Transition Models from Pediatric to Adult Health Care: Innovative Strategies

Patience White, MD, MA, FAAP, FACP
Got Transition
Center for Health Care Transition Improvement

CENTER FOR HEALTH CARE TRANSITION IMPROVEMENT
got transition?

Disclosures

The presenter has no disclosures, and no conflicts of interest.

Presentation Learning Objectives

After this presentation, you will be able to:

- Discuss the background need and national context for Health Care Transition from Pediatric to Adult Health Care
- Review the AAP/AAFP/ACP Clinical Report and the ***Six Core Elements of Health Care Transition*** through the lens of a pediatric practice transitioning youth to an Adult Practice
- Discuss the resources available at Gottransition.org and the current national activitives of the Got Transition

Background Need for Transition Improvements

- There are an estimated 18 million adolescents, ages 18-21, about ¼ of whom have chronic conditions; many more millions if you count those 12-26, the population affected by transition from pediatric to adult care. All Adolescents need to transition to adult-centered care
- Emerging young adults (ages 18-25):
  - fare worse than adolescents (ages 12-17) or young adults (ages 26-35).
  - have the highest use of ER among those younger than age 75
  - most likely to report no health care visits in last 12 months even with the ACA changes in health insurance.
- Without transition support, data show health is diminished, quality of care is compromised, and health care costs are increased*
- Majority of youth and families are ill-prepared for this change.
- Surveys of health care providers consistently show they lack a systematic way to support youth, families, and young adults in transition from pediatric to adult health care

*Prior et. al. *Pediatrics* 134:1213 2014

National Context for Transition

- ACA: Insurance expansions for young adults, transition an essential health home service
- NCQA medical home standards on transition (plan of care, self-care support, transfer of medical records)
- Healthy People 2020 goals
- Title V new Transition Performance Measure
- CMS/CMMI focus on transition from hospital to home

TRANSITION FERVOR

California High Speed Rail Authority (Public Domain)

State of Health Care Transition from Pediatric to Adult Health Care Approaches

What to do? Where to start?

Photo: Jon Candy (CC BY-SA 2.0)

AAP/AAFP/ACP Clinical Report on Health Care Transition

- In 2011, Clinical Report on Transition published as joint policy by AAP/AAFP/ACP
- Targets all youth, beginning at age 12
- Algorithmic structure with:
  - Branching for youth with special health care needs
  - Application to primary and specialty practices
- Extends through adult approach to care/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 and parents for adult approach to care and 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

"Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home" (*Pediatrics*, July 2011)

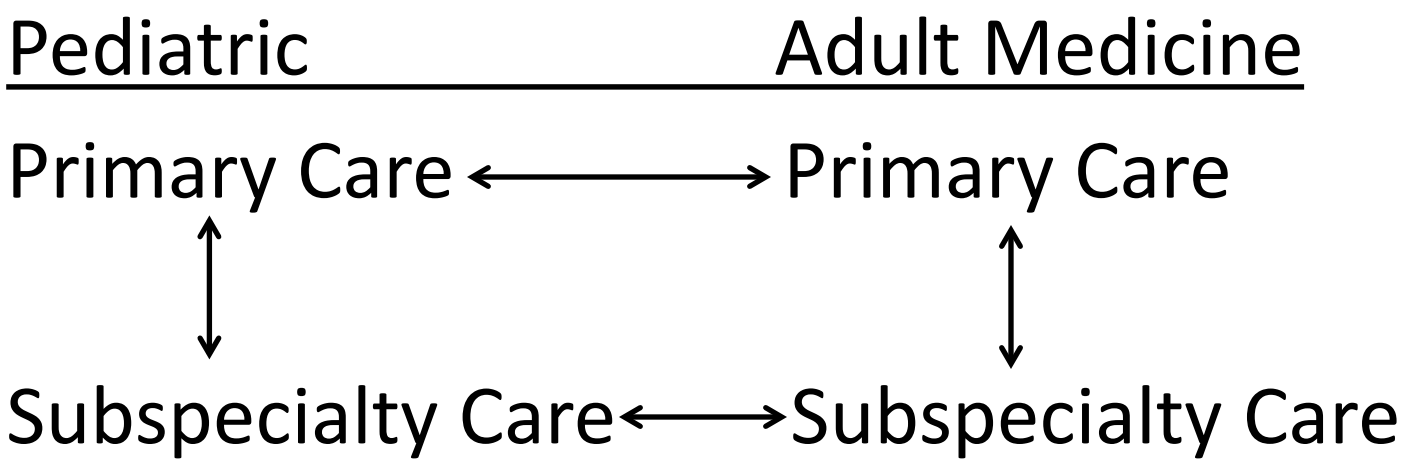
HCT Quality Improvement: Six Core Elements of Health Care Transition

