Improving Transition from Pediatric to Adult Health Care

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Health Care Transition (HCT)

- **Transfer**: event, physical transfer from pediatric to adult care
- **Transition**: process, transition from childhood to adulthood

Source: Blum et al., 1993
Why is HCT Important?

“A poor transition in health care can threaten health and undermine other transitions, for example in education, work, social relationships, and independent living.”

Source: Institute of Medicine, 2007
Factors Impacting HCT

- Youth development & family support
- Health insurance
- Availability of developmentally appropriate care by adult providers
- Preparation by pediatricians
<table>
<thead>
<tr>
<th>Transition services</th>
<th>For nearly all or most</th>
<th>For some</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist with referral to specific family or internal medicine physicians</td>
<td>47</td>
<td>33</td>
</tr>
<tr>
<td>Assist with establishing referral to specific adult specialists</td>
<td>45</td>
<td>32</td>
</tr>
<tr>
<td>Discuss consent and confidentiality issues prior to age 18</td>
<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Assist with medical documentation for program eligibility (e.g., Supplemental Security Income, vocational rehabilitation, college)</td>
<td>32</td>
<td>34</td>
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<tr>
<td>Discuss assent to care issues prior to age 18</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td>Assist in creating a portable medical summary</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>Support family or internal medicine physicians with education and consultation</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Assist with identifying options to maintain health care insurance after age 18</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Create an individualized health care transition plan</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>Provide adolescents/parents with an educational packet or handouts</td>
<td>11</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: AAP Periodic Survey of Fellows #71, 2008
How Are We Doing?

- National Survey of Children with Special Health Care Needs (every 4 years)
  - State and National Level Reporting

- 4 questions — anticipatory guidance for YSHCN ages 12-17 about:
  - Changing health needs in adulthood
  - Transition to adult health provider
  - Insurance needs into adulthood
  - Youth encouraged to take increased responsibility for care
State-Level Performance

**Florida**: 37%

**Nat’l Avg**: 40%

**Range**: 22% - 53%

Goals for Transition

- Manage their own health
  - Disease self-management
  - Prevention, substance use, safety, sexuality

- Appropriately access adult primary care, specialists, therapies, equipment, supplies, etc.

- Access to adequate and continuous health insurance

- Implement education and vocational goals

Integrated Model of HCT
Population Model of HCT

Chronic Condition Care Coordination

Enhanced Planning

Assessment and Transition Plan

Information & Referral

Pediatric Care System

All Youth

YSHCN

Adult Care System
AAP/ACP/AAFP Transitions Clinical Report

- Published in Pediatrics, July 2011
- Provides framework for developmentally appropriate transition services:
  - For all youth
  - Enhanced planning activities for YSHCN
  - Move from pediatric to adult model of care at age 18-21, even if there is no transfer (e.g., Med Peds, Family Medicine)
  - Within context of a medical home
Facilitating HCT

- Maintain list/registry of transitioning patients
  - Document, monitor HCT activities (e.g. EMR)

- Establish and share HCT practice policy
  - Post them in the office—stimulate discussion

- Encourage self-determination and independence
  - Fill prescriptions, take medication, schedule appointments, decision-making, etc.
  - Talk directly to youth, meet separately w/youth
Facilitating HCT

- Assess readiness for transition
  - Focus on skills needed to be successful
- Maintain an up-to-date health care summary
- Help patients access adult primary and specialty care providers
Facilitating HCT Enhanced Activities for YSHCN

Social Supports

- Coordinate linkages to community-based adult services - Education, Vocation

- Review legal rights/ responsibilities before age 18
  - Discuss guardianship or decision-making options

- Encourage positive social networking experiences with other teens who have similar life challenges
Health Care Transition Planning Algorithm for All Youth and Young Adults Within a Medical Home Interaction

Row 1: Medical Home Interaction

1. Medical Home Interaction for Patients ≥ 12 Years of Age

Row 2: Age Ranges

2a. Is the Patient 12–13 Years of Age?
2b. Is the Patient 14–15 Years of Age?
2c. Is the Patient 16–17 Years of Age?
2d. Is the Patient ≥ 18 Years of Age?

