Transitioning Adolescents to an Adult Model of Health Care

Janet Hess, DrPH
USF Department of Pediatrics

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Provider 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?
Agenda

1. Background
2. Current Policy and Tools
3. State and National Resources
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.
Children and youth with special health care needs (CYSHCN) are those who “have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition who also require health and related services of a type or amount beyond that required by children generally.”

Source: Pediatrics; Volume 102, Nov/July 1998
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?
## Cognitive Development: Piaget’s Formal Operational Thought

<table>
<thead>
<tr>
<th>EARLY (11-13)</th>
<th>MIDDLE (14-16)</th>
<th>LATE (17-21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concrete thought</td>
<td>Abstraction</td>
<td>Established abstract thought</td>
</tr>
<tr>
<td>No future perspective</td>
<td>Has future perspective; not always used</td>
<td>Future oriented</td>
</tr>
</tbody>
</table>
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>
</tr>
</thead>
<tbody>
<tr>
<td>Child-friendly</td>
<td>Cognitive</td>
</tr>
<tr>
<td>Family-centered</td>
<td>Patient-centered</td>
</tr>
<tr>
<td>Interact primarily with parents</td>
<td>Interact with patient</td>
</tr>
<tr>
<td>Nurturing</td>
<td>Empower individual</td>
</tr>
<tr>
<td>Prescription</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Developmental Focus</td>
<td>Disease Focus</td>
</tr>
</tbody>
</table>
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
  ○ 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
  ○ 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
  ○ 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

In 2011 (and affirmed in 2018), 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

<table>
<thead>
<tr>
<th>Age</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Youth and family aware of transition policy</td>
</tr>
<tr>
<td>14</td>
<td>Health care transition planning initiated</td>
</tr>
<tr>
<td>16</td>
<td>Preparation of youth/parents for adult approach to care; discussion of preferences and timing for transfer to adult health care</td>
</tr>
<tr>
<td>18</td>
<td>Transition to adult approach to care</td>
</tr>
<tr>
<td>18-22</td>
<td>Transfer of care to adult medical home and specialists with transfer package</td>
</tr>
</tbody>
</table>

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
Sets of tools are currently available for the following subspecialties and diseases (with more to be added over time):

- General Internal Medicine
- Cardiology
- Endocrinology
- Gastroenterology
- Hematology
- Nephrology
- Neurology
- Rheumatology

www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/pediatric-to-adult-care-transitions-initiative/condition-specific-tools
# Transition Planning Activities

## 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 of 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

Low, moderate, or high
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.

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Sample Transfer Letter
Six Core Elements of Health Care Transition 2.0

Dear Adult Provider,

_Name_ is a _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 _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
Starting a Health Care Transition Improvement Process

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.

www.gottransition.org/resourceGet.cfm?id=369
Six Core Elements of Health Care Transition

Listed in the table below are PDFs of the sample tools used in the Six Core Elements of Health Care Transition. Complete packages are available to download and customize for your practice or plan.

<table>
<thead>
<tr>
<th>Six Core Elements of Health Care Transition</th>
<th>Transitioning Youth to Adult Health Care Providers (Pediatric, Family Medicine, and Med-Peds Providers)</th>
<th>Transitioning to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Med-Peds Providers)</th>
<th>Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, and Med-Peds Providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Package</td>
<td>Full Package</td>
<td>En Español</td>
<td>Full Package</td>
</tr>
<tr>
<td>Summary of Six Core Elements</td>
<td>Transitioning Youth to an Adult Health Care Provider</td>
<td>En Español</td>
<td>Transitioning Youth to an Adult Approach to Health Care Without Changing Providers</td>
</tr>
<tr>
<td>1) Transition Policy</td>
<td>Transition Policy</td>
<td>En Español</td>
<td>Transition Policy</td>
</tr>
<tr>
<td>2) Transition Tracking and Monitoring</td>
<td>Individual Transition Flow Sheet</td>
<td>En Español</td>
<td>Individual Transition Flow Sheet</td>
</tr>
<tr>
<td>3) Transition Readiness</td>
<td>Transition Readiness Assessment for Youth</td>
<td>En Español</td>
<td>Transition Readiness Assessment for Youth/Young Adult</td>
</tr>
<tr>
<td>4) Transition Planning</td>
<td>Plan of Care</td>
<td>En Español</td>
<td>Medical Summary and Emergency Care Plan</td>
</tr>
<tr>
<td>5) Transfer of Care</td>
<td>Transfer Checklist</td>
<td>En Español</td>
<td>Condition Fact Sheet</td>
</tr>
<tr>
<td>6) Transition Completion</td>
<td>Health Care Transition Feedback Survey for Youth</td>
<td>En Español</td>
<td>Health Care Transition Feedback Survey for Young Adults</td>
</tr>
</tbody>
</table>

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 the Florida Department of Health. It supports 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
- Independent Living
- For Youth & Families
- Decision Making & Guardianship
- Education & Training for Health Care Professionals
- Service Delivery & Models of Care
- Health Insurance & Financing
- Advocacy
- Secondary & Post-Secondary Education
- Juvenile Justice System
- Regional Coalitions
- HillsboroughHATS
- Northeast FloridaHATS
- PanhandleHATS
- South FloridaHATS
- Contact
- Archive

Some Resources

- Understanding Florida Medicaid Managed Care: From Family Network on Disabilities (2016)
- My Health Care: A classroom curriculum to improve health literacy, communication, and self-advocacy skills

Some Materials for Youth and Families

- Just the Facts: The 411 on Health Insurance for Young Adults Ages 18-30 in Florida (2015)
- Transition 2 Go: Informational Briefs on Florida Guardianship, Employment, Social Security, and

Some Tools for Providers

- Condition-Specific Tools for Subspecialists From the American College of Physicians. Tools are now available for the following subspecialties: general internal medicine, intellectual/developmental disabilities, and physical disabilities.

