# Florida Strategic Plan for Health Care Transition

*11/1/2010*

## Foundation

### *Our Mission*

To ensure successful transition from pediatric to adult health care for all youth and young adults (Y/YA) in Florida, including those with disabilities or special health care needs.

### *Our Core Values*

1. Y/YA and their families will participate in decision-making at all levels, and be satisfied with the services they receive.

2. Y/YA will receive coordinated, ongoing, comprehensive care within a medical home.

3. Y/YA will have adequate private and/or public insurance to pay for the services they need.

4. Y/YA will be continuously screened to detect other conditions and prevent secondary disabilities.

5. Community-based systems will be integrated, collaborative, and organized so Y/YA and their families can use them easily.

6. Y/YA will receive services that meet their physical, social, and developmental needs.

## Strengths

### *What we do best*

Florida leaders have been at the forefront in recognizing challenges faced by youth as they age out of pediatric health care and developing innovative programs to meet the needs of emerging adults with disabilities or special health care needs.

## Key Strategies

### *How we will get there*

**Leverage the infrastructure of Children's Medical Services (CMS) and its federally mandated responsibility for health care transition planning to establish a state Office of Health Care Transition within CMS that:**

- Provides leadership, expertise, and resources to create and sustain a statewide comprehensive system of care.
- Supports and monitors local public/private transition coalitions.
- Is guided by a statewide Advisory Council comprised of Y/YA, families, key state agencies, advocacy organizations, professional associations, and other stakeholders.

## Goals and Statewide Objectives

### *Health Care Financing*

**1 Health Care Benefits. Y/YA obtain and maintain adequate, affordable health insurance.**

1.1. Develop a technical assistance guide to help identify insurance options available to Y/YA.
1.2 Implement a Medicaid Buy-In option

**2 Service Compensation. Insurers reimburse providers for services needed to effectively care for Y/YA.**

2.1 Work with Medicaid program to implement medical homes for Y/YA.
2.2 Work with Medicaid program and private insurers to develop policies relating to co-management of Y/YA.
2.3 Advocate for insurance payments to reflect the time and resources required for appropriate care of Y/YA.
2.4 Accept federal Medicaid matching funds for education and outreach to adults with Sickle Cell Disease.
2.5 Extend CMS Network coverage for Y/YA to age 25 or 29.

### *Education and Training*

*Policy Makers and Funders* *Education/Allied Professionals* *Health Care Professionals* *Y/YA and Families* *Students in Training*

**3 Material Development. Develop, adapt, and disseminate health care transition educational and training materials.**

3.1 Identify educational and training needs.
3.2 Coordinate development or adaptation of education and training materials for each target market.
3.3 Utilize existing state and community networks and organizations to assist in production and dissemination of materials.

**4 Accredited Training. Provide multi-modal training approved for CME/CEU credit at no cost to the individual.**

4.1 Provide accredited health care transition- specific training for professionals and families.
4.2 Advocate for mandatory disability-related training for health care professionals.

**5 Outreach and Promotion. Engage high visibility spokespersons to communicate messages related to health care transition.**

5.1 Engage a physician champion for outreach to the health care community; explore feasibility of Surgeon General.
5.2 Engage a Y/YA for outreach to his/her peers and families.

### *Services and Models of Care*

**6 Regional Coalitions. Organize local public/private health care transition coalitions.**

6.1 Develop planning guidelines to assist in local coalition-building.
6.2 Identify geographic regions for local coalitions.
6.3 Pilot local coalition development in 3 selected regions, 2 urban and 1 rural.
6.4 Identify external funding sources to support expansion of local coalition development; see Infrastructure.

**7 Information Clearinghouse. Establish a centralized, searchable database of providers, best practices, and resources.**

7.1 Collect clinical guidelines in treatment of chronic disease and pediatric onset conditions.
7.2 Collect patient-centered health care tools.
7.3 Identify model health care transition programs that local coalitions can replicate based on their needs and resources.
7.4 Identify resources to assist Y/YA with employment, benefits, independent living, decision-making options, housing.
7.5 Create and maintain database of adult primary care physicians and specialists.

**8 Evaluation. Develop and monitor performance measures at the state and local levels.**

8.1 Identify process, impact, and outcome measures for the state, local coalitions, organizations, and Y/YA.
8.2 Consider MCHB core outcomes for CYSHCN as well as current CMS health care transition indicators.

### *Infrastructure*

**9 Funding and Policy. Identify policy and secure funds for plan implementation.**

9.1 Advocate for increased state funding from general revenue.
9.2 Advocate for increased federal funding of Title V Block Grant.
9.3 Recommend new health care transition objective in HP2020 Plan.
9.4 Identify external funding to support expansion of local coalitions.

**10 Stakeholder Collaboration. Coordinate plan development and implementation across agency and stakeholder groups.**

10.1 Share legislative report and solicit participation from key agencies and organizations.
10.2 Coordinate cross-organization advocacy for improved systems and quality of life for Y/YA.
10.3 Increase participation of Y/YA and families in planning and implementation.

**11 Governance. Establish operational and oversight systems for State Office of Health Care Transition.**

11.1 Identify and hire program staff.
11.2 Establish a statewide Advisory Council.

## Vision

### *What our State will look like*

All youth in Florida, including those with disabilities or special health care needs, will successfully transition to all aspects of adult life, including adult health care, work, and independence.

## Implementation

### *How we make strategy a habit*

The Task Force, CMS's Office of Health Care Transition, FDDC, and other partners will:

- Communicate the Strategic Plan to all stakeholders throughout the state.
- Involve stakeholders in the creation of objectives and action items to support goals.
- Hold parties responsible for achievement of assigned objectives.
- Monitor the plan quarterly.
- Hold regularly scheduled teleconference calls to report on progress.
- Change the plan if something is not working; take corrective action or move to build on success.
- Link strategy to performance.
- Celebrate when goals are reached.

**www.FloridaHATS.org**

Graduating from pediatric to adult care
Florida HATS
Health and Transition Services

Florida Developmental Disabilities Council

Florida Department of Health

cms network
Children's Medical Services