Health Care Transition, Person Centered Thinking

&

Supporting Families of/and Individuals with
Intellectual & Developmental Disabilities

Presented by:

Laura G. Buckner, M.Ed., L.P.C., M.O.M.

The Institute for Person Centered Practices
A Collaborative Partnership with The Center on Disability Studies at the University of Texas and
The Center on Disability and Development at Texas A&M University

http://person-centered-practices.org/
Welcome to our Community of Learning

Charting the LifeCourse is designed to be used for your own life, for your family members, or in the work you do. The framework and tools will help you organize your ideas, vision, and goals, as well as problem solve, navigate, and advocate for supports.

What can Charting the LifeCourse do for You?

- People are using it to communicate their needs.
- People are advocating for the supports they need to accomplish their goals.
- Parents are setting higher expectations for their children.
- Students are learning how life experiences impact their career goals.
- Practitioners are enhancing the services they deliver to their clients.
Healthy Living Trajectory

VISION for a GOOD LIFE

OVERALL GOOD LIFE

VISION FOR HEALTHY LIFE

What I DON'T Want

DON'T WANT – OVERALL LIFE

DON'T WANT – HEALTHY LIFE

Developed by the UMKC Institute for Human Development, UCEDD | More tools and resources at lifecoursetools.com

Updated NOV 2016

https://www.lifecoursetools.com/
**Important TO**

What is important to a person includes those things in life which help us to be satisfied, content, comforted and happy. It includes:

- People to be with / relationships
- Things to do
- Places to go
- Rituals or routines
- Rhythm or pace of life
- Status & control
- Things to have

It includes what matters most to the person – their own definition of quality of life.

What is important to a person includes only what the person “says”:

- with their words
- with their actions

When words and actions are in conflict, listen to action. Ask why?

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**Important FOR**

What is important for a person includes:

### Issues of health:

- Prevention of illness
- Treatment of illness / medical conditions
- Promotion of wellness (e.g.: diet, exercise)

### Issues of safety:

- Environment
- Well being - physical and emotional
- Free from Fear

What others see as necessary to help the person:

- Be valued
- Be a contributing member of their community
YOUTH & YOUNG ADULTS

Transitioning to adult health care is a big step in your life. Got Transition has tools and resources for you to help make it a smooth process!

LEARN MORE

Got Transition aims to help youth and young adults move from pediatric to adult health care.

Six Core Elements™
(For Clinicians)

Youth & Young Adults
(FAQ & Resources)

Parents & Caregivers
(FAQ & Resources)

Resources & Research
(By Categories)

News & Announcements

Updated Six Core Elements of Health Care Transition™ 3.0 out now!

Got Transition has updated its Six Core Elements of Health Care Transition™ with revised tools, samples, and recommendations.

Step-by-Step Implementation Guides for the Six Core Elements

Got Transition now offers step-by-step Implementation Guides for each Six Core Element with real world examples for practices.

Family Toolkit on Health Care Transition

A toolkit from Got Transition developed for families to use during the transition from pediatric to adult health care. The toolkit includes a list of resources and steps on how to make the transition smooth.

Are you ready to take charge of your health? These 5 easy steps should help you find out!

2020 Transition Coding and Reimbursement Tip Sheet Available

Got Transition and the American Academy of Pediatrics have released their 2020 Transition Coding and Reimbursement Tip Sheet, which includes new CPT codes, current Medicare fees and ICDs for the codes, and more.

2020 Transition Conferences

Save the Date for two health care transition conferences (October 28-30, 2020)

For more News & Announcements, click here.
**Side-by-Side Comparison**

The Six Core Elements of Health Care Transition™ 3.0 are intended for use by pediatric, family medicine, med-peds, and internal medicine practices to assist youth and young adults as they transition to adult-centered care. They are aligned with the AAP/AAFP/ACP Clinical Report on Health Care Transition. Sample tools, implementation guidance, measurement, and payment resources are available at [www.GotTransition.org](http://www.GotTransition.org).