Need Training?

- Health Care Transition Training for Health Care Professionals. This course is appropriate for all practitioners and support staff involved in the care of adolescents and young adults.
- Illinois Transition Care Project Offers...
Readiness Assessment

Sample Transition Readiness Assessment for Youth
Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what you already know about your health and how to use health care and the areas that you need to learn more about. If you need help completing this form, please ask your parent/guardian.

Date:
Name: Date of Birth:

Transition Importance and Confidence
On a scale of 0 to 10, please circle the number that best describes how your skill level.

How happy are you with your ability to prepare for change to adult life?

Managing Medications
1. Do you fill your prescription if you need to?  
2. Do you know what to do if your prescription requires a change in your medications?  
3. Do you take medications correctly and on your own?  
4. Do you remember medications before they run out?  

Appointment Keeping
5. Do you call the doctor’s office to make an appointment?  
6. Do you follow up on any referrals for tests, check-ups, or labs?  
7. Do you arrange for your ride to medical appointments?  
8. Do you call the doctor about unusual changes in your health (for example: Allergic reactions)?  
9. Do you apply for health insurance if you lose your current coverage?  
10. Do you know how your health insurance works?  
11. Do you manage your money or budget household expenses (for example: Use checking deposits)?  

Tracking Health Issues
12. Do you fill out the medical history form, including a list of your allergies?  
13. Do you keep a calendar or other list of medical and other appointments?  
14. Do you make a list of questions before the doctor’s visit?  
15. Do you get financial help with school or work?  

Talking with Providers
16. Do you tell the doctor or nurse what you are feeling?  
17. Do you answer questions that are asked by the doctor, nurse, or clinic staff?  

Managing Daily Activities
18. Do you help plan or prepare meals?  
19. Do you keep home/homework clean or order after meals?  
20. Do you use neighborhood stores and services (for example: Grocery stores and pharmacy stores)?

© Wood, Sorensen, Reiss, Livingston & Kremer, 2014
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 Diagnosis: ____________________________ Secondary Diagnosis: ____________________________

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>
<tbody>
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</tbody>
</table>

Initial Date of Plan: ____________________________ Last Updated: ____________________________ Parent/Caregiver Signature: ____________________________

Clinician Signature: ____________________________ Care Staff Contact: ____________________________ Care Staff Phone: ____________________________

© Get Transition™ Center for Health Care Transition Improvement, 2014. Get Transition™ is a program of The National Alliance to Advance Adolescent Health. E040629-06-17. www.GetTransition.org
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 parents are 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 questions you will be filling out at the IEP meeting, which typically include:
1. 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
2. Goals and Objectives - the general academic, linguistic, 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.
3. 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.

Children age 14 and older that will help them meet postsecondary goals, employment, and independent living. Transition services for those students for whom transition planning is appropriate include:

- Independent living skills
- Community participation
- Continuing education
- Employment training
- Vocational education

and services within your school district (as well as those outside of your school district) that will meet your child’s needs. Examples include:

- Specialized instruction
- Cooperative education
- Transition services

Are these things important? Many parents wonder if there is a need for a particular program or service.

In the IEP meeting, if you don’t agree with the IEP, it’s a good idea for you to put together a blueprint you want beforehand. This will not only help you learn your materials, but also demonstrate that you need the educational help you want for your child. 
Health Insurance

- Plan for change in insurance coverage
  - Medicaid
  - Parents’ plan
  - Employer-based
  - Marketplace plans
  - Plan for change in insurance coverage

Just the Facts: The 411 on Health Insurance for Young Adults Ages 18-30 in Florida

Including Those with Chronic Health Conditions or Disabilities

Version 1.4, July 2016 Edition
• 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/VRAppli cation.ft.

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

- 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](http://www.aheceducation.com)
  - Modules also posted on [www.FloridaHATS.org](http://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 smooth transition for every patient, including those with special health care needs.

This online course from FloridaHATS includes evidence-based materials from Our 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 developmental, 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](http://www.FloridaHATS.org) for free CME/CE credit. Visit [www.aheceducation.com](http://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, GPHI, University of South Florida, jhess@health.usf.edu or (813) 259-6604.
Web-Based Training for Professionals

- Training for teachers, school nurses and other professionals in the school setting
  - Available at www.FloridaHATS.org
## Other Transition Resources

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<th>Category</th>
<th>Resource</th>
</tr>
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<td>Assistive Technology and Equipment</td>
<td>FAAST</td>
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<tr>
<td>Independent Living</td>
<td>Centers for Independent Living</td>
</tr>
<tr>
<td>Housing</td>
<td>Housing in Florida: A Resource Guide for Individuals with Developmental Disabilities</td>
</tr>
<tr>
<td>Transportation</td>
<td>Access to Florida’s Transportation Disadvantaged Program for Individuals with Disabilities</td>
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Contact

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