Row 3: Action Steps for Specific Age Ranges

3a. Yes → STEP 1: Discuss Office Transitions Policy With Youth & Parents
3b. Yes → STEP 2: Ensure Step 1 Is Complete, Then Initiate a Jointly Developed Transition Plan With Youth & Parents
3c. Yes → STEP 3: Ensure Steps 1 & 2 Are Complete, Then Review & Update Transitions Plan & Prepare for Adult Care
3d. Yes → STEP 4: Ensure Steps 1, 2, & 3 Are Complete, Then Implement Adult Care Model

Row 4: Determination of Special Needs

4. Does Patient Have Special Health Care Needs?

Row 5: CCM and Follow-up

5a. Yes → Incorporate Transition Planning in Chronic Condition Management
5b. Yes → Have Age-Appropriate Transitions Issues Been Addressed?
5c. Yes → Initiate Follow-up Interaction

Row 6: Interaction Complete

Transitions Component of Interaction Complete

Legend:
- Start
- Action/Process
- Decision
- Stop

APPENDIX 1

※The federal Maternal and Child Health Bureau defines children with special health care needs as: “Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.” (Hoffman ML, Arango P, Fox M, et al. A new definition of children with special health care needs. Pediatrics 1998;101(2) at 113-118.)
Implementation Tools
National Health Care Transition Center
HCT Learning Collaboratives
www.gottransition.org
Florida’s clearinghouse for health care transition information at [www.FloridaHATS.org](http://www.FloridaHATS.org)
Florida HATS

- Program established in 2009
- Positioned in the Department of Health, Children’s Medical Services (state Title V program)
- Administered by USF Peds
- Implement a state HCT plan
For Health Care Providers

If you provide health-related services to young adults with chronic health conditions or disabilities, please be sure you are listed in our Health Services Directory for Young Adults. Visit Submission Instructions to add or update your program information.

Training for Professionals

FREE CME/CEU Credits!

A new training program is now available for free CME/CEU credits through Florida Gulfcoast AHEC. See our brochure on the Health Care Transition Training Program developed by the Institute on Child Health Policy at the University of Florida, and get started today by visiting www.aheceducation.com.

Transition Assessment

- TRAQ 4.1 (JaxHATS transition readiness tool)

Medical Summary Forms

- Health Care Transition Summary (2 page summary to carry at all times)
- Electronic Care Plan (University of Wisconsin)
- Electronic Transition Information Form (HealthyTransitionsNY)
- My Health Passport (Sickkids Good 2 Go Transition Program)

General Checklists & Care Plans

- Transition Timeline (from Shriner's Hospitals and University of Washington)

Workbook from the Institute of Child Health Policy at University of Florida and CMS:

- Workbook for Ages 12-14 (English)
- Workbook for Ages 12-14 (Spanish)
- Workbook for Ages 15-17 (English)
- Workbook Ages 15-17 (Spanish)
- Workbook for Ages 18+ (English)
- Workbook for Ages 18+ (Spanish)
Welcome to JaxHATS

Transition to adulthood is a time of change and one that takes preparation. For teens and young adults with disabilities and special health care needs there are many complex issues to learn about. Through this time of transition, it is important to stay as healthy as possible, since good health promotes success in the adult roles of employment, lifelong learning, and independent community living.

The transition from pediatric health care to adult-oriented health care can be very complicated for people with disabilities and chronic health conditions. The Jacksonville Health and Transition Services (JaxHATS) clinic was created to help make this transition easier. JaxHATS serves teens and young adults, ages 16-26, with chronic medical or developmental problems. Services are open to residents of Duval, Nassau, Baker, Clay, and St. Johns counties in Florida. For immediate assistance, please call us at (904) 244-9233.

Explore this Web Site
- About JaxHATS
- Youth & Families
- Youth Only
- Parent’s Corner
- Health Care Providers

New Location
- Please note our new office location and phone numbers.
  - Office Location and Phone Numbers »
Welcome

This Transition Toolkit was designed to provide a step-by-step approach to accessing resources that will help you with transition from pediatric care to adult care. The toolkit is designed for pediatric providers, other health care personnel (e.g., social workers, nurse care coordinators) and patients & families. The resources provide guidance or information to support youth and families during transition to adulthood and to adult health care. You will be asked a series of questions that will help determine which resources be most useful to you (depending on your role) to support the transition process.

Let's Get Started!

If you are a returning user, please use the login form at the right to complete and/or review your Transition Toolkit. If you are a first time user, please register to create a new account.
Instructions: Please select one the following that best describes you. You will then be asked a series of questions. Resources will be provided to you based on your answers.

Ready? Let's get started!

Which of the following best describes you?