- Original Six Core Elements, developed in 2011, as QI strategy based on AAP/AAFP/ACP Clinical Report with set of sample tools and transition index.
- HCT Learning Collaboratives (with primary and specialty care practices)
  - Conducted between 2010-2012 in DC, Boston, Denver, New Hampshire, Minnesota, Wisconsin
  - Used well-tested Learning Collaborative methodology from the National Initiative for Children's Healthcare Quality and pioneered by Institute for Healthcare Improvement
  - Demonstrated Six Core Elements and tools feasible to use in clinical settings and resulted in quality improvements in transition process*

* McManus et al. *Journal of Adol Health* 56:73 2014

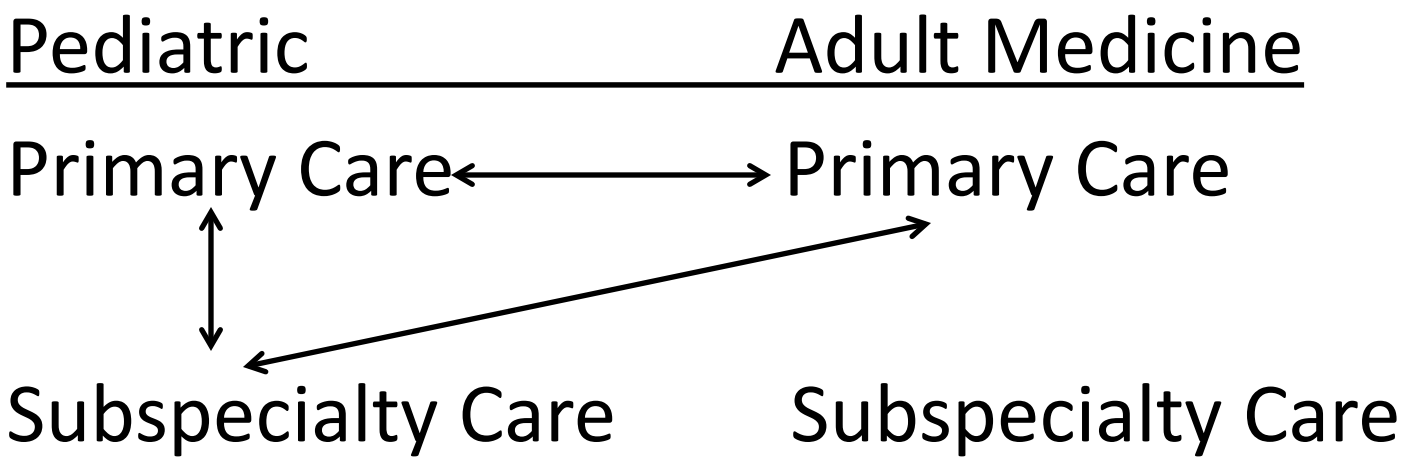
Models of Care Transfer

Pediatric diseases where there are both pediatric and Adult subspecialty providers available e.g. pediatric rheumatology



