

Health Care Transition

About Technical Assistance Briefs. The MCH Evidence Center provides ongoing technical assistance (TA) to Title V agencies related to the emerging evidence base, strategies, and measures related to many topics interconnected with National Performance Measures and other critical topics in MCH. *Technical Assistance Briefs* are an outcome of these TA sessions that are designed to act as *conversation starters* in thinking about programs that can be developed to address issues that affect women, infants, children, adolescents, youth, families, and communities. These briefs are not meant to be comprehensive; full analyses of the NPM topic areas are provided in [Evidence Analysis Reports](#).

The Center makes these customized briefs available during TA and on the program website to identify evidence-based/informed strategies, promising practices, examples of ESMs from the field and peer-reviewed resources. Please [contact us](#) if you would like us to develop a similar report for topics that you are working on.

Initial Query for this Brief. Identify measures and best practices around Health Care Transition.

Evidence-Based Strategy Measures

ESM: Program Integration. These ESMs have been chosen by other states. You can review the ESMs to see if any resonate with your goals. Evidence Center staff are available to talk through how you could modify select ESMs to serve your needs.

State	ESMs
AL	ESM 12.2: Percent of YSHCN enrolled in State CSHCN program who report satisfaction with their transition experience to adulthood.
AS	ESM 11.3: Percent of CSHCN families receive transition training.A
AZ	ESM 12.2: Number of pediatric providers registered for the GoT transition modules who already serve CYSHCN.
AZ	ESM 12.6: Number of providers receiving GoT transition training resources.
AK	ESM 12.1: Percent of PCP practices of transition age children (12 through 17) receiving Title V CSHCN services that participate in the Six Core Elements of Health Care Transition self-assessment
AK	ESM 12.2: Percent of key stakeholders and referral sources who participated in the Title V CSHCN Health Care Transition training with increased knowledge of Health Care Transition and Health Care Transition services provided by Title V CSHCN
AK	ESM 12.3: Percent of transition age CSHCN (ages 12 through 17) served by Title V CSHCN who received transition services and supports in the past 12 months from Title V CSHCN
AK	ESM 12.4: Number of School District Special Education Teachers/Professionals attending professional development training that complete a Title V Health Care Transition Readiness Assessment Survey
AK	ESM 12.5: Number of School-based Health Center Coordinators that complete a Title V Health Care Transition Readiness Assessment Survey with questions regarding the school district's health center
DC	ESM 12.1: Number of CSHCN provided with transition services
FL	ESM 11.4: Number of Adult Care Providers/ Practices that report accepting CYSHCN transitioning to adult care.
GA	ESM 12.2: Number of stakeholders, state agencies, and community partners that collaborate with the Department to improve health care transition for youth/young adults with or without special health care needs.

HI	ESM 12.1: Degree to which the Title V Children and Youth with Special Health Needs Section promotes and/or facilitates transition to adult health care for Youth with Special Health Care Needs (YSHCN), related to Six Core Elements of Health Care Transition 2.0.
IL	ESM 12.1: Percent of provider practices that were provided technical assistance on transition and have incorporated the six Core Elements of Transition into their practices
IL	ESM 12.2: Percent of DSCC program participants ages 12-21 with a transition goal included in the person-centered care plan
IN	ESM 12.2: Number of adult and pediatric providers who have received training in transition services and caring for CYSHCN.
IA	ESM 12.1: Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
KS	ESM 12.1: Percent of youth with special health care needs, ages 12 to 21, who have one or more transition goals achieved on their action plan by the target completion date
KY	ESM 12.1: Employ Health Care Transitions (HCT) Process Measurement tool towards assessing progress on implementation of Six Core Elements of Health Care Transitions statewide
LA	ESM 11.1: Number of health care providers trained on Medical Home, Care Coordination and Youth Health Transition
MD	ESM 12.1: Number of CYSCHN and their families who participate in health care transition planning activities
MA	ESM 12.1: Percent of youth ages 14 and older receiving services from the DPH Care Coordination Program who receive health transition information and support from their Care Coordinator
NV	ESM 12.1: Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition
NV	ESM 12.2: Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition
NJ	ESM 12.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service
NY	ESM 12.1: Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.
ND	ESM 12.1: Percentage of individuals ages 14 through 21 served in SHS multidisciplinary clinics that received a transition assessment.
ND	ESM 12.2: Number of educational opportunities provided to health care professionals/providers from Title V regarding health care transition.
ND	ESM 12.3: Number of educational opportunities provided to school personnel from Title V regarding health care transition.
ND	ESM 12.4: Percentage of families served by family support contracts who received education and / or training on healthcare transition.
MP	ESM 12.1: Percentage of students and/or parents who indicate increased knowledge about the importance of transition after presentations.
OH	ESM 12.1: Percent of CSHCN ages 12-17 enrolled in Children with Medical Handicaps with a transition plan in place
OK	ESM 12.1: The number of providers who address transition to adult health care in their practice
OR	ESM 12.1: Young adult with medical complexity/family participation in transition preparation appointments
PA	ESM 11.12: Number of youth age 14 and older enrolled in the Community to Home program who received a transition plan to transition to adult health care
PR	ESM 12.1: Percent of YSHCN who receive care at the RPCs and has completed a transition readiness assessment in Puerto Rico by September 2021-2025
PR	ESM 12.2: Percent of YSHCN at the CSHCN Program who has a transition action plan in place after completing a transition readiness assessment (4th core element of Got Transition).
SC	ESM 12.1: Percent of pediatric providers that use telehealth to assist CYSHCN transition to adult care
TN	ESM 12.2: Number of transition resource kits disseminated