<table>
<thead>
<tr>
<th>Transitioning Youth to an Adult Health Care Clinician (For use by Pediatric, Family Medicine, and Med-Peds Clinicians)</th>
<th>Transitioning to a Adult Approach to Health Care without Changing Clinicians (For use by Family Medicine and Med-Peds Clinicians)</th>
<th>Integrating Young Adults into Adult Health Care (For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop a transition and care policy/guide with input from youth and parents/caregivers that describes the practice’s approach to transition, an adult approach to care in terms of privacy and consent, and age of transfer to an adult clinician.</td>
<td>• Develop a transition and care policy/guide with input from youth/young adults and parents/caregivers that describes the practice’s approach to transition and an adult approach to care in terms of privacy and consent.</td>
<td>• Develop a transition and care policy/guide with input from young adults that describes the practice’s approach to transition, accepting and partnering with new young adult patients, and an adult approach to care in terms of privacy and consent.</td>
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<tr>
<td>• Educate all staff about the practice’s approach to transition and distinct roles of the youth, parent/caregiver, and pediatric and adult health care team in the transition process, taking into account cultural preferences.</td>
<td>• Educate all staff about the practice’s approach to transition and distinct roles of the youth/young adult, parent/caregiver, and health care team in the transition process, taking into account cultural preferences.</td>
<td>• Educate all staff about the practice’s approach to transition and distinct roles of the young adult, parent/caregiver, and adult health care team in the transition process, taking into account cultural preferences.</td>
</tr>
<tr>
<td>• Display transition and care policy/guide somewhere accessible in practice space, discuss and share with youth and parent/caregiver, beginning at age 12 to 14, and regularly review as part of ongoing care.</td>
<td>• Display transition and care policy/guide somewhere accessible in practice space, discuss and share with youth/young adult and parent/caregiver, beginning at age 12 to 14, and regularly review as part of ongoing care.</td>
<td>• Display transition and care policy/guide somewhere accessible in practice space, discuss and share with young adult at first visit, and regularly review as part of ongoing care.</td>
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<tr>
<td><strong>2. Tracking and Monitoring</strong></td>
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<td>• Establish criteria and process for identifying transition-aged youth.</td>
<td>• Establish criteria and process for identifying transition-aged youth/young adults.</td>
<td>• Establish criteria and process for identifying transitioning young adults.</td>
</tr>
<tr>
<td>• Develop process to track receipt of the Six Core Elements, integrating with electronic medical records (EMR) when possible.</td>
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<td><strong>3. Transition Readiness</strong></td>
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<td><strong>3. Orientation to Adult Practice</strong></td>
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<tr>
<td>• Conduct regular transition readiness assessments, beginning at age 14 to 16, to identify and discuss with youth and parent/caregiver their needs for self-care and how to use health care services.</td>
<td>• Conduct regular transition readiness assessments, beginning at age 14 to 16, to identify and discuss with youth and parent/caregiver their needs for self-care and how to use health care services.</td>
<td>• Identify and list adult clinicians within your practice interested in caring for young adults.</td>
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<td></td>
<td></td>
<td>• Establish a process to welcome and orient new young adults to adult health care services.</td>
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### Side-by-Side Comparison (Continued)