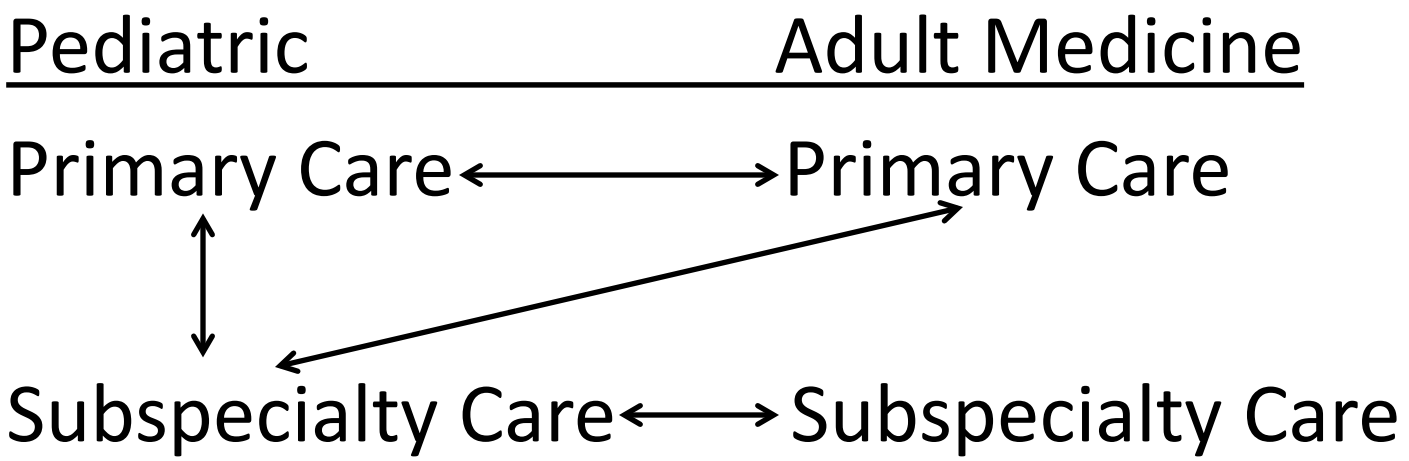
Models of Care Transfer

Pediatric diseases where there are few adult subspecialty providers available e.g. congenital heart disease

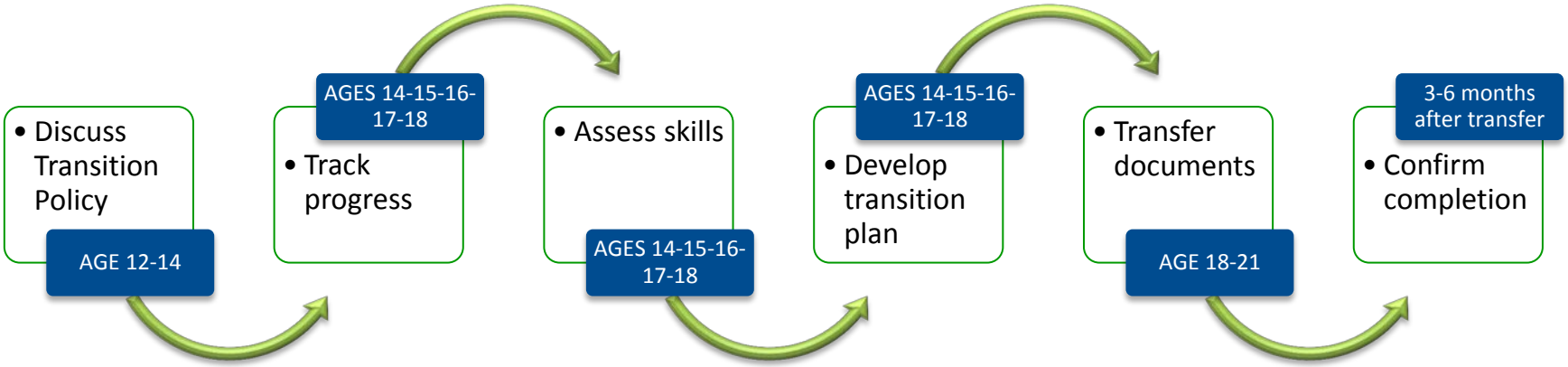


Models of Care Transfer

Pediatric Disease where adult primary care manages some of pediatric subspecialty e.g. pediatric type II diabetes, Pediatric leukemia



Six Core Elements of Transition 2.0



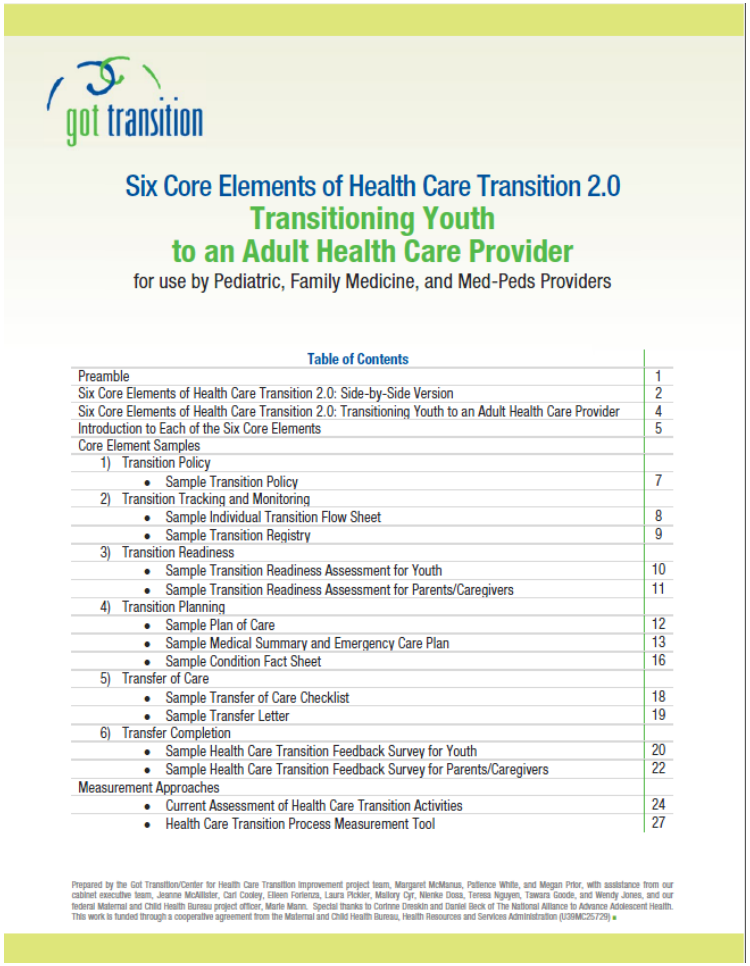
1. **Transition Policy**
2. **Transition Tracking and Monitoring**
3. **Transition Readiness**
4. **Transition Planning**
5. **Transfer of Care**
6. **Transition Completion**

