Transitioning Adolescents to Adult Care: Are YOU Prepared?

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Self-Check

Does your practice have a policy for transitioning patients to an adult model of care?

What steps do you take to prepare adolescents and their families for changes in adulthood?

Do you have standardized processes for planning, transferring, integrating patients into adult care?

What resources do you use to support patient transition?
Background
Health Care Transition (HCT)

The purposeful, planned movement of adolescents and young adults, with and without SHCN, from child-centered to adult-oriented health care systems.

Preparation
Increased responsibility for health care self-management; understanding and planning for changes in health needs, insurance, and providers in adulthood; should occur across ages 12-21+

Transfer of Care
Discrete event, physical transfer from a pediatric to an adult provider; should occur between ages 18-21+

Successful Transition
Patients are engaged in and receive ongoing patient-centered adult care.
Changing Epidemiology of Childhood Conditions

- **Congenital Heart Disease**
  - ~1,000,000 adults in the U.S. have CHD
  - Slightly more adults than children

- **Cerebral Palsy**
  - Up to ~1,000,000 people in U.S. have CP
  - Lifespan approaching that of general population

Sources: Centers for Disease Control and Prevention, [www.cdc.gov/ncbddd/heartdefects/data.html](http://www.cdc.gov/ncbddd/heartdefects/data.html) (2016)

Sickle Cell Disease

24.4% of youth aged 12-17 have SHCN

What Can Happen?

• Without adequate support in moving from pediatric to adult care, youth may:
  – Loss/gaps in insurance
  – Have poor connections to the adult health care system
  – Have decreased adherence with medicine, self-care
  – Increased ER visits, hospitalizations
  – Experience short term deterioration in health and worse long term outcomes
“When we left pediatric care, it was as if someone flipped the switch and turned the lights off.”

- parent of child with developmental disability
“It’s like taking 18 years to build a fine canoe and then riding it over a waterfall.”
What Are the Issues?
The Adolescent Brain

- 10-year NIH MRI study
- 5-20 y.o. participants
- Brain continues to change until mid 20s

## Culture Shock

### Professional culture and traditions

<table>
<thead>
<tr>
<th>Pediatrics</th>
<th>Adult Physicians</th>
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<tr>
<td>- Child-friendly</td>
<td>- Cognitive</td>
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<td>- Family-centered</td>
<td>- Patient-centered</td>
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<tr>
<td>- Interact primarily with parents</td>
<td>- Interact with patient</td>
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<tr>
<td>- Nurturing</td>
<td>- Empower individual</td>
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<tr>
<td>- Prescription</td>
<td>- Collaborative</td>
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<td>- Developmental Focus</td>
<td>- Disease Focus</td>
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Communication Gaps

Among providers

Pediatric knowledge of adult system physicians, resources and services

Lack of systematic transfer of records and co-management of care during transition

Between adult provider and youth
Adult System of Care

- Provider capacity and training
- Lack of physicians who are
  - Trained in pediatric onset conditions
  - Willing to take primary responsibility for care
- Service fragmentation
  - Minimal case management in adult practices
  - Lack of linkages to community-based adult services
- Low Medicaid reimbursement rates
Adequate Insurance Coverage

- Aging out of childhood health insurance plans can create gaps/loss in coverage
- Benefits in temporary jobs often limited, unavailable, or have high premiums
- Increased salary may lower/eliminate public benefits
- Limited benefits provided in adult Medicaid package
Current Policy and Tools
Why Do Adolescents Need a Structured Health Care Transition Process?

