

Module 10: Conclusion

Getting Started!

- ▶ Key points
- ▶ Using tools
- ▶ Next steps
- ▶ Claim CME/CE credit

Introduction to Transition

- ▶ Transition is a process
- ▶ Best started early
- ▶ For ALL youth

Adolescent Development and Transition

- ▶ Developmental processes
- ▶ Transition stages
- ▶ Support self-efficacy

Working with Caregivers during Transition

- ▶ Independence in self-care
- ▶ Build gradually
- ▶ Practice

Assessing Transition Readiness

- ▶ Assess annually
- ▶ Planning Guides support TRAQ
- ▶ All patients start with first guide

Developing Patient Skills

- ▶ Create plan to address 1-3 skills
- ▶ Tailor to individual needs
- ▶ Update annually with reassessment

Legal and Financial Considerations

- ▶ Range of options
- ▶ Use transition plan
- ▶ Start early

Health Insurance and Transition

- ▶ Specific information for individual needs
- ▶ Dense, but important
- ▶ Be persistent!

Working with Adult Medicine

- ▶ Adult medicine is new to transition
- ▶ Adult medicine best qualified for adults' care
- ▶ Support colleagues to address shortage

Care Transfer

- ▶ Care transfer akin to culture shock
- ▶ Prepare patient for care transfer
 - ▶ Event itself
 - ▶ New providers
- ▶ Goal: Avoid interruptions in care



Health Care Transition: Resources

FloridaHATS

FloridaHATS

Graduating from pediatric to adult health care

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Navigation

- Home
- About FloridaHATS
- Calendar of Events
- Health Services Directory for Young Adults
- Tool Box
 - For Health Care Practitioners
 - For Youth & Families
 - Education & Training for Health Care Professionals
 - Health Insurance & Financing
 - Secondary & Post-Secondary Education
 - Independent Living
 - Decision-Making & Guardianship
 - Service Delivery & Models of Care
 - Advocacy
 - Web Links
 - Juvenile Justice System
- Regional Coalitions
- Medical Advisory

Home

Florida Health and Transition Services (HATS)

Welcome to the FloridaHATS Web site! FloridaHATS is a collaborative initiative of the Florida Department of Health, Children's Medical Services Network, Florida Developmental Disabilities Council, and other partners throughout the state.

Our Mission

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.

Our Vision

All youth in Florida will successfully transition to every aspect of adult life, including adult health care, work, and independence.

Our Values

Youth and young adults will:

1. Participate in decision-making at all levels, and be satisfied with the services they receive,
2. Receive coordinated, ongoing, comprehensive care within a medical home,
3. Have adequate private and/or public insurance to pay for the services they need,
4. Be continuously screened to detect other conditions and prevent secondary disabilities,
5. Access community-based systems that are integrated, collaborative, and organized so they can be easily used, and
6. Will receive services that meet their physical, social, and developmental needs.





FloridaHATS Tools

- ▶ TRAQ
- ▶ 3 Planning Guides
- ▶ 3 Self-Advocacy Booklets
- ▶ Transition 2 Go: Guardianship
- ▶ Transition 2 Go:VR
- ▶ Transition Health Care Summary
- ▶ Just the Facts: Insurance Guide

Got Transition

- ▶ 6 Core Elements
- ▶ Tools for Family Medicine, Internists, and Specialists
- ▶ Coding & reimbursement tip sheet
- ▶ Sample transition policy
- ▶ Facebook page for youth
- ▶ Newsletter for caregivers

American College of Physicians

- ▶ Targets primary care and specialists
- ▶ Integrating new transition-age patients into practice
- ▶ Condition specific tools

Tools from Module 2

- ▶ Bright Futures 3rd Edition Pocket Guide
- ▶ Bright Futures 3rd Edition Visit Planner & Visit Forms
- ▶ Self-Efficacy Tip Sheet – Providers
- ▶ Self-Efficacy Guidance – Caregivers
- ▶ Sexuality Across the Lifespan for Children and Adolescents with Developmental Disabilities

Tools from Module 3

- ▶ Path to Independence
- ▶ Seattle Children's Hospital

Tools from Module 4

- ▶ TRAQ
- ▶ Planning Guides
- ▶ Center for Health Care Transition Improvement
- ▶ Illinois Transition Care Project

