Health Care Transition Training for Health Care Professionals

Part 1: Modules 1 - 5
Module 1: Introduction to Health Care Transition
Course Focus

Patients’ transition from pediatric to adult health care
Course Modules

Part 1

1. Introduction
2. Adolescent Development
3. Working with Caregivers
4. Assessing Transition Readiness
5. Patient Skill Development

Part 2

7. Insurance
8. Working with Adult Medicine
9. Care Transfer
10. Conclusion
Course Learning Objectives

- Define health care transition and its significance
- Identify challenges to transition
- Describe policies that affect transitioning youth
- Implement strategies to prepare patients & caregivers
Module 1 Learning Objectives

- Define health care transition
- Explain the importance of health care transition for patients
- Describe the current state of health care transition
Important Phrases

- Youth with Special Health Care Needs
  - YSHCN

- Parents and caregivers

- Adult medicine
  - Adult-oriented providers
What is Health Care Transition?
The purposeful, planned movement of adolescents and young adults, with or without special health care needs, from child-centered to adult-oriented health care systems.
Successful Transition

“The goal of a planned health care transition is to maximize lifelong functioning and well-being for all youth, including those who have special health care needs and those who do not.”

Preparation & Planning across ages 12-21
Increase self-management

Transfer between ages 18-21
Discrete event

Engagement in adult medical home
Provides framework for:

- All youth
- Enhanced planning activities for YSHCN
- Move from pediatric to adult model of care
Key Points for Youth

- Communicating with providers
- Medical decision-making
- Responsibility for self-care
- Advocating for themselves
Key Points for YSHCN

- Prepare to their fullest abilities
- Direct and manage care
- Adult medicine and social services
Key Points for Providers

- Developmentally appropriate
- Continuous
- Coordinated
Key Points for Caregivers

- Prepare patients to complete tasks
- Inevitable and healthy
- Child becomes decision-maker
Health Care Transition: Significance
Normative Development
## An Emerging Issue

### Children and Youth with Special Healthcare Needs, by age

<table>
<thead>
<tr>
<th></th>
<th>0-5 years old - percentage of CYSHCN</th>
<th>6-11 years old – percentage of CYSHCN</th>
<th>12-17 years old – percentage of CYSHCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide</td>
<td>20.8%</td>
<td>38.7%</td>
<td>40.5%</td>
</tr>
<tr>
<td>Florida</td>
<td>22.0%</td>
<td>36.3%</td>
<td>41.7%</td>
</tr>
</tbody>
</table>
Cystic Fibrosis

Median Predicted Survival Age, 1988-2012 In 5-Year Bands

- 40: 2008-2012
Down Syndrome

<table>
<thead>
<tr>
<th>1983 Life Expectancy</th>
<th>2014 Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 years</td>
<td>60 years</td>
</tr>
</tbody>
</table>
Transition & Common Conditions

- Autism
- ADHD
- Asthma
A National Priority

- Healthy People 2020
- Maternal and Child Health Bureau
- ADA/IDEA
- National Center for Health Care Transition Improvement
Up Next: Video Clip!

- Interview with patient, Jeff
- First of 2 videos in this module
Transition Importance: Patient Perspective
Health Care Transition: Evidence Base
Current State of Health Care Transition
Interactive Question

Have you discharged patients after they reach adulthood?

If yes, what factors have led to their discharge?
Common Outcomes

- Everything Stays the Same
- Mixed Transition
- Full Transition
- Dropping Out
Everything Stays the Same?

21-year-old patient
- Physiologically similar to an adolescent
- Brain still developing
- May rely on parent for insurance/financial management

38-year-old patient
- Physiological needs/risks different
- Completed biological development
- May support children or elderly parents
Mixed Transition

- Primary care transfers
- Specialty care remains pediatric
- Hospital care varies
Full Transition

- Primary care transfers
- Specialty care transfers
- Hospital care becomes adult-oriented
Dropping Out

From Pediatric Care

- Transition, without transfer
- Transfer to referral list
- Discharge without transition or transfer

From Adult Medicine

- Transfer without transition preparation
- Miss appointments, no follow-up
- Dissatisfied with new provider
Health Care Transition: Barriers
Barriers Providers Face

- How to broach topic
- Caregivers’ and patients’ fears
- Shortage of adult-oriented providers
Barriers Providers Create

- Abrupt transfer
- Promising not to discharge
- Directing communication to parent
Barriers for Youth
Barriers for Caregivers

- Fear
- Fear
- Fear
Up Next: Video Clip!