A further look…

Transitioning Youth to Adult Health Care Providers
(Pediatric, Family Medicine, and Med-Peds Providers)

Transitioning to an Adult Approach to Health Care Without Changing Providers
(Family Medicine and Med-Peds Providers)

Integrating Young Adults into Adult Health Care
(Internal Medicine, Family Medicine, and Med-Peds Providers)



got transition

Six Core Elements of Health Care Transition 2.0
Transitioning Youth to an Adult Health Care Provider
for use by Pediatric, Family Medicine, and Med-Peds Providers

Table of Contents

Prepared by the Got Transition/Center for Health Care Transition Improvement project team, Margaret McManus, Patience White, and Megan Prior, with assistance from our cabinet executive team, Jeanne McAllister, Cari Cooley, Eileen Forienza, Laura Pickler, Mallory Cyr, Nienke Doss, Teresa Nguyen, Tawara Goode, and Wendy Jones, and our federal Maternal and Child Health Bureau project officer, Marie Mann. Special thanks to Corinne Dreskin and Daniel Beck of The National Alliance to Advance Adolescent Health. This work is funded through a cooperative agreement from the Maternal and Child Health Bureau, Health Resources and Services Administration (U39MC25729).

Transition Policy

- Distinctive policy examples in the 3 packages
- Emphasis on adult approach to care and legal changes at age 18, including options for supported decision-making
- Clarity about support offered by practice and ages and expectation for transfer
- This core element was particularly welcomed by families and youth

Transition Policy

got transition

Sample Transition Policy

Six Core Elements of Health Care Transition 2.0

[*Pediatric Practice Name*] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult's consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.

Transition Policy: Benefits

Why is it important?

- Building consensus
- Addressing fairness
- Meeting expectations of young adults
- Allowing for planning and systematic processes
- Young adults who reviewed the pilot policy said they were grateful for the information
- Now everyone understands (young adults/parents/providers):
  - What is expected in an adult model of care or a new adult practice
  - Confidentiality and consent


TRACKING
& MONITORING
PHOTO: FLICKR/GIDZY (CC BY 2.0)

Tracking and Monitoring

- Support the practice to focus on initial QI for a pilot population
- Distinctive tracking issues in 3 packages
- Tools available for those with and without electronic health records for tracking documentation options
- Individual Transition Flow Sheet for use in paper chart or EHR
- Registry set up as an Excel file

TRANSITION READINESS

Transition Readiness

- Literacy level (Grade 5.7)
- Validated questions on importance and confidence
- Youth/Young adults and caregivers appreciate reviewing/learning what general skills are needed to be successful in an adult practice

got transition | **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/caregiver.

Date:

Name: Date of Birth:

Transition Importance and Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

How important is it to you to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health *Please check the box that applies to you right now.*	*Yes, I know this*	*I need to learn*	*Someone needs to do this... Who?*
I know my medical needs.	☐	☐	☐
I can explain my medical needs to others.	☐	☐	☐
I know my symptoms including ones that I quickly need to see a doctor for.	☐	☐	☐
I know what to do in case I have a medical emergency.	☐	☐	☐
I know my own medicines, what they are for, and when I need to take them.	☐	☐	☐
I know my allergies to medicines and medicines I should not take.	☐	☐	☐
I carry important health information with me every day. (e.g. insurance card, allergies, medications, emergency contact information, medical summary)	☐	☐	☐
I understand how health care privacy changes at age 18 when legally an adult.	☐	☐	☐
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
I know or I can find my doctor's phone number.	☐	☐	☐
I make my own doctor appointments.	☐	☐	☐
Before a visit, I think about questions to ask.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know to show up 15 minutes before the visit to check in.	☐	☐	☐
I know where to go to get medical care when the doctor's office is closed.	☐	☐	☐
I have a file at home for my medical information.	☐	☐	☐
I have a copy of my current plan of care.	☐	☐	☐
I know how to fill out medical forms.	☐	☐	☐
I know how to get referrals to other providers.	☐	☐	☐
I know where my pharmacy is and how to refill my medicines.	☐	☐	☐
I know where to get blood work or x-rays if my doctor orders them.	☐	☐	☐
I have a plan so I can keep my health insurance after 18 or older.	☐	☐	☐
My family and I have discussed my ability to make my own health care decisions at age 18.	☐	☐	☐

Transition Importance and Confidence

On a scale of 0 to 10, please circle the number that best describes how you feel right now.

How important is it to you to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health — *Please check the box that applies to you right now.*	*Yes, I know this*	*I need to learn*	*Someone needs to do this… Who?*
I know my medical needs.	☐	☐	☐
I can explain my medical needs to others.	☐	☐	☐
I know my symptoms including ones that I quickly need to see a doctor for.	☐	☐	☐
I know what to do in case I have a medical emergency.	☐	☐	☐
I know my own medicines, what they are for, and when I need to take them.	☐	☐	☐
I know my allergies to medicines and medicines I should not take.	☐	☐	☐
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	☐	☐	☐
I understand how health care privacy changes at age 18 when legally an adult.	☐	☐	☐
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
I know or I can find my doctor's phone number.	☐	☐	☐

Transition Readiness

PEDIATRIC COMPONENT

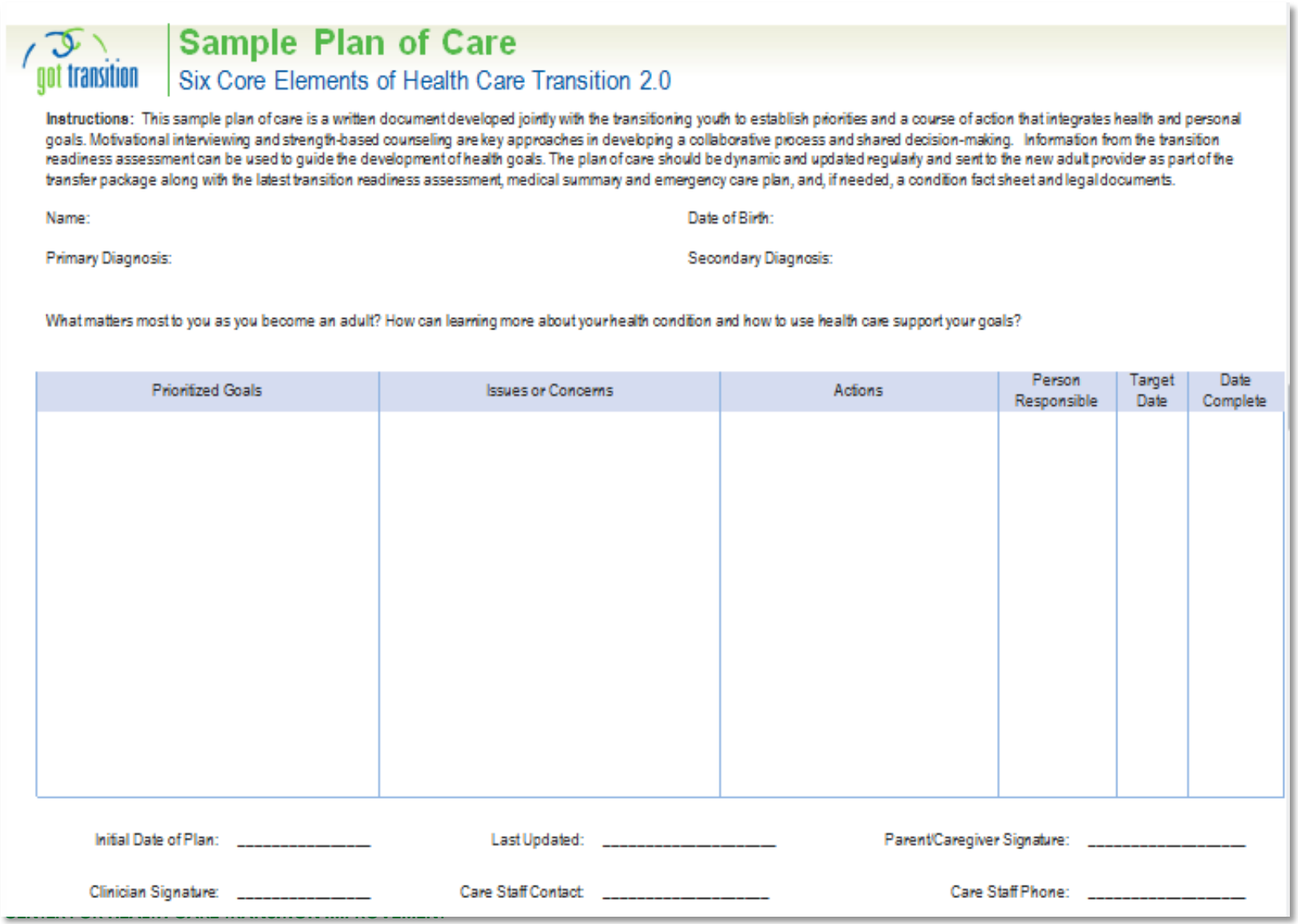
- Assess readiness for an adult approach to care with transition skill readiness assessments several times during the transition process
- Locate adult practices interested in collaborating /receiving prepared youth/young adults
- Ask the Adult practice to create and share their practice policy emphasizing the Confidentiality and Consent components (modified if decision making support is needed) and welcome and orientation materials with the pediatric practice