Tools from Module 5

- ▶ Transition Plan
- ▶ Since You're Not a Kid Anymore
- ▶ Now That You're in High School
- ▶ When You're 18, You're in Charge
- ▶ Health Care Transition Summary
- ▶ My Health Passport
- ▶ Downloadable apps
 - ▶ My Medical
 - ▶ My Med Schedule
- ▶ Project 10
- ▶ Health Goals and IEPs
- ▶ Embedding Health Goals and IEPs
- ▶ Florida Alliance for Assistive Technology

Financial Tools from Module 6

- ▶ Ticket to Work
- ▶ Plan for Achieving Self-Support
- ▶ Vocational Rehabilitation
- ▶ Centers for Independent Living listing
- ▶ Benefits for Children with Disabilities
- ▶ ssa.gov
- ▶ Disability Determination in Florida

Guardianship Tools from Module 6

- ▶ Legal Guide for New Adults
- ▶ Florida Disability Rights
- ▶ Guardianship application form
- ▶ Video: Becoming an Adult: Legal & Financial Planning

Tools from Module 7

- ▶ [healthcare.gov/young-adults](https://www.healthcare.gov/young-adults)
- ▶ CMS Plan
- ▶ Florida Division of Consumer Services
- ▶ Extraordinary Parent
- ▶ Navigators
- ▶ Agency for Persons with Disabilities
- ▶ [healthykids.org](https://www.healthykids.org)
- ▶ Healthy Kids Benefit Summary
- ▶ Florida Medicaid
- ▶ Medicaid regional offices list

Tools from Module 8

Build Referral Network

- ▶ Contact hospitals
- ▶ Adult Disability Agencies
- ▶ Florida Board of Medicine
- ▶ Florida Chapter AFP
- ▶ Florida Chapter of ACP

Educate Colleagues

- ▶ Six Core Elements for Adult-Oriented Providers
- ▶ Grand Rounds
- ▶ Bridge visits
- ▶ Offer consultation services

Tools from Module 9

- ▶ Center for Transition Improvement Sample Policy
- ▶ Center for Medical Home Improvement Sample Policy
- ▶ Six Core Elements