Please select one of the following:

<table>
<thead>
<tr>
<th>Type</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Provider</td>
<td>Transition Toolkit Available</td>
</tr>
<tr>
<td>Youth and Caregiver</td>
<td>Transition Toolkit Available</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Transition Toolkit Available</td>
</tr>
<tr>
<td>Teacher</td>
<td>Transition Toolkit Available</td>
</tr>
</tbody>
</table>
# Medical Provider

Your Transition Toolkit is a collection of resources provided to you based on the answers you supplied from the questionnaire. Answers can be changed at any time by selecting the appropriate question below.

## Your Transition Toolkit

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>Answer</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you have a Transition Policy established in your practice or facility?</td>
<td>No</td>
<td>[Download Transition Policy (DOC)]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[Download Transition Policy (PDF)]</td>
</tr>
<tr>
<td>2</td>
<td>Do you have a checklist or method that helps patients through the transition process?</td>
<td>No</td>
<td>• [Transition Checklist for Providers (PDF)]</td>
</tr>
<tr>
<td>3</td>
<td>Do you currently provide your patients with a portable health summary after each visit?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you currently use a Transition Readiness (TRAQ 4.1) Assessment Tool?</td>
<td>No</td>
<td>• [Transition Readiness (TRAQ 5.0) Assessment Tool (PDF)]</td>
</tr>
<tr>
<td>5</td>
<td>Age range of patients?</td>
<td>No Answer</td>
<td>NA</td>
</tr>
</tbody>
</table>
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 educational needs. See local 2.1.1 Helping for other social services.

**Step 2:** Ensure Step 1. Assess transition readiness (see TRAQ-5.0). 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.

**Determinant of Services Needed**

- **Is patient eligible for APD?**
  - No
    - **Does patient have IEP?**
      - No
        - **Is patient eligible for VR?**
          - No
            - **Needs help with decision-making?**
              - Yes
                - Discuss SSI/private and public insurance options with youth/family. Provide 411 Insurance Guide 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
                - **Insurance patient will have as adult?**
                  - Yes
                    - **Start at age 15, send referral with patient information.**
                      - VR sends information to contact group, support area for placement with VR counselor. Patient may be looking for work to receive services. Patient may be on waiting list.
                    - **Assist with age of majority issues before patient's 18th birthday (advocacy, legal guardianship, voting other legal needs).**
                      - Refer youth/family to Florida Legal Services or legal aid. Refer patient to local Center for Independence Living for additional guidance.
                  - No
                    - **Discuss SSI/private and public insurance options with youth/family. Provide 411 Insurance Guide 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.**

**Care Coordination Support**

- **Have age appropriate transition issues been addressed?**
  - No
    - **Initiate follow-up interaction.**
  - Yes
    - Transition component of interaction complete.

**Glossary:**

- **APD:** Agency for Persons with Disabilities
- **CMS:** Children's Medical Services, Department of Health
- **IEP:** Individual Educational Plan
- **TRAQ-5.0:** Transition Readiness Questionnaire 5.0 (or use other checklists)
- **VR:** Vocational Rehabilitation Program

Graduating from pediatric to adult care

FloridaHATS
Health and Transition Services
www.FloridaHATS.org

9/1/12
Health Services Directory for Young Adults

Use the form below to search for health care programs and providers in your area that serve young adults, including those with disabilities or chronic health conditions.

Providers: For instructions on adding a service to our service directory or updating an existing entry, please visit our Submission Instructions page.

Disclaimer: A listing in this directory does not imply an endorsement from FloridaHATS, Florida Developmental Disabilities Council, Florida Department of Health, or Children’s Medical Services. The information is solely for your convenience in locating services from those available in your area. Individuals should perform their own research of any organization they choose. If the service is covered on an insurance plan, first check the plan’s provider network. However, if you believe a particular listing in this directory does not meet our criteria of serving young adults with chronic health conditions or disabilities, please contact us here.

Related Service Directories in Florida:
- Project 10’s Florida District Resource Directory
- Health Resource Directory for Persons with Intellectual Disabilities in Florida
- Find-a-Ride Florida Resource Directory
- CMS Provider Search
- Where To Find Help in Florida

More Info >

Search by: Categories AND/OR Keyword(s)

City, State, County: -- Any City --

County: -- Any County --

Health Category: -- Any Health Category --

Search by Keyword(s):

Submit Query  Reset
Resources

Insurance

Guardianship

HEALTH CARE TRANSITION AND DECISION MAKING

For a young person who has intellectual disabilities or has a health care transition, often raises questions for health care providers and families about guardianship. This brief provides a high-level look at guardianship and other decision-making supports as well as resources that will provide more in-depth information.