• Evidence of need for transition services
  o 2016 National Survey of Children’s Health shows that, nationally, only 16.5% of youth with special health care needs, and 14.2% without special health care needs, received the services necessary to make transitions to adult care
  o Florida is below national average: 7.5% of youth with special health care needs, and 7.0% without special health care needs, received the necessary services

• Evidence of improved outcomes with a structured approach
  o Evaluation studies indicate improvement in population health (adherence to care, perceived health and quality of life, self-care); increased patient and family satisfaction; decreased barriers to care; improved utilization of ambulatory care in adult settings; reduced hospitalizations

Sources: 2016 National Survey of Children's Health, [http://childhealthdata.org](http://childhealthdata.org)
In 2011, Clinical Report on Transition published as joint policy by AAP/AAFP/ACP

- Targets all youth, beginning at age 12
- Algorithmic structure with:
  - Focus on planning, transfer, integration into adult care
  - Branching for youth with special health care needs
  - Application to primary and specialty practices
- Extends through transfer of care to adult medical home and adult specialists

Age 12: Youth and family aware of transition policy
Age 14: Health care transition planning initiated
Age 16: Preparation of youth/parents for adult approach to care; discussion of preferences and timing for transfer to adult health care
Age 18: Transition to adult approach to care
Age 18-22: Transfer of care to adult medical home and specialists with transfer package

National Center for Health Care Transition Improvement

http://www.gottransition.org/
Six Core Elements Approach to Health Care Transition

1. **Transition Policy**
   - Discuss Transition Policy
   - Ages 12-14

2. **Transition Tracking and Monitoring**
   - Track progress
   - Ages 14-18

3. **Transition Readiness**
   - Assess skills annually
   - Ages 14-18

4. **Transition Planning**
   - Develop transition plan, including medical summary
   - Ages 14-18

5. **Transfer/Integration into Adult-Centered Care**
   - • Transfer to adult-centered care
   - • Integration into adult practice
   - Ages 18-21

6. **Transition Completion and Ongoing Care**
   - • Confirm transfer completion
   - • Elicit consumer feedback
   - Ages 18-26
# Six Core Elements

Adapted Toolkit for ID/DD

## Intellectual Disabilities/Developmental Disabilities (ID/DD)

### Developed by:
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Physicians
- American College of Obstetricians and Gynecologists
- Got Transition/Center for Health Care Transition
- Health Care Transitions Research Network
- Medicine-Pediatrics Program Directors Association
- Society for Adolescent Health and Medicine
- Society of General Internal Medicine

### How Developed:
Young Adults with intellectual disabilities or other developmental disabilities face many challenges as they strive to transition from childhood to adulthood. Along with striving for greater independence and to participate in the educational, vocational, and social activities typical of their age, they also have to move from the pediatric providers that have cared for them to new adult providers. This transition can be difficult for all involved due to some of the unique needs of these young adults. In order to help facilitate this transition and ensure good communication and care coordination, the primary care work group developed tools specific to the needs of young adults with intellectual disabilities or other developmental disabilities. The work group included input from primary care providers and young adults as well.

## Tool Name

<table>
<thead>
<tr>
<th>Tool Name</th>
<th>Description of Tool</th>
<th>How to Use Tool</th>
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<tbody>
<tr>
<td>Transition Readiness Assessment for Youth with Intellectual Disabilities or Developmental Disabilities (Pediatric)</td>
<td>Modified to a 4th-grade literacy level. An assessment tool intended to be filled out by the identified disabled youth and utilized by the pediatric care team or other clinicians caring for youth to begin the conversation about the youth’s needed skills to manage his/her health and health care. This tool indicates the elements specifically related to the clinical condition that should be assessed and documented by the transferring pediatric practice.</td>
<td>This form is suggested to help assess the need to ensure the young adult’s knowledge of their health care needs and their skills in managing them. It is intended to be given to the adolescent patient as early as age 14 and intermittently thereafter up until the time the patient transfers to an adult provider. Useful as a guide for the provider, patient, and their family’s efforts to help the teen develop skills identified as areas of concern. A final assessment prior to transfer will provide important information for the pediatric team to convey to their adult counterparts.</td>
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## Server Assessment for Young Adults with Intellectual Disabilities or Developmental Disabilities

| Server Assessment for Young Adults with Intellectual Disabilities or Developmental Disabilities (Pediatric) | Modified to a 4th-grade literacy level. An assessment tool to be filled out by the identified disabled youth and utilized by the adult care team to assess remaining gaps in self-care knowledge and skills or additional issues that need to be addressed to ensure optimal management of the medical conditions. | This tool should be given by the adult health care team to the young adult once they establish care. Its purpose is to help the adult provider and their practice and the young adults to better understand what areas the young adult will need assistance and support with to ensure that their care quality remains high and to help determine areas for continued education and skill development. |