Patient interview
Transition Barriers: Patient Experience
Health Care Transition: In Practice
## The Transition Process

1. Envisioning a Future
2. Basic Knowledge
3. Health Care Practices
4. Medications & Equipment
5. Doctor Visits
6. Health Care Transition
7. Transition to Adulthood
8. Health Care Systems
## 6 Core Elements

<table>
<thead>
<tr>
<th>Transitioning Youth to Adult Health Care Providers</th>
<th>Transitioning to an Adult Approach to Health Care Without Changing Providers</th>
<th>Integrating Young Adults into Adult Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Pediatric, Family Medicine, and Med-Peds Providers)</em></td>
<td><em>(Family Medicine and Med-Peds Providers)</em></td>
<td><em>(Internal Medicine, Family Medicine, Med-Peds Providers)</em></td>
</tr>
<tr>
<td><strong>1.</strong> Transition Policy</td>
<td><strong>1.</strong> Transition Policy</td>
<td><strong>1.</strong> Young Adult Transition and Care Policy</td>
</tr>
<tr>
<td><strong>2.</strong> Transition Tracking and Monitoring</td>
<td><strong>2.</strong> Transition Tracking and Monitoring</td>
<td><strong>2.</strong> Young Adult Tracking and Monitoring</td>
</tr>
<tr>
<td><strong>3.</strong> Transition Readiness</td>
<td><strong>3.</strong> Transition Readiness</td>
<td><strong>3.</strong> Transition Readiness/Orientation to Adult Practice</td>
</tr>
<tr>
<td><strong>4.</strong> Transition Planning</td>
<td><strong>4.</strong> Transition Planning/Integration into Adult Approach to Care</td>
<td><strong>4.</strong> Transition Planning/Integration into Adult Practice</td>
</tr>
<tr>
<td><strong>5.</strong> Transfer of Care</td>
<td><strong>5.</strong> Transfer to Adult Approach to Care</td>
<td><strong>5.</strong> Transfer of Care/Initial Visit</td>
</tr>
<tr>
<td><strong>6.</strong> Transfer Completion</td>
<td><strong>6.</strong> Transfer Completion/Ongoing Care</td>
<td><strong>6.</strong> Transfer Completion/Ongoing Care</td>
</tr>
</tbody>
</table>
Resource: ACP Tools

Condition-Specific Tools

The ACP Pediatric to Adult Care Transitions Toolkit contains disease-specific tools that are critical for the young adult in transition to be aware of and understand in order to successfully achieve optimal self-care as an emerging adult.

Each set of tools was required to include at least the three minimum elements described below, which have been customized to include disease/condition-specific elements that are an important part of the transition process for emerging adults in learning self-care. Practices utilizing these tools should also consider incorporating some of the generic tools from the Got Transition Six Core Elements in establishing a process and procedures for pediatric patient transitioning to adult care. The disease/condition-specific sets of tools found below on this page contain the following customized...
Health Care Transition Preparation for Youth and Young Adults with Special Health Care Needs in Florida

**Step 1**
Provide age-appropriate counseling and transition materials to youth and family.
Identify APD eligibility and education needs. See local 2-1-1 Helpline for other social services.

**Step 2**
Ensure Step 1. Assess transition readiness (TRAQ or other tool). Explore post-high school options; identify decision-making needs. Establish timeline for transfer to adult primary and subspecialty care.

**Step 3**
Ensure Steps 1 and 2. Identify insurance coverage, adult service and employment needs. Transfer to adult primary and subspecialty care.

- **Is patient 12-14 years?**
  - Yes: Provide age-appropriate counseling and transition materials to youth and family. Identify APD eligibility and education needs. See local 2-1-1 Helpline for other social services.
  - No: Next step.

- **Is patient 15-17 years?**
  - Yes: Ensure Step 1. Assess transition readiness (TRAQ or other tool). Explore post-high school options; identify decision-making needs. Establish timeline for transfer to adult primary and subspecialty care.
  - No: Next step.

- **Is patient 18-21 years?**
  - Yes: Ensure Steps 1 and 2. Identify insurance coverage, adult service and employment needs. Transfer to adult primary and subspecialty care.
  - No: Next step.

- **Is patient eligible for MedWaiver program?**
  - Yes: See handout on Medicaid Waiver programs. For patients with I/DD, APD does intake; send all patient documents to APD. Patient is put on waitlist for APD’s Home and Community-Based Medicaid Waiver. Patient may come off waitlist if urgent/emergent.
  - No: Next step.

- **Does patient have IEP?**
  - Yes: See handout on Medicaid Waiver programs. For patients with I/DD, APD does intake; send all patient documents to APD. Patient is put on waitlist for APD’s Home and Community-Based Medicaid Waiver. Patient may come off waitlist if urgent/emergent.
  - No: Next step.

- **Is patient eligible for VR?**
  - Yes: Starting at age 15, send referral with patient information. VR sends information to correct geographic area for placement with VR counselor. Patient must be looking for work to receive services. Patient may be put on waiting list (handout).
  - No: Next step.