TRANSITION
PLANNING

Transition Planning

- Make sure the Y/YA HCT Plan of care incorporates health into young adult's overall priorities (key issue for the GT young adult review panel)
- Develop combined medical summary and emergency care plan – pay special attention to the section where you can state what is special about this youth to assist the next provider in engaging the youth in a new health care relationship
- Share Medical Summary, ECP and HCT Plan of Care with youth/young adult so they have a copy to share when needed
- Youth with intellectual challenges (if needed):
  - Review supported decision making plan
  - Understand their unique communication needs

Plan of Care Template



got transition

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?

Prioritized Goals	Issues or Concerns	Actions	Person Responsible	Target Date	Date Complete

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

Clinician Signature: _____ Care Staff Contact: _____ Care Staff Phone: _____

got transition?

Sample Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

This document should be shared with and carried by youth and families/caregivers.		
Date Completed:		Date Revised:
Form completed by:		
Contact Information		
Name:		Nickname:
DOB:		Preferred Language:
Parent (Caregiver):		Relationship:
Address:		
Cell #: Home #:		Best Time to Reach:
E-Mail:		Best Way to Reach: Text Phone Email
Health Insurance/Plan:		Group and ID #:
Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		
Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations
Special Concerns for Disaster:		
Allergies and Procedures to be Avoided		
Allergies	Reactions	
To be avoided	Why?	
☐ Medical Procedures:		

TRANSFER OF CARE

Transfer of Care

Your practice responsibility when transferring to a new adult provider

Transfer letter to the new adult provider with:

- Appropriate documentation
- Statement that the youth's care is covered by your practice until first visit
- Offer to be a consultant as needed

- Readiness assessment
- Medical summary and emergency care plan
- Plan of care & decision support documents
- Condition fact sheet, if needed

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

Transfer of Care to Initial Adult Practice Visit

Adult practice responsibility when accepting a Y/YA into their practice

Suggestions on what youth prefer from their provider prior to and during initial visit

- Pre-visit contact recommended
- At first 2 visits, discussion about:[1]

- Discuss transfer concerns/orientation to adult care/practice
- Discuss young adult's partnership with adult provider (privacy and confidentiality) and best approach to communication (phone, text, email)
- Decision making support (if needed) or review legal documents provided (guardianship)
- Review medical summary and update emergency care plan with young adult.
- Review transition readiness assessment/administer self-care assessment and review and update plan of care


TRANSFER COMPLETION
+ ONGOING CARE

Transfer Completion

- Transition feedback surveys
- Learn how the integration into the adult practice is going
- Several questions adapted from new questions under development for National Survey of Children's Health and AHRQ survey on transition
- Asking for feedback can build a bond between the young adult and the new practice so they will return to the new adult provider

got transition

Sample Health Care Transition Feedback Survey for Youth

Six Core Elements of Health Care Transition 2.0

This is a survey about your experience changing from pediatric to adult health care. You may choose to answer this survey or not. Your responses to this survey are confidential.