## Medical Summary for Young Adult with Intellectual Disabilities or Developmental Disability (Pediatric) |

| Medical Summary for Young Adult with Intellectual Disabilities or Developmental Disability (Pediatric) | A medical record summary indicates essential clinical information specifically related to the clinical condition to be included in the case medical record upon transfer to the adult practice. |

## Self-Care Assessment for Parents or Caregivers of Young Adults with Intellectual Disabilities or Developmental Disabilities

| Self-Care Assessment for Parents or Caregivers of Young Adults with Intellectual Disabilities or Developmental Disabilities | A tool to be filled out by a parent and/or caregiver of an identified disabled youth and utilized by the adult care team to assess remaining gaps in self-care knowledge and skills or additional issues that need to be addressed to ensure optimal management of the medical conditions. |

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www.gottransition.org/resources/index.cfm#intellectualdevelopmentaldisabilitiesandtransition
Several validated tools are available, such as Got Transition and the TRAQ
## Planning tasks

Develop and regularly update the plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents. Documents could also be utilized by client/caregiver to create their own medical binder.

Prepare youth and parent/caregiver for adult approach to care at age 18, including changes in decision-making and privacy and consent, self-advocacy, and access to information.

Determine level of need for decision-making supports for youth with intellectual challenges; make referrals to legal resources.

Plan with youth/guardian for optimal timing of transfer.

Obtain consent from youth/guardian for release of medical information.

Assist youth in identifying an adult provider and communicate with selected provider about pending transfer of care.

Provide linkages to insurance resources, self-care management information and culturally appropriate community supports.
Sample Transfer of Care Checklist

Six Core Elements of Health Care Transition 2.0

Patient Name: _______________ Date of Birth: _______________

Primary Diagnosis: _______________ Transition Complexity: _______________

-Prepared transfer package including:
  - Transfer letter, including effective date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including transition goals and pending actions
  - Updated medical summary and emergency care plan
  - Guardianship or health proxy documents, if needed
  - Condition fact sheet, if needed
  - Additional provider records, if needed

-Sent transfer package ___________
  Date

-Communicated with adult provider about transfer ___________
  Date
How Can You Ensure a Smooth Transition to the New Adult Care Provider?

One of the most effective transition tools is physician-to-physician communication.

Sample Transfer Letter

Six Core Elements of Health Care Transition 2.0

Dear Adult Provider,

_Name_ is an _age_ year-old patient of our pediatric practice who will be transferring to your care on _date of this year_. _His or her_ primary chronic condition is _condition_ and _his or her_ secondary conditions are _conditions_. _Name’s_ related medications and specialists are outlined in the enclosed transfer package that includes _his or her_ medical summary and emergency care plan, _plan of care_, and transition readiness assessment. _Name_ acts as _his or her_ own guardian, and is insured under _insurance plan_ until _age_.

I have had _name_ as a patient since _age_ and am very familiar with _his or her_ health condition, medical history, and specialists. I would be happy to provide any consultation assistance to you during the initial phases of _name’s_ transition to adult health care. Please do not hesitate to contact me by phone or email if you have further questions.

Thank you very much for your willingness to assume the care of this young _man or woman_.

Sincerely,
Is There a Way to Bill for Transition Services?

Got Transition and the American Academy of Pediatrics developed a transition payment tip sheet to support the delivery of recommended transition services in pediatric and adult primary and specialty care settings.

The 2018 tip sheet provides a comprehensive listing of transition-related CPT codes, corresponding Medicare fees and several clinical vignettes.

https://www.gottransition.org/resourceGet.cfm?id=352
In response to popular requests for use of the Six Core Elements for PCMH certification, Got Transition completed a series of key informant interviews with clinical and administrative leaders in the health field and developed a tip sheet.