Guardianship Issues

Reaching the age of 18 — Opportunities and Challenges for Young Adults with Disabilities

Breathing the age of majority (18 years), independent status, and responsibilities come with the territory, and, unfortunately, that’s no longer a “tiger.” As the young person takes on the rights and responsibilities that come with their transition, the family needs to be prepared to continue their support.

Decision Making — A Skill that Requires Practice and a Variety of Experiences

Decision-making is a learned skill. Children and youth who have a support and assistance planning what to wear, eat, and other social activities, will gradually become more independent. This skill will evolve over time. As the young person matures, they will be able to make decisions that affect their personal health and well-being.

Adapted Bright Futures Patient Handout

Links:

www.FloridaHATS.org
www.Project10.org
www.GotTransition.org
www.RehabWorks.org
www.211AtYourFingertips.org
10 Steps to Successful Health Care Transition

Success in the classroom, within the community and on the job requires that young people stay healthy. The best ways to stay healthy are to understand your health, participate in health care decision making, and receive age-appropriate care. Here are 10 ways to ensure a smooth transition from pediatric to adult health care for teens and young adults with disabilities or chronic health conditions.

1. **Start early!** Begin preparing for transition even when very young, like starting a health summary and talking about health needs.

2. **Focus on responsibility for health care.** Taking responsibility for health care should be based on age and abilities. Become more independent by learning the skills for managing health care, like scheduling appointments, arranging transportation, taking medication, filling prescriptions, and talking to doctors.

3. **Create a health summary.** Put important information about personal health in one place, including medications and plans for an emergency.

4. **Create a health care transition plan.** Work with your pediatric provider to develop a written health care transition plan that includes future goals, services that will be needed, who will provide them, and how they will be paid for.

5. **Maintain wellness.** Support good habits that will continue into adulthood! Talk about risky behaviors such as alcohol use and smoking as well as sexuality and relationships. You can ask to speak to your physician alone.

6. **Know options for health insurance and public assistance programs in adulthood.** If you’re unsure about eligibility, it’s always best to go ahead and apply.

7. **Find adult providers.** If still in the care of pediatric providers, identify a primary care physician and specialists (including mental health professionals) who work with adults.

8. **Include health in other areas of transition.** Ask your primary care physician to provide documentation of medical conditions and special health care needs for other programs or agencies, as needed.

9. **Integrate health care transition activities in the student’s Individualized Education Plan (IEP) or 504 Plan.** Consider self-determination and self-advocacy skills, understanding personal health conditions and needs, and health care self-management skills.

10. **Learn about other community services and supports for adults.** Be knowledgeable about rights and responsibilities at age 18!

Visit www.FloridaHATS.org to find resources and services. Become a fan on Facebook and share your health care transition experience!
Transition 2 Go

Health Insurance

This is the first in a series of informational bits called Transition 2 Go. This series will include tips and resources about highlighted health care transition issues that you can share with you and one, wherever you are.

The first issue of Transition 2 Go focuses on health care coverage for transitioning adolescents and young adults. It is a timely topic given the U.S. Supreme Court’s recent decision to uphold major portions of the Affordable Care Act (ACA).

One of the biggest barriers to receiving appropriate health care among young adults is access to adequate health care coverage. Many out-of-pocket costs, lack of preparation and knowledge about available insurance options can contribute to critical lapses in coverage during early adulthood. The ACA improves the importance of medical homes in assisting patients to identify and access health insurance. The assistance is essential for patients preparing to transition to adult systems, especially for youth with special health care needs.

Just the Facts: The ACA’s Health Insurance for Young Adulthood Ages 19-25 in Florida provides comprehensive, Florida-specific information about insurance options. In the first issue of young adults, the 8-page guide outlines coverage options for individuals of all ages, including those with disabilities or chronic health conditions. A hard copy (English only) can be downloaded in English, Spanish and Haitian Creole from the Florida HCIS website at www.FloridaHCIS.org/Young (Adolescents).

In addition to descriptions of various private and public insurance plans, the guide identifies locally and programs for low-income residents, such as those offered in Hillsborough, Pinellas, Dade, Palm Beach and Polk Counties. The map on the inside cover gives a brief snapshot of the range of options currently available. Florida.