<table>
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<tr>
<th>Transitioning Youth to an Adult Healthcare Clinician</th>
<th>Transitioning to an Adult Approach to Healthcare Without Changing Clinicians</th>
<th>Integrating Young Adults into Adult Health Care</th>
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<tbody>
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<td><strong>4. Transition Planning</strong></td>
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<td><strong>4. Integration into Adult Practice</strong></td>
</tr>
<tr>
<td>- Develop and regularly update the plan of care, including readiness assessment findings, youth's goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents.</td>
<td>- Develop and regularly update the plan of care, including readiness assessment findings, youth's goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents.</td>
<td>- Communicate with young adult's pediatrician(s) and arrange for consultation assistance, if needed.</td>
</tr>
<tr>
<td>- Prepare youth and parent/caregiver for an adult approach to care, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information.</td>
<td>- Prepare youth and parent/caregiver for an adult approach to care, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information.</td>
<td>- Prior to first visit, ensure receipt of transfer package, including final transition readiness assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional clinical records.</td>
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<tr>
<td>- Determine need for decision-making supports for youth and make referrals to legal resources.</td>
<td>- Determine need for decision-making supports for youth and make referrals to legal resources.</td>
<td>- Make pre-visit appointment reminder welcoming new young adult and identifying any special needs and preferences.</td>
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<tr>
<td>- Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult care. If both primary and subspecialty care are involved, discuss optimal timing for each.</td>
<td>- Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult specialty care, if needed.</td>
<td>-</td>
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<tr>
<td>- Assist youth in identifying an adult clinician(s) and provide linkage to insurance resources, self-care management information, and community support services.</td>
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<td>- Obtain consent from youth/parent/caregiver for release of medical information.</td>
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<td>-</td>
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<tr>
<td>- Take cultural preferences into account throughout transition planning.</td>
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<td>-</td>
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<tr>
<td><strong>5. Transfer of Care</strong></td>
<td><strong>5. Transition to Adult Approach to Care</strong></td>
<td><strong>5. Initial Visits</strong></td>
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<tr>
<td>- Complete transfer package, including final transition readiness assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional clinical records.</td>
<td>- Address any concerns youth/young adult has about transferring to an adult approach to care.</td>
<td>- Prepare for initial visit by reviewing transfer package with appropriate team members.</td>
</tr>
<tr>
<td>- Confirm date of first adult clinician appointment.</td>
<td>- Clarify an adult approach to care (shared decision-making, privacy and consent, access to information), adherence to care, preferred methods of communication, and health literacy needs.</td>
<td>- Address any concerns young adult has about transferring to adult care and take into account any cultural preferences.</td>
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<tr>
<td>- Prepare letter with transfer package, send to adult clinician, and confirm adult clinician's receipt of transfer package.</td>
<td>- Conduct self-care skills assessment if not recently completed and discuss young adult's needs for self-care and how to use health care services.</td>
<td>- Clarify an adult approach to care (shared decision-making, privacy and consent, access to information), adherence to care, preferred methods of communication, and health literacy needs.</td>
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<td>- Communicate with selected adult clinician about pending transfer of care.</td>
<td>- Offer education and resources on needed skills identified through the self-care skills assessment.</td>
<td>- Conduct self-care skills assessment if not recently completed and discuss their needs for self-care and how to use health care services.</td>
</tr>
<tr>
<td>- Confirm the pediatrician's responsibility for care until youth/young adult is seen by an adult clinician.</td>
<td>- Review youth/young adult's health priorities as part of their plan of care.</td>
<td>- Offer education and resources on needed skills identified through the self-care skills assessment.</td>
</tr>
<tr>
<td>- Transfer youth/young adult when their condition is as stable as possible.</td>
<td>- Continue to update and share with youth/young adult their medical summary and emergency care plan.</td>
<td>- Review youth adult's health priorities as part of their plan of care.</td>
</tr>
<tr>
<td><strong>6. Transfer Completion</strong></td>
<td><strong>6. Ongoing Care</strong></td>
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<tr>
<td>- Contact youth/young adult and parent/caregiver 3 to 6 months after transfer.</td>
<td>- Assist youth/young adult in connecting with specialists and other community resources.</td>
<td>- Communicate with pediatric practice confirming completion of transfer process.</td>
</tr>
</tbody>
</table>
What People Like and Admire about ___

__________________________

What is Important to ___

How to best support ____________________
Health Care Transition: Building a Program for Adolescents and Young Adults with Chronic Illness and Disability

Albert C. Hergenroeder & Constance Wiemann, Editors

HEALTH CARE TRANSITION RESOURCES:

http://www.supporteddecisionmaking.org/

https://www.gottransition.org/
With thanks to
The Learning Community for Person Centered Practices
(www.learningcommunity.us)
and
The Community of Practice for Supporting Families of Individuals with Intellectual & Developmental Disabilities
http://supportstofamilies.org/

Laura G. Buckner, M.Ed., LPC
Texas Center for Disability Studies, University of Texas at Austin
Laura.buckner@utexas.edu
512-232-0741
www.person-centered-practices.org
https://tcds.edb.utexas.edu/