This resource includes an easy-to-use chart displaying specific NCQA criteria and guidance with links to related Six Core Elements tools.

http://gottransition.org/resourceGet.cfm?id=444
This resource includes a step approach to starting a health care transition process in a practice/health care delivery system. It was developed with input from the integrated health care delivery systems who have incorporated the Six Core Elements into their practice processes.
State and National Resources for Practitioners
http://www.gottransition.org/
Florida’s clearinghouse for HCT information

www.FloridaHATS.org
Florida Health and Transition Services

Welcome to the FloridaHATS Website. 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
- Decision-Making & Guardianship
- Education & Training for Professionals
- Service Delivery Models & Systems
- Advocacy
- Health Insurance & Financing
- Secondary & Post-Secondary Education
- Independent Living

Condition-Specific Materials

- Autism Spectrum Disorders
  - Autism Transition Resources (CT), Massachusetts Department of Developmental Services
  - Autism Specific Transition Toolkit (version 2.0), see www.autismspecific.org
  - Individuals with autism often face challenges during procedures like physical examinations and vaccinations due to communication deficits and sensory issues. Read these and other resources available at helping prepare for medical procedures. Please share these resources with families from the Autism Research Institute

- Cerebral Palsy
  - General Fact Sheet (Glen & Stetten, 2011)

- Cornelia de Lange Syndrome
  - Navigating Health Care Transitions for Parents and Caregivers (2015), from Cornelia de Lange Syndrome Foundation
  - The Adult Years: Pediatric to Adult Medical Care Presentation from CDS Foundation Conference, Orlando (2016)

- Cystic Fibrosis
  - Managing Cystic Fibrosis, (University of Wisconsin)

- Diabetes
  - National Diabetes Education Program (NDEP)
  - Best Practice Guidelines for Diabetes Transition Program in Queensland
  - Manual: Transition from Pediatric to Adult Diabetes Care (American Diabetes Association)

- HIV/AIDS

- Illness Transition Care Project Offers
Health Summary & Emergency Care Plan

### Health Care Transition Summary

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
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<th>Support Person</th>
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<th>Reaction</th>
<th>Date of last reaction</th>
<th>Date of allergy test</th>
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<th>Recent Lab, X-ray Findings</th>
<th>Height</th>
<th>Weight</th>
<th>Dietary/Nutritional Needs</th>
<th>Primary Care Provider</th>
<th>Phone</th>
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<th>Phone</th>
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<th>Current Medications</th>
<th>Current Medications</th>
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<th>Current Therapies</th>
<th>Frequency</th>
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My Health Passport

- **If you are a health care professional** who will be helping me.
- **PLEASE READ THIS** before you try to help me with my care or treatment.

- **My full name is:**
- **I like to be called:**
- **Date of birth:**
- **My primary care physician:**
- **Physician’s phone number:**

This passport has important information so you can better support me when I visit/day in your hospital or clinic.

Please keep this with my other notes, and where it may be easily referenced.

- **My signature:**
- **Date completed:**

You can talk to this person about my health:
- **Phone number:**

I communicate using: (e.g., speech, preferred language, sign language, communication devices or aids, non-verbal sounds, also state if extra time support is needed)
## Sample Plan of Care

**Six Core Elements of Health Care Transition 2.0**

**Instructions:** This sample plan of care is a written document developed jointly with the transitioning youth to establish priorities and a course of action that integrates health and personal goals. Motivational interviewing and strength-based counseling are key approaches in developing a collaborative process and shared decision-making. Information from the transition readiness assessment can be used to guide the development of health goals. The plan of care should be dynamic and updated regularly and sent to the new adult provider as part of the transfer package along with the latest transition readiness assessment, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents.