- **Needs help with decision-making?**
  - Yes: Assist with age of majority issues before patient’s 18th birthday (advance directive, levels of guardianship, voting, other legal needs). Refer youth/family to Florida Legal Services for legal aid. Refer patient to local Center for Independent Living for additional guidance. (handout).
  - No: Next step.

- **Insurance patient will have as adult?**
  - Yes: Discuss SSI/private and public insurance options with youth/family. Provide 411 Insurance Guide (or handout) and local contact information. Help find providers for patients; see Young Adult Health Services Directory. Call physician offices to see whether they will accept patient.
  - No: Next step.

**Determinant of Services Needed**

**Glossary:**
- **APD:** Agency for Persons with Disabilities
- **CMS:** Children’s Medical Services, Department of Health
- **I/DD:** Individuals with intellectual or developmental disabilities
- **IEP:** Individual Educational Plan
- **TRAQ-5.0** Transition Readiness Questionnaire 5.0 (or use other checklists)
- **VR:** Vocational Rehabilitation Program

*Handouts are available in English, Spanish and Haitian Creole at www.FloridaHATS.org"
Discuss Health Care Transition with Patients & Families
Start Early!
Age Appropriate

Is patient 12-14 years?

Yes

Step 1
Provide age-appropriate counseling and transition materials to youth and family. Identify ADP eligibility and education needs.

No

Is patient 15-17 years?

Yes

Step 2
Ensure Step 1. Assess transition readiness (TRACQ or other tool). Explore post-high school options. Identify service and employment needs.

No

Is patient 18-21 years?

Yes

Step 3
Ensure Steps 1 and 2. Identify insurance coverage, adult service and employment needs.
When to Discuss

- Well visits
- Chronic condition management
- During health & stability
Interactive Question

When will you discuss health care transition with your patients?

Slide will automatically advance in 1 minute!
Health Care Transition: Resources
Florida Health and Transition Services

Welcome to the FloridaHATS Web site! FloridaHATS is a program of Florida Department of Health, Children's Medical Services Managed Care Plan (CMS Plan). Our mission is to ensure successful transition from pediatric to adult health care for all youth and young adults in Florida, including those with disabilities, chronic health conditions or other special health care needs. To learn more about our program, visit About Us.

Tool Box

Our health care transition tool box contains documents and links to a variety of local, state and national resources. Materials for youth, families and professionals are organized in these categories:

- For Health Care Practitioners
- For Youth & Families
- Education & Training for Professionals
- Health Insurance & Financing
- Independent Living
- Secondary & Post-Secondary Education
- Advocacy
- Decision-Making & Guardianship
- Service Delivery & Models of Care
- Juvenile Justice System

For Health Care Practitioners

- For Youth & Families

Independent Living

- Decision-Making & Guardianship

Education & Training for Professionals

- Service Delivery & Models of Care

Health Insurance & Financing

- Advocacy

Secondary & Post-Secondary Education

- Juvenile Justice
Regional Coalitions

- Tampa-Hillsborough County
- Northeast Florida
- Panhandle Area
- South Florida
CMS Plan

- Facilitate communication between among providers, with educators, and with community-based agencies

- Support for patients

- Assistance for providers
Got Transition aims to improve transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and youth and families.

News & Announcements

Got Transition’s New Home
With funding support from the Maternal and Child Health Bureau, The National Alliance to Advance Adolescent Health is the new “home” for Got Transition’s Center for Health Care Transition Improvement. [more>]

Six Core Elements 2.0
Got Transition launches its new website and releases the new Six Core Elements (2.0) with corresponding clinical tools and measurement resources. [more>]

Transition as MCHB National Performance Measure
Transition from pediatric to adult health care has been proposed as one of the Maternal and Child Health Bureau’s national performance measures. [more>]

Employment & Transition Partnerships
Got Transition has formed a new partnership with the Department of Labor’s Office of Disability Employment Policy and the HSC Foundation’s National Youth Transitions Initiative. [more>]

Health Care Providers
Find out about how to implement health care transition quality improvement in your practice or plan using the new Six Core Elements of Health Care Transition (2.0). Download accompanying clinical resources and measurement tools for use in any setting.

Youth & Families
Hear what young adult and parent experts have to say about common transition questions and discover new resources to make this process work easier.

Researchers & Policymakers
Find new transition policy developments, research and measurement approaches, and federal and state transition initiatives.
Summary Points

- Transition is a process
- Best started early
- For ALL youth
Summary of Tools

Health Care Transition Training for Health Care Professionals
2014 Course Release

Course Toolkit

Module 1. Introduction to Health Care Transition

1. Florida Algorithm

2. Joint Statement

3. 6 Core Elements
   http://www.gottransition.org/6-core-elements
Citations


4. Six Core Elements of Health Care Transition 2.0 – Transitioning Youth to an Adult Health Care Provider. 2014. Got Transition/National Center for Health Care Transition Improvement.