1. How often did your previous health care provider explain things in a way that was easy to understand?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Never
2. How often did your previous health care provider listen carefully to you?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Never
3. Did your previous health care provider respect how your customs or beliefs affect your care?
   - ☐ A lot
   - ☐ Some
   - ☐ A little
   - ☐ Not at all
4. Did your previous health care provider discuss with you or have an office policy that informed you at what age you may need to change to a new provider who treats mostly adults?
   - ☐ Yes
7. Did your previous health care provider actively work with you to think about and plan for the future (e.g., take time to discuss future plans about education, work, relationships, and development of independent living skills)?*
   - ☐ A lot
   - ☐ Some
   - ☐ A little
   - ☐ Not at all
8. How often did you schedule your own appointments with your previous health care provider?
   - ☐ Never
   - ☐ Sometimes
   - ☐ Usually
   - ☐ Always
9. Did your previous health care provider explain legal changes in privacy, decision-making, and consent that take place at age 18?
   - ☐ Yes
   - ☐ No
10. Did your previous health care provider actively work with you to create a written plan to meet

Transfer Completion

Follow up responsibilities of provider:

- Confirm transfer completion with next provider
- Reach out and offer consultation with next provider as needed
- Build ongoing collaborative relationship with adult primary and specialty care providers
- Have a list of adult specialty providers willing to care for young adults as needed

Measurement Options

Measurement Options

1 Initial Health Care Transition Assessment

- Qualitative self-assessment tool modeled after index
- Provides a snapshot of where practice is in implementing transition processes
- New questions on consumer feedback and leadership

got transition

Current Assessment of Health Care Transition Activities for Transitioning Youth to Adult Health Care Providers

Six Core Elements of Health Care Transition 2.0

Element	Level 1	Level 2	Level 3	Level 4	Score
1. Transition Policy	Clinicians vary in their approach to health care transition, including the appropriate age for transfer to adult providers.	Clinicians follow a uniform but not a written policy about the age for transfer. The approach for transition planning differs among clinicians.	The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information and addresses the practice's transition approach and age of transfer. The policy is not consistently shared with youth and families.	The practice has a written transition policy or approach, developed with input from youth and families that includes privacy and consent information, a description of the practice's approach to transition, and age of transfer. Clinicians discuss it with youth and families beginning at ages 12 to 14. The policy is publicly posted and familiar to all staff.	
2. Transition Tracking and Monitoring	Clinicians vary in the identification of transitioning youth, but most wait until close to the age of transfer to identify and prepare youth.	Clinicians use patient records to document certain relevant transition information (e.g., future provider information, date of transfer).	The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete some but not all transition processes.	The practice has an individual transition flow sheet or registry for identifying and tracking transitioning youth, ages 14 and older, or a subgroup of youth with chronic conditions as they progress through and complete all "Six Core Elements of Health Care Transition 2.0," using EHR if possible.	

got transition

1 Current Assessment of Health Care Transition Activities for Integrating Young Adults into Adult Health Care

Six Core Elements of Health Care Transition 2.0

Instructions for completing this Assessment are on page 1

Transition Activity	Level 1	Level 2	Level 3	Level 4	Score
1. Young Adult Transition and Care Policy	Clinicians vary in their approach to new young adult patients, and most often approach new young adults as any new patient group, requesting that they complete new patient information forms.	Clinicians follow a uniform, but not a written health care transition policy about the practice's approach for accepting new young adults, assisting them in gaining knowledge of the adult health care system.	The practice has a written health care transition and care policy or approach, developed with input from young adults, which describes the practice's approach for partnering with new young adult patients and explains privacy and consent in understandable language.	The practice has a written health care transition and care policy or approach, developed with input from young adults, and it is publicly displayed and discussed with new young adult patients. All staff are familiar with the policy.	
2. Tracking and Monitoring	Clinicians have no mechanism to identify new young adults in the practice and their level of self-care skills.	Clinicians use patient charts to record certain relevant transition information (e.g., medical summary, self-care assessment).	The practice has an individual transition flow sheet or transition registry for identifying and tracking new young adult patients, or a subgroup of young adults with chronic conditions, as they progress through and complete some but not all transition processes.	The practice has an individual transition flow sheet or registry for identifying and tracking new young adult patients, or a subgroup of young adults with chronic conditions, as they progress through and complete all *Six Core Elements of Health Care Transition*, using EHR if possible.	
3. Transition Readiness/ Orientation to Adult Practice	Clinicians have no welcome process tailored to new young adult patients, and there is no organized process within the practice to identify clinicians interested in caring for young adults.	Clinicians within the practice have self-selected to accept new young adult patients, and the practice makes available general introductory information for all new patients of all ages.	The practice has a list of providers interested in caring for young adults that it shares with new young adult patients and pediatric practices. It also makes available general introductory information for all new patients.	The practice has a packet of materials tailored to young adults orienting them to the practice and including a list of providers interested in caring for young adults. The practice offers get-acquainted appointments, if feasible.	