**Name:**
**Date of Birth:**
**Primary Diagnoses:**
**Secondary Diagnoses:**

*What matters most to you as you become an adult? How can learning more about your health condition and how to use health care support your goals?*

<table>
<thead>
<tr>
<th>Prioritized Goals</th>
<th>Issues or Concerns</th>
<th>Actions</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Date Complete</th>
</tr>
</thead>
</table>

**Initial Date of Plan:**

**Last Updated:**

**Parent/Caregiver Signature:**

**Clinician Signature:**

**Care Staff Contact:**

**Care Staff Phone:**

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Self-Advocacy Guides

www.floridahats.org/?page_id=616
Self-Management Videos

Short Videos with step-by-step instructions
School

- Incorporate self-advocacy and self-management skills in school IEP
- Transition IEPs, which are introduced at age 14 in Florida, should outline a pathway to post-secondary independent living
- Project 10 (www.project10.info) is Florida Department of Education’s statewide transition initiative
  - Includes employment training, post-secondary education and independent living resources
Transition for Students with Disabilities
How Parents Can Be Effective Advocates in the IEP Meeting

If you’re a parent of one of the 5 million children with disabilities in the U.S., you’re probably aware of the Individual Educational Plan (IEP) meeting. Under the Individuals with Disabilities Education Act (IDEA), parents of a child who receives special education services meet at least once a year with representatives of the local school district to prepare their child’s IEP—a detailed, written description of the child’s educational program. You don’t need to be a special education expert to be an effective advocate for your child in the IEP process. What you must do is be prepared and plan ahead. Every parent—whether it’s their first or their 10th IEP meeting—will benefit from reviewing these 10 Steps in advance of the meeting.

Step 1: Understand your child’s legal rights to special education.
Your school district is required by IDEA to give you copies of special education statutes, regulations, and policies. Read these carefully. Keep in mind that under the law, parents and equal partners with school representatives in decision-making. You are just as important as everyone else at the IEP meeting!

Step 2: Obtain a copy of your school district’s IEP form.
Become familiar with the sections you will be filling out at the IEP meeting, which typically include:
- Program or Class - the appropriate learning environment for your child, such as a regular classroom for all or part of the school day, a special class or a private school
- Goals and Objectives - the general academic, social, communication, vocational, cognitive, self-help and other goals you have for your child, such as reading or math skills, healthy peer relationships or independent living skills, plus the specific steps your child will have to take to reach these goals.
- Related Services - developmental, corrective, and other services necessary to support your child’s placement in a regular class or to allow your child to benefit from special education. Examples include a one-to-one aide in the classroom, speech therapy, or transportation to and from school.

Parent/Student Handouts

Lesson Plans

Classroom Curriculum
Health Insurance

• Plan for change in insurance coverage
  ○ Medicaid
  ○ Parents’ plan
  ○ Employer-based
  ○ Marketplace plans
  ○ Plan for change in insurance coverage
Sexual Health

- High incidence of sexual abuse among persons with intellectual and developmental disabilities
  - Most abusers are service providers
- Lack of education about how to properly act on urges can cause major issues
  - Unacceptable public displays
  - Unwarranted sexual harassment
- Sexuality & Developmental Disabilities Across the Lifespan
  - Helps educators and family members assist with exploration of self and sexuality
• Individuals with a developmental disability should apply to APD as early as age 3

• Don’t wait to get on the Home and Community – Based Waiver Waiting List (called iBudget)
Age of Majority

- Legal responsibilities
  - Financial
  - Decision-Making
  - Florida Bar’s #JustAdulting Legal Survival Guide for new adults
    www.justadulting.com/
- Disability benefits determined by ability to work
Consider decision making options, such as guardian advocacy

Explore long-term financial planning options, such as a special needs trust
Decision-Making

See Nemours video at https://youtu.be/CpvIyfiRjRM
Supplemental Security Income

- Redetermination at age 18
- Stricter eligibility requirements
Employment

• Apply to Division of Vocational Rehabilitation 2 years before leaving high school

• Can help pay for post-secondary education and job training programs

• Assists in job placement

Transition 2 Go
in Florida

School to Work Transition Vocational Training

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. Students who may benefit from VR services should apply at least 2 years before leaving high school, e.g., apply at age 14 if leaving high school at age 16. VR can also assist students with community work experience while they are still in high school. Applications can be downloaded at http://rehabworks.org/docs/vr/Application.f1t.