School to Work Transition

Vocational Rehabilitation

Most teens and young adults look forward to having a job and being independent. For young Floridians with disabilities whose goals include employment, the Florida Department of Education’s Division of Vocational Rehabilitation (VR) can provide critical support services. This federal-state program works with people who have physical or mental disabilities to prepare for, gain and/or retain employment.

Transition planning for individuals whose health conditions interfere with their ability to work should address eligibility for an array of VR programs, including the School to Work Transition program. The School to Work Transition program specifically helps students ages 16-22 prepare for employment and adult life. VR transition activities can help students enter training, continue education, and or find a job after leaving high school.

Any student with a disability may be eligible for VR services starting at age 16. For students who receive special education services, schools often take the lead in referral to VR as part of the student’s transition Individualized Education Plan (IEP). However, having an IEP is not a VR eligibility requirement. Health care professionals can help assure that all youth people with disabilities and their families are aware of VR as a potential source of services and support, and facilitate access by making referrals as needed.

Students who may benefit from VR services should apply at least 2 years before leaving high school, e.g., apply at age 16 if leaving high school at age 18. VR can also assist students with community work experience while they are still in high school. Applications can be downloaded at www.rehabflorida.org (click on VR Office Directory). To learn more about the School to Work Transition program, visit www.rehabflorida.org/Docs/SchooltoWork.pdf.

For more information about this topic, contact Janet Hess at Jhess@health.usf.edu or (813) 229-4604.

September 2012
Training for Health Care Professionals

Are you a professional looking for FREE continuing education credits on a health care topic that really matters to your adolescent and young adult patients and their families?

Health Care Transition Training Program

Training Program Overview
This training program includes information about how professionals can help prepare youth with chronic health conditions and disabilities for their eventual transition from pediatric to adult health care.

Contents of Module 1:
- Introduction to Juvenile Care
- Ensuring Successful Transitions for Patients to Adult Health Care
- What is Health Care Transition?
- HTC and Emerging Issues
- Transition Stages and Issues
- "The Story"
- Policies and Practices of Health Care Providers and Facilities
- Pediatric and Adult Care: Transitions Across Different Cultures
- Transition and Health Outcomes
- Transition in Education
- Transition in Vocational Rehabilitation
- Legal Rights of 16-Year-Olds

Contents of Module 2:
- College and Beyond
- Developmental Stages of Health Care and Children/Adulthood
- Professional Relationships
- Therapeutic Transition of Chronic Care
- Transition Planning Guide
- Transition Resources
- Perspectives for Youth and Young Adults for Decision and Healthcare Provider
- Transition Resources of the Board of Child Health Policy, University of Florida

Accreditation
The four-hour long Health Care Transition Training Program is broken down into two one-hour modules. The accreditation statements below apply to each module for a total of four (4) contact hours.

Pharmacists
- This activity has been planned and implemented in accordance with the Standards of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Florida AHEC Network, University of Florida College of Health and Sciences, Florida Department of Health, and the Florida Medical Association. The Florida AHEC Network is accredited by the Florida Medical Association to provide continuing medical education for physicians.

The Florida AHEC Network designates this educational activity for a maximum of 2.0 AMA PRA Category 1 Credits. Each physician should claim credit commensurate with the extent of their participation in the activity.

CERTIFIED NURSES MGT.
- This activity has been planned and implemented in accordance with the Standards of the National Commission for Certifying Agencies (NCCA) through joint sponsorship of the Florida AHEC Network, University of Florida College of Health and Sciences, Florida Department of Health, and the Florida Medical Association. The Florida AHEC Network is accredited by the Florida Medical Association to provide continuing nursing education for nurses.

The Florida AHEC Network designates this educational activity for a maximum of 2.0 contact hours for each one-hour module.

The Florida AHEC Network designates this educational activity for a maximum of 2.0 contact hours for each one-hour module.

The program meets the requirements for up to 2.0 continuing education credits for each one-hour module.

Social Workers
- This program is approved as a continuing education provider by the Florida Board of Social Work Examiners number #58-1250. The program meets the requirements for up to 4.0 contact hours for each one-hour module.