Measurement Options

2 Health Care Transition Process Measurement Tool

- Objective scoring method with documentation requirements
- Measures implementation of Six Core Elements, consumer feedback and leadership, and dissemination
- Intended to be conducted at start of QI initiative as baseline measure and repeated to assess progress

Measurement Tool: Policy Example

Health Care Transition Process Measurement Tool for Transitioning Youth to Adult Health Care Providers (continued)

Six Core Elements of Health Care Transition 2.0

A) Implementation in Practice/Network	Yes or No	Possible	Actual	Possible Documentation
1. Transition Policy				
Developed a written transition policy/statement that describes the practice's approach to transition		Yes = 4		Transition policy
Included information about privacy and consent at age 18 in transition policy/statement		Yes = 2		Transition policy
Posted policy/statement (public clinic spaces, practice website etc.)		Yes = 2		Photo
Educated staff about transition policy/statement and their role in transition process		Yes = 2		Date(s) of program
Designated practice staff to incorporate *Six Core Elements* into clinical processes		Yes = 4		Job description
Transition Policy Subtotal:		14		

B) Youth and Family Feedback and Leadership	Yes or No	Possible	Actual
Included youth and families in developing policy		Yes = 2	

C) Dissemination in Practice/Network						Possible	Actual
Percent of Patients in Practice Receiving Transition Elements:	1–10%	11–25%	26–50%	51–75%	76–100%		
Score Points:	1	2	3	4	5		
1. Transition Policy							
Sharing policy with families and youth ages 12–21 (letter or visit)						0 to 5	
					Transition Policy Subtotal:	5	

Additional Resources

New Got Transition Center for HCT Improvement Goals: 2014-2018

1. Build on Transition Quality Improvement work and disseminate to larger populations and practices
2. Transition education and training
3. Young adult and family engagement
4. Transition policy interventions
5. Transition information dissemination

Integrated Care Systems working with Got Transition on HCT QI

Cleveland Clinics
Primary Care

Health Partners (MN)
Primary Care

Henry Ford Health System (MI)
Primary Care

Kaiser Northern California
Primary Care

University of Rochester
Specialty Care

Walter Reed National Military Medical Center (MD)
Specialty Care

- Partnership in implementing and evaluating new *Six Core Elements* packages
- Pediatric and adult provider (includes Med-Peds and Family Medicine) teams participating
- Coaching support to networks by Got Transition
- **Goal:** to learn about dissemination of transition QI and ROI

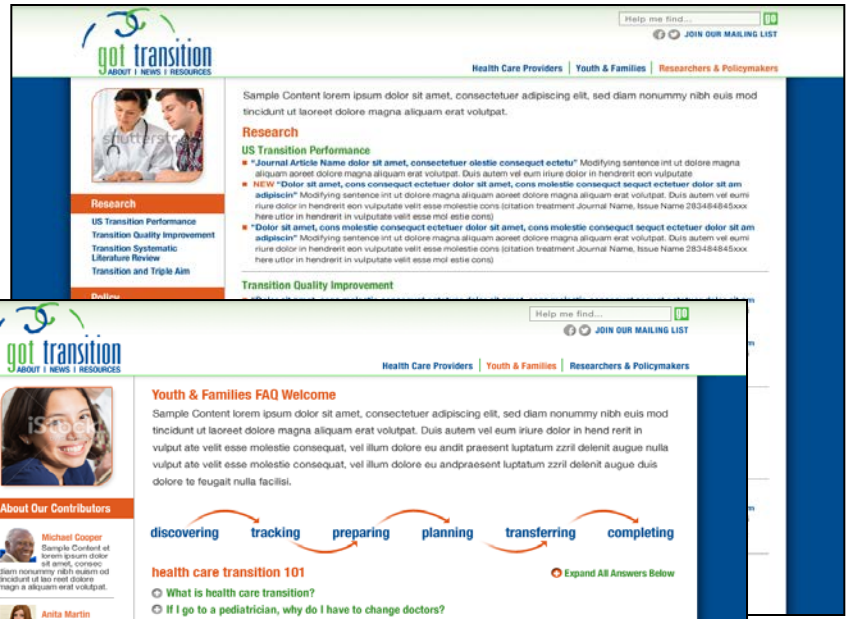
Examples of Got Transition's National Efforts

