropriate Transitions Issues Been Addressed?</b></p>	
<p><b>Initiate Follow-up Interaction</b></p>	<p><b>5c.</b> Focused tasks involving little detail or complexity can be addressed by the medical home care coordinator, medical provider, or other appropriate staff through telephone or electronic media. More complex issues may necessitate face-to-face office visits.</p>	
<p><b>6.</b> The provider is finished with the transition tasks for that specific interaction or visit; transition planning is an ongoing activity that occurs at every interaction.</p>		<p><b>Transitions Component of Interaction Complete</b></p>