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www.aheceducation.com
Florida HATS

- Regional HCT coalitions in Hillsborough County, NE Florida, Panhandle area; South Florida and Orlando in the planning stage

- Public health strategic planning process (MAPP)

- Workgroup updates posted regularly on www.FloridaHATS.org (under “Regional Coalitions”)
USF’s HCT Pilot Program
Education and Quality Improvement

- Incorporate new clinical care guidelines in training Peds and Med/Peds residents
- Utilize EHR as an experiential teaching tool
- Implement HCT QI activities
Program Components

- Introduced Summer 2012
  - Resident Noon Conference
  - PPT and video posted on web
- EHR prompts in Allscripts and Epic
  - Adapted from AAP Medical Home templates, Children’s Hospital Boston, HCT clinical guidelines
  - Age-specific discussions at all well child visits
- Accompanying patient handouts, including modified GAPS, Bright Futures materials
Florida Pediatric Medical Home Demonstration Project
AIM Statement

USF Pediatrics will aim to improve, by October 2012, our Medical Home through improved patient care. Our team will focus on implementing the AAP’s new transitional care guidelines (Pediatrics, July 2011) by utilizing tools that facilitate anticipatory guidance, coordination of care, and appropriate documentation.

Goal: 90% of all adolescents and young adults ages 12-21 will have discussed critical transition issues with their provider.

We will collaborate with USF Division of Adolescent Medicine to implement 3 components of a resident education intervention that the division recently introduced. Specifically, we will:

1) Promote utilization of a new “Transition” tab in the EMR that includes important discussion items and transition plan components for all adolescents and young adults, including those with special health care needs.
2) Disseminate a Patient Visit Summary (e.g., patient handout) that provides transition-related anticipatory guidance as well as a web site link with resources (www.FloridaHATS.org).
3) Implement a modified Adolescents GAPS questionnaire that includes 4 transition questions.

The resident education intervention is part of a larger research project that has been reviewed by the USF IRB. For our September Medical Home project, evaluation will include a) monthly patient chart reviews, and b) a short 2-3 question survey that assesses patient satisfaction administered.
12-14 year old prompts

Patient can name his/her chronic conditions, if any (yes/needs help/no)
Patient can name his/her allergies, if any (yes/needs help/no)
Patient can name his/her medications, if any (yes/needs help/no)
Patient answers questions asked by provider (yes/needs help/no)
Patient asks questions of provider (yes/needs help/no)
Discussed importance of keeping a personal health care record (yes/no)

For YSHCN:
Family is working with patient to help them be independent (yes/no/NA)
Patient has attended an IEP meeting (yes/no/NA)
IEP includes health care transition goals/activities, such as health care self-management (yes/no/NA)
Patient has applied for APD/ Medicaid Home and Community-Based Waiver (yes/no/NA)
Subspecialty Provider Contacts:

15-17 year old prompts

Patient can describe how his/her chronic conditions (if any) impact their health (yes/needs help/no)
Patient can describe how his/her medications (if any) impact their health (yes/needs help/no)
Patient can take his/her medications (if any) without supervision (yes/needs help/no)
Patient has tried to refill a medication (yes/needs help/no)
Patient has scheduled a doctor’s appointment on his/her own (yes/needs help/no)
Patient meets with provider without parents/caregivers present (for part of visit) (yes/no)
Patient is keeping his/her own health care summary (yes/needs help/no)
Patient knows source of own medical insurance (yes/needs help/no)
Patient family are investigating adult doctors for both primary and specialty care (yes/needs help/no)
Patient family are investigating secondary education or vocational opportunities (yes/no)
Patient has received “10 Steps to Successful Health Care Transition” handout (yes/no)

For YSHCN:
Family has begun Voc Rehab application (yes/no/NA)
Family has begun guardianship applications (by age 17) (yes/no/NA)
Subspecialty Provider Contacts:

18-21 year old prompts

Patient has selected adult doctors for primary and specialty care (yes/no)
* Include name/address for Transfer Summary
Patient can refill own medication (yes/needs help/no)
Patient has insurance/SSI benefits (yes/no)
Patient has received “Just the Facts” insurance guide (yes/no)
Transfer Summary has been/will be forwarded to new providers (yes/no)

For YSHCN:
There is a formal plan in place for post-secondary education/adult living/vocation (yes/no/NA)
Have will verbally communicate with new provider(s) (yes/no/NA)
Subspecialty Provider Contacts:
Note Type: MHP WCC Pt. Vis...
For: 24 Apr 2012

Defined Sections:
- Date of Visit
- Case Manager
- Allergies
- Chief Complaint
- HPI
- Personal Hx
- Family Hx
- PMH
- PSH
- Current Meds
- ROS
- Physical Exam
- Results
- Active Problems
- Assessment Plan
- Transition
- Attestation
- Signature