VR referrals can be made by anyone by contacting the local VR office at www.rehabworks.org (click on VR Office Directory). To learn more about the School to Work Transition program, visit www.rehabworks.org/docs/SchooltoWork.pdf.

In addition to VR, CareerSource Florida offers job training for income eligible clients, including youth ages 14-21, WIA Youth Program and individuals with disabilities.
College Students with Disabilities

Secondary & Post-Secondary Education

College Resources for Students with Disabilities

- Scholarships and Financial Aid for Students with Disabilities, from accreditedschoolsonline.org
- Study Tips for College Students with Dyslexia and Dysgraphia
- Studying with ADHD
- Going to College with ASD
- Thriving in Trade School with a Disability
- Heading for College with Special Health Care Needs (YouTube video)
  Dr. Kitty O'Hare of Boston Children's Hospital, provides practical considerations for a student's health care transition, in preparation for a successful adjustment to college life, prepared by Got Transition.
- Radio Episodes from Got Transition
  - Radio Episode 2
    Healthcare Transition & College- It Doesn't Have to be Learned the Hard Way!
  - Radio Episode 3
    Healthcare Transition & College- It Doesn't Have to be Learned the Hard Way! Part 2
- Transitioning from High School to Post-Secondary Education, article by Dr. Marilyn Bartlett, Texas A&M
- Resources for College Students from BestColleges.com, including information on disability, mental health, academics and college life

Transfer of Care

- Transfer of care
  - Primary Care
  - Specialty Care

www.floridahats.org/service-directory/search-service-directory
Web-Based Training for Professionals

- Cross-disciplinary training for practitioners in the clinical setting
  - 10 modules, 15-20 minutes each
  - Free CME/CE for physicians, physician assistants, LPNs, RNs, and other allied health professionals, through Florida AHEC Network at www.aheceducation.com
  - Modules also posted on www.FloridaHATS.org

FREE CME/CE for physicians, PAs, RNs, LPNs, ARNPs, social workers and other allied health practitioners

Online modules offer valuable training for all practice staff

November 2017
Visit www.FloridaHATS.org

Transitioning Adolescents to Adult Care: Are YOU Prepared?

Does your practice have a policy for transitioning patients to an adult model of care?
What steps do you take to prepare adolescents and their families for changes in adulthood?

The American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians recommend transition planning as a standard of care for all adolescents. Health Care Transition Training for Health Care Professionals will equip you with the knowledge and tools you need to facilitate a smooth transition for every patient, including those with special health care needs.

This online course from FloridaHATS includes evidence-based materials from Out Transition’s Six Core Elements 2.0, a tip sheet on coding and reimbursement, and condition-specific tools for subspecialists from the American College of Physicians. You will learn about development, social, legal, and financial considerations in planning for transition, using interactive tools and a Florida-specific planning algorithm to connect to local services and resources.

Health Care Transition Training for Health Care Professionals is comprised of 10 sequential modules, each lasting about 15 minutes. You can link to the modules below or go to www.FloridaHATS.org. For free CME/CE credit, visit www.aheceducation.com. Quality improvement methods, videos, and a downloadable Course Toolkit are used throughout these sessions:

1. Introduction
2. Adolescent Development
3. Working with Caregivers
4. Assessing Transition Readiness
5. Patient Skill Development
7. Insurance
8. Working with Adult Medicine
9. Care Transfer
10. Conclusion

FloridaHATS offers many additional web-based resources for both practitioners and consumers, including a searchable Health Services Directory for Young Adults.

For more information: Janet Hess, DNP, University of South Florida, jhess@health.usf.edu or (813) 259-6044.
Web-Based Training for Professionals

- Training for teachers, school nurses and other professionals in the school setting
  - Available at [www.FloridaHATS.org](http://www.FloridaHATS.org)
## Other Transition Resources

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<td>Housing</td>
<td>Housing in Florida: A Resource Guide for Individuals with Developmental Disabilities</td>
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<td>Transportation</td>
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Additional References


Autism Speaks Toolkit, [www.autismspeaks.org](http://www.autismspeaks.org)

Association of University Centers on Disabilities, [www.aucd.org](http://www.aucd.org)

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