TX	ESM 12.1: Percent of families of transition age youth with special health care needs receiving professional help with their child's transition to adulthood
TX	ESM 12.3: Decrease percent of families of transition-age youth who have not prepared for medical transition to adulthood
UT	ESM 12.1: Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.
UT	ESM 12.2: Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.
UT	ESM 12.3: Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.
VT	ESM 12.1: % of CYSHN that have had a transition planning meeting by their 18th birthday
VA	ESM 12.1 Number of providers in Virginia who have completed the transition training module.
WI	ESM 12.1: Percent of Regional Center information and referral staff who report competence in explaining youth health transition concepts
WI	ESM 12.2: Percent of participants trained on youth health care transition concepts who report a change in knowledge, skills, or intended behavior following the training
WI	ESM 12.3: Percent of systems or practices that have a transition policy or guideline (formal written commitment)

Evidence-Based Strategies – What Works for Health

The following programs have been identified as effective models related to Health Care Transition:

Title	Link	Category
Patient navigators	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/patient-navigators	Scientifically Supported

Evidence-Based Strategies – Innovation Hub

The following programs have been identified as effective models related to Health Care Transition:

Title	Link	Category
Texas Children's Hospital Healthcare Transition Planning Tool	https://amchp.org/wp-content/uploads/2021/05/Texas-Childrens-Hospital-Healthcare-Transition-Planning-Tool.pdf	Best
Oregon Youth Transition Program	https://amchp.org/wp-content/uploads/2021/05/Oregon-Youth-Transition-Program.pdf	Best
Got Transition's Six Core Elements of Health Care Transition in Medicaid Managed Care	https://amchp.org/wp-content/uploads/2021/05/Got-Transition.pdf	Promising
Transition Interagency Group Envisioning Realization of Self (T.I.G.E.R.S)	https://amchp.org/wp-content/uploads/2021/05/TIGERS_2015.pdf	Emerging
Youth and Young Adult Transition – Children's Medical Service	https://amchp.org/wp-content/uploads/2021/05/Youth-and-Young-Adult-Transition-Childrens-Medical-Service.pdf	Emerging

Resources for Increasing Workforce Capacity around Adolescent Transition of Care

Six Core Elements of Health Care Transition: <https://www.gottransition.org/six-core-elements/>
AMCHP's implementation toolkit for National Performance Measure 12: Percent of adolescents with and without special healthcare needs who received services necessary to make transitions to care. This toolkit contains examples of strategies state Title V programs can use to address National Performance Measure 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult care. Strategies are listed in these categories: (1) youth and family education and leadership development; (2) health care professional workforce development; (3) care coordination; (4) communications and social media; and (5) measurement and

assessment.

<https://create.piktochart.com/output/34444572-npm-12-implementation-toolkit>

Medicaid contract language to expand the availability of pediatric-to-adult transitional care. This document describes contract language options states can use to provide for the availability of pediatric-to-adult transitional care, in the areas of definitions, member services and education, provider networks, covered services, care coordination, and quality and evaluation. Appendices list actual 2018/2019 contract language on the same topics from selected states.

<https://www.thenationalalliance.org/publications/2020/9/11/medicaid-managed-care-contract-language-transition-care>

Incorporating pediatric-to-adult transition into NCQA patient-centered medical home

recognition: 2019 update: This resource is intended to facilitate the application of nationally-recognized transition tools to address specific criteria developed by the National Committee for Quality Assurance (NCQA) in their 2017 Patient-Centered Medical Home standards. Contents include NCQA criteria and guidance cross-walked with relevant sample tools. Topics include team-based care and practice organization, knowing and managing patients, patient-centered access and continuity, care management and support, care coordination and care transitions, and performance measurement and quality improvement. Descriptions of the tools are also provided.

<http://gottransition.org/resource/incorporating-hct-into-hcqa-2019>

Healthcare transition: Building a program for adolescents and young adults with chronic illness and disability. This book addresses aspects of transitioning from pediatric to adult health care for adolescents and young adults with chronic illness or disability. It includes a framework, tools, and case-

based examples to inform developing and evaluating a health-care-transition (HCT)-planning program that can be implemented regardless of an individual's disease or disability. Selected topics include defining successful transition, financing transition, special issues in transition, and models of HCT programs. One chapter provides an overview of the Dental Education in the Care of Persons with Disabilities Program at the University of Washington School of Dentistry.

<https://link.springer.com/book/10.1007%20%2F978-3-319-72868-1>

Health Care Transition: Technical Assistance Brief

Last Updated: July, 2022

Access other resources at <https://www.mchevidence.org>

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC31613, Strengthen the Evidence for Maternal and Child Health Programs, \$3.5 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.