Health Care Transition: Next Steps

Strategic Plan for Transition

Florida Strategic Plan for Health Care Transition

11/3/2010

<h3>Foundation</h3> <p><i>Our Mission</i></p> <p>To ensure successful transition from pediatric to adult health care for all youth and young adults (YJA) in Florida, including those with disabilities or special health care needs.</p> <p><i>Our Core Values</i></p> <ol style="list-style-type: none"> YJA and their families will participate in decision-making at all levels, and be satisfied with the services they receive. YJA will receive coordinated, ongoing, comprehensive care within a medical home. YJA will have adequate private and/or public insurance to pay for the services they need. YJA will be continuously screened to detect other conditions and prevent secondary disabilities. Community-based systems will be integrated, collaborative, and organized so YJA and their families can use them easily. YJA will receive services that meet their physical, social, and developmental needs. 	<h3>Goals and Statewide Objectives</h3> <p><i>Health Care Financing</i></p> <ol style="list-style-type: none"> Health Care Benefits. YJA obtain and maintain adequate, affordable health insurance. <ol style="list-style-type: none"> Develop a technical assistance guide to help identify insurance options available to YJA. Implement a Medicaid Buy-in option. Service Coordination. Insurers reimburse providers for services needed to effectively care for YJA. <ol style="list-style-type: none"> Work with Medicaid program to implement medical homes for YJA. Work with Medicaid program and state insurers to develop policies relating to co-management of YJA. Advocate for insurance payments to reflect the time and resources required for appropriate care of YJA. Accept federal Medicaid matching funds for education and outreach to adults with DMED and DMED. Extend CMS Network coverage for YJA to age 26 or 29. <p><i>Education and Training</i></p> <table border="0"> <tr> <td> Policy Makers and Funders Education/Health Professional </td> <td> Health Care Professionals </td> <td> YJA and Families </td> <td> Students in Training </td> </tr> </table> <ol style="list-style-type: none"> Material Development. Develop, adapt, and disseminate health care transition educational and training materials. <ol style="list-style-type: none"> Identify educational and training needs. Coordinate development or adaptation of education and training materials for each target market. Utilize existing state and community networks and organizations to assist in production and dissemination of material. Accredited Training. Provide multi-modal training approved for CME/CEU credit at no cost to the individual. <ol style="list-style-type: none"> Provide accredited health care transition-specific training for professionals and families. Advocate for mandatory disability-related training for health care professionals. Outreach and Promotion. Engage high-visibility spokespersons to communicate messages related to health care transition. <ol style="list-style-type: none"> Engage a physician champion for outreach to the health care community, explore feasibility of Surgeon General. Engage a YJA for outreach to higher peers and families. <p><i>Services and Models of Care</i></p> <ol style="list-style-type: none"> Regional Coalitions. Organize local public/private health care transition coalitions. <ol style="list-style-type: none"> Develop planning guidelines to assist in local coalition-building. Identify geographic regions for local coalitions. Prioritize coalition development in 3 selected regions, 2 urban and 1 rural. Identify external funding sources to support expansion of local coalition development; see Infrastructure. Information Clearinghouse. Establish a centralized, searchable database of providers, best practices, and resources. <ol style="list-style-type: none"> Collect critical questions in treatment of chronic disease and pediatric onset conditions. Collect patient-oriented health care tools. Identify model health care transition programs that local coalitions can replicate based on their needs and resources. Identify resources to assist YJA with employment, benefits, independent living, decision-making options, housing. Create and maintain database of adult primary care physicians and specialists. Evaluation. Develop and monitor performance measures at the state and local levels. <ol style="list-style-type: none"> Identify process, input, and outcome measures for the state, local coalitions, organizations, and YJA. Consider MOHE core outcomes for CYOHCN as well as current CMS health care transition indicators. <p><i>Infrastructure</i></p> <ol style="list-style-type: none"> Funding and Policy. Identify policy and secure funds for plan implementation. <ol style="list-style-type: none"> Advocate for increased state funding from general revenue. Advocate for increased federal funding of Title V Block Grant. Recommend new health care transition objective in H2020 Plan. Identify external funding to support expansion of local coalitions. Stakeholder Collaboration. Coordinate development and implementation across agency and stakeholder groups. <ol style="list-style-type: none"> Share legislative report and solicit participation from key agencies and organizations. Coordinate cross-organization advocacy for improved systems and quality of life for YJA. Release participation of YJA and families in planning and implementation. Governance. Establish operational and oversight systems for State Office of Health Care Transition. <ol style="list-style-type: none"> Identify and hire program staff. Establish a statewide Advisory Council. 	Policy Makers and Funders Education/Health Professional	Health Care Professionals	YJA and Families	Students in Training	<h3>Vision</h3> <p><i>What our vision will look like</i></p> <p>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.</p>
Policy Makers and Funders Education/Health Professional	Health Care Professionals	YJA and Families	Students in Training			
<h3>Strengths</h3> <p><i>Where we are good</i></p> <p>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.</p>	<h3>Implementation</h3> <p><i>How we will accomplish our vision</i></p> <p>The Task Force, CMS's Office of Health Care Transition, FQHC, and other partners will:</p> <ul style="list-style-type: none"> Communicate the Strategic Plan to all stakeholders throughout the state. Invite 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 regular scheduled teleconference calls to report on progress. Change the plan if something is not working, take corrective action or move to build or success. Link all steps to performance. Celebrate when goals are reached. 					
<h3>Key Strategies</h3> <p><i>How we will get there</i></p> <p>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:</p> <ul style="list-style-type: none"> 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 YJA, families, key state agencies, advisory organizations, professional associations, and other stakeholders. 	<p>www.FloridaHATS.org</p> <div style="display: flex; justify-content: space-around;">   </div> <div style="display: flex; justify-content: space-around;">   </div>					

Health Care Financing

Goal: Young people are able to work and contribute to their communities without loss of health care benefits



Education and Training

Develop and disseminate educational materials and resources for patients, families, caregivers, health care providers, teachers and other professionals



Service Delivery System

Provide guidance in identifying best practices,
establishing quality of care guidelines,
and developing model programs



Advocacy

Promote policies that empower and support young people in their transition to adult life



Join FloridaHATS to Improve Care

- ▶ Connect patients and families to resources
- ▶ Sign up for the FloridaHATS mailing list
- ▶ Participate in webinars
- ▶ Join your regional coalition
- ▶ Become a transition champion!



