Transitioning Adolescents to Adult Care: Are YOU Prepared?

John Reiss, Ph.D.
April 10, 2019
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**, and **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. Transition is a process.

**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**
A discrete event. Discharge from pediatrics and enrollment with an adult-oriented provider; Should occur between ages 18-21+

**Successful Transition**
Patients are engaged in and receive on-going patient-centered adult-oriented 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
  - Estimated 1,000,000 people in U.S. have CP
  - Expected 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

Prevalence

Children who have special health care needs (CSHCN)
Children age 0-17 years
Nationwide

24.4% of youth aged 12-17 have SHCN

What Can Happen?

• Without adequate transition support, when transferring from pediatric to adult care, youth may:
  – Lose/have gaps in insurance
  – Have poor connections to the adult health care system
  – Have decreased adherence with medicine, self-care
  – Have 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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<tbody>
<tr>
<td><em>Child-friendly</em></td>
<td><em>Cognitive</em></td>
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<td><em>Family-centered</em></td>
<td><em>Patient-centered</em></td>
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<tr>
<td><em>Interact primarily with parents</em></td>
<td><em>Interact with patient (but not with parents)</em></td>
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<tr>
<td><em>Nurturing</em></td>
<td><em>Empower individual</em></td>
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<td><em>Prescriptive</em></td>
<td><em>Collaborative</em></td>
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<td><em>Developmental Focus</em></td>
<td><em>Disease Focus</em></td>
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</table>
Communication Gaps

Communication gaps among providers

Pediatric knowledge of adult system, adult-oriented physicians, resources and services is limited

Records not systematically transferred and poor co-management of care during transfer of care

Cultural gaps between adult provider & youth
Adult System of Care

- Oriented to care of adults age 40 ++
- Provider capacity and training
  - Few adult-oriented physicians who are
    - Trained in pediatric onset conditions
    - Willing to take primary responsibility for care of YASHCN
- Service fragmentation
  - Minimal case management in adult practices
  - Lack of linkages to community-based adult services
- Low Medicaid reimbursement rates (compared to Medicare)
Adequate Insurance Coverage

- Aging out of childhood health insurance plans can create gaps/loss in coverage
- Benefits provided by entry level and temporary jobs often limited, unavailable, or have high premiums
- Increase in salary may lower/eliminate public benefits
- Limited benefits provided by Medicaid for adults (21+)
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
    - only **14.2%** without special health care needs, received the services necessary to make transitions to adult care

  - Florida is below national average:
    - **only 7.5%** of youth with special health care needs, and
    - **only 7.0%** without special health care needs received necessary services

Sources: 2016 National Survey of Children's Health, [http://childhealthdata.org](http://childhealthdata.org)
Why Do Adolescents Need a Structured Health Care Transition Process?

- 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 use of ambulatory care in adult settings;
    - Reduced hospitalizations

Sources: 2016 National Survey of Children's Health, [http://childhealthdata.org](http://childhealthdata.org)
### AAP/AAFP/ACP Clinical Report on Health Care Transition*

- Clinical Report on Transition published as joint policy AAP/AAFP/ACP 2011
- Targets all youth, beginning at age 12
- Algorithmic structure with:
  - Focus on planning, transfer, and integration into adult care
  - Branching for youth with special health care needs
  - Application to primary and specialty practices
- Includes transfer & integration into adult medical home and adult specialty care

#### 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

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National Center for Health Care Transition Improvement

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

1. Transition Policy
2. Transition Tracking and Monitoring
3. Transition Readiness
4. Transition Planning
5. Transfer/Integration into Adult-Centered Care
6. Transition Completion and Ongoing Care

- Discuss Transition Policy
- Ages 12-14
- Discuss Transition Policy
- Ages 14-18
- Assess skills annually
- Ages 14-18
- Develop transition plan, including medical summary
- Ages 14-18
- Transfer to adult–centered care
- Integration into adult practice
- Ages 18-21
- Confirm transfer completion
- Elicit consumer feedback
- Ages 18-26
Six Core Elements
Adapted Toolkit for Specific Conditions

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
### 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 by 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: _______________
  - Low, moderate, or high

- 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
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

Dear Adult Provider,

[...]

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.

- 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 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.

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
Stepwise approach to starting health care transition process in a practice or health care delivery system. Developed with input from integrated health care delivery systems that incorporated Six Core Elements into their practice processes.

www.gottransition.org/resourceGet.cfm?id=369
State and National Resources for Practitioners
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>Core Element</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Transitioning Youth to Adult Health Care Providers (Pediatric, Family Medicine, and Med-Peds Providers)</td>
<td>Complete Package: Full Package</td>
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<tr>
<td>Transitioning to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Med-Peds Providers)</td>
<td>Complete Package: Full Package</td>
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<tr>
<td>Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, and Med-Peds Providers)</td>
<td>Complete Package: Full Package</td>
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</table>

- **Summary of Six Core Elements:**
  - Transitioning Youth to an Adult Health Care Provider | En Español
  - Transitioning Youth to an Adult Approach to Health Care Without Changing Providers | En Español
  - Integrating Young Adults into Adult Health Care | En Español

1. **Transition Policy**
   - Transition Policy | En Español
   - Young Adult Transition and Care Plan | En Español

2. **Transition Planning and Monitoring**
   - Individual Transition Flow Sheet | En Español
   - Transition Registry | En Español
   - Individual Transition Flow Sheet | En Español
   - Transition Registry | En Español