Edema (82.9)
Fever (On Exam) (780.60)
Generalized Pain (780.96)
Headache (784.0)
Migraine Headache (346.90)
Normal Routine History And Physical (V70.0)
Normal Routine History And Physical Adult (V70.0)
Normal Routine History And Physical Geriatric (80 +) (V70.0)
Normal Routine History And Physical Senior Citizen (65-80) (V70.0)
Preventive Medicine Estab Patient Checkup Adult 40-64 (V70.0)
Preventive Medicine Estab Patient Checkup Adult Over 64 (V70.0)
Preventive Medicine New Patient Evaluation Adult 18-39 (V70.0)
Preventive Medicine New Patient Evaluation Adult 40-64 (V70.0)
Preventive Medicine New Patient Evaluation Adult Over 64 (V70.0)
Skin Abscess Of The Right Little Finger (581.00)
Visit For: Routine Adult H&P (V70.0)

Transition

12-14 year old
Patient can name her chronic conditions, if any
Patient can name her allergies, if any
Patient can name her medications, if any
Patient answers questions asked by provider
Patient asks questions of provider
Discussed importance of keeping a personal health care record

For YSHCN:
Family is working with patient to help them be independent
Patient has attended an IEP meeting
IEP includes health care transition goals/activities, such as health care self-management
Patient has applied for APD: Medicaid Home and Community-Based Waiver
Subspecialty providers if any:
Epic

15-16 YEAR FORM

INTERVAL Hx/CONCERNS/ROS:
Adolescent Questionnaire Reviewed: Yes
TB Risk Reviewed: Yes
Home: Lives with
Education: school, grade
Activities/Sports:
Sports Pre-participant Form Completed:
Diet:
Drugs/ETOH/Cig.: No
Depression/Stressors: No
Sex-Hx: No
Menstrual History: menarche: , menstrual cycles q month, duration:

Transition to adult care history:
Patient can describe how his/her chronic conditions (if any) impact their health. {yes/no:311199}
Patient can describe how his/her medications (if any) impact their health {yes/no:311199}
Patient can take his/her medications (if any) without supervision. {yes/no:311199}
Patient has tried to refill a medication {yes/no:311199}
Patient has scheduled a doctor’s appointment on his/her own {yes/no:311199}
Patient meets with provider without parents/caregivers present (for part of visit) {yes/no:311199}
Patient is keeping his/her own health care summary {yes/no:311199}
Patient knows source of own medical insurance {yes/no:311199}
Patient/family are investigating adult doctors for both primary and specialty care {yes/no:311199}
Patient/family are investigating secondary education or vocational opportunities {yes/no:311199}
Patient has received “10 Steps to Successful Health Care Transition” handout {yes/no:311199}

Transition for Youth with Special Health Care Needs
Family has begun Vocational Rehab application {yes/no:311199}
Family has begun guardianship application (by age 17) {yes/no:311199}
Subspecialty Providers:
USF Pediatrics

Transition of Care Policy for Teens and Young Adults

USFPediatrics works with each patient and family to prepare for a smooth transition to adult care. We believe this process requires gradual transition from a pediatric to an adult health care model, and eventual transfer of care to adult providers. Successful transition also requires that patients, as developmentally able, learn to manage their health care independently with the assistance of a provider, and that responsibility for care gradually shifts from the family to the young adult.

Our staff works closely with patients and families throughout this process, which requires joint planning, preparation and implementation. Our office endorses and follows the policies below to prepare our patients for adult care and adulthood:

- With most patients, transition planning and preparation begins at ages 12-14.
- By age 21, most patients will be fully transitioned to an adult care model and/or transferred to an adult medical provider.
- The transition process is tailored for individuals, as needed.
- At the patient’s last visit, a transfer summary will be provided for the new physician.

Our approach to the care of young adults age 18 and older meets HIPAA and state privacy consent requirements. These requirements make the young adult the sole decision-maker about their care, and allow the young adult to direct the sharing of their personal health information. Exceptions to this require legal authority through the signed consent of the young adult, legally valid custodial care or power of attorney documentation, or an adjudicated guardianship arrangement.

This USF Pediatrics policy is in accordance with guidelines provided by the American Academy of Pediatrics’ joint clinical report on transition and Bright Futures initiative.
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