Interactive Questions

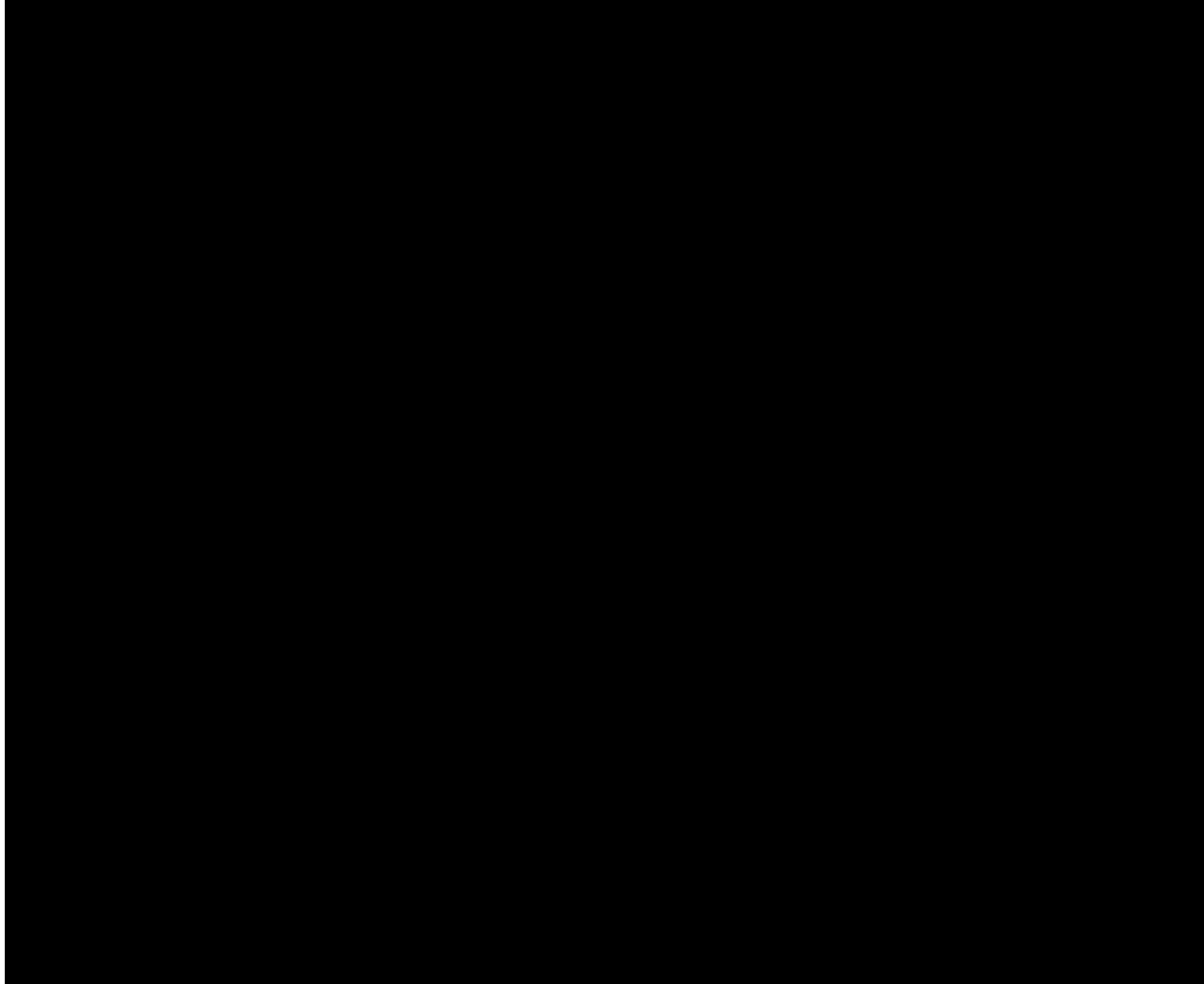
- ▶ What strategies are ready to implement?
- ▶ Which would be easiest?
- ▶ Which need time or resources?



Practice-Based Strategies

- ▶ Write practice transition policy
- ▶ Use TRAQ with patients
- ▶ Provide *Transition Planning Guide*
- ▶ Create annual transition plans
- ▶ Address legal, financial, and insurance needs
- ▶ Transfer care between ages 18 and 22
- ▶ Engage adult medicine

Summing It Up



Claiming CME/CE Credit

- ▶ Return to AHEC website
- ▶ Complete post-test
- ▶ Complete evaluation

Course Media Credits

- ▶ Course narrator – Kat Evans
- ▶ Patient panel videos – Utah Medical Home Integrated Services Project
- ▶ Jim Olsen and Jeff Walden interview videos – Institute for Child Health Policy, University of Florida
- ▶ Becoming an Adult: Legal & Financial Planning video – Nemours Children’s Health System
- ▶ Resource images – see module citations
- ▶ All other images – from Flickr Commons or Google public domain images

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