3. **Transition Readiness**
   - Transition Readiness Assessment for Youth | En Español
   - Transition Readiness Assessment for Parents/Caregivers | En Español
   - Welcome and Orientation of Young Adults | En Español

4. **Transition Planning**
   - Plan of Care | En Español
   - Medical Summary and Emergency Care Plan | En Español
   - Condition Fact Sheet | En Español
   - Plan of Care | En Español
   - Medical Summary and Emergency Care Plan | En Español
   - Condition Fact Sheet | En Español

5. **Transfer of Care**
   - Transfer of Care Checklist | En Español
   - Transfer Letter | En Español
   - Self-Care Assessment for Young Adults | En Español

6. **Transfer Compliance**
   - Health Care Transition Feedback Survey for Youth | En Español
   - Health Care Transition Feedback Survey for Parents/Caregivers | En Español
   - Health Care Transition Feedback Survey for Young Adults | En Español
   - Health Care Transition Feedback Survey for Parents/Caregivers | En Español

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, Children’s Medical Services Managed Care Plan. Our mission is to ensure successful transition from pediatric to adult healthcare 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 Professionals
- Service Delivery & Models of Care
- Advocacy
- Secondary & Post-Secondary Education
- Juvenile Justice System
- Health Insurance & Financing
- Regional Coalitions
- Secondary & Post-Secondary Education
- National
- Local
- Florida
- Health Care Practitioners
- Decision Making & Guardianship
- Service Delivery & Models of Care
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- Health Insurance & Financing
- Regional Coalitions
- National
- Local
- Florida

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)
- Illinois Transition Care Project Offers

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.
### Health Summary & Emergency Care Plan

**Sample Medical Summary and Emergency Care Plan**

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

**Date Completed:**

**Date Given:**

**Form compiled by:**

**Contact Information:**

**Name:**

**Address:**

**City:**

**State:**

**Zip:**

**Relationship:**

**Preferred Emergency Contact:**

**Address:**

**City:**

**State:**

**Zip:**

**Relationship:**

**Health Care Plan:**

**Emergency Contact:**

**Address:**

**City:**

**State:**

**Zip:**

**Relationship:**

**Special Concerns for Disasters:**

**Amenities and Procedures to Be Avoided:**

**To Be Avoided:**

**Medical Procedures:**

**Medications:**

**Diagnoses and Current Problems:**

**Problem:**

**Diagnosis:**

**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/stay 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)

1. 

2. 

3. 

4. 

5. 

Current Medications

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Current Therapies

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# Readiness Assessment

## Sample Transition Readiness Assessment for Youth

### Six Core Elements of Health Care Transition 2.0

**Directions to Youth and Young Adults:** Please check the box that best describes your skill level in the following areas that are important for transition to adult health care. There is no right or wrong answer and your answers will remain confidential and private.

**Directions to Caregivers/Parents:** If your youth or young adult is unable to complete the tasks below on their own, please check the box that best describes your skill level.

**Check here** if you are a parent/caregiver completing this form.

### Transition Readiness Assessment Questionnaire (TRAQ)

**Date of Birth:**

**Patient Name:**

**Date of Birth:**

**Today’s Date:**

### Managing Medications

1. Do you fill a prescription if you need to?
2. Do you know what to do if you are having a bad reaction to 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 what your health insurance covers?
11. Do you manage your money & budget household expenses (for example: use checking/debit cards)?

### 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 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 your home/house clean or clean-up after meals?
20. Do you use neighborhood stores and services (for example: grocery stores and pharmacy stores)?

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© Wood, Snavicki, Reiss, Livingood & Knaezer, 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 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 IEPs

• Transition IEPs, which start at age 14 in Florida, should outline a pathway to post-secondary independent living

• Project 10 ([www.project 10.info](http://www.project 10.info)) is Florida Department of Education’s statewide transition initiative
  ○ Includes employment training, post-secondary education and independent living resources
Classroom Curriculum

Lesson Plans

Parent/Student Handouts

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 must meet at least once a year with representatives of the local school district to discuss 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 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 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 areas of improvement 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 educational and special education 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.

If your child is 14 and older that will help them meet postsecondary employment, independent living, and independence goals. Transition services for those for students who are 16 and older, including else your child needs to succeed, such as particular teaching of the child’s educational performance and needs. Further and other school representatives, and gather opinions from your child’s teacher, occupational therapist, who have evaluated your child, and other parents. Visit many of these programs as you can.

To the IEP together, it’s a good idea for you to put together a blueprint you want beforehand. This will not only help you learn your masters, but also help the child, needs the educational help you want for...
Health Insurance

• Plan for change in insurance coverage
  ○ Medicaid
  ○ Parents’ plan
  ○ Employer-based
  ○ Marketplace plans
  ○ Plan for change in insurance coverage
• 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
- VR 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/vrApplication.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

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 clinical settings
  - 10 modules, 15-20 minutes each
  - Free CME/CE for Florida 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

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: 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, CRNP, University of South Florida, jhess@health.usf.edu or (813) 259-6004.
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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<tr>
<th>Category</th>
<th>Resource</th>
</tr>
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<tbody>
<tr>
<td>Assistive Technology and Equipment</td>
<td>FAAAST</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

John Reiss, PhD
Retired, University of Florida College of Medicine
Associate, FloridaHATS
johngreiss@gmail.com

Janet Hess, DrPH
Director, FloridaHATS
University of South Florida
jhess@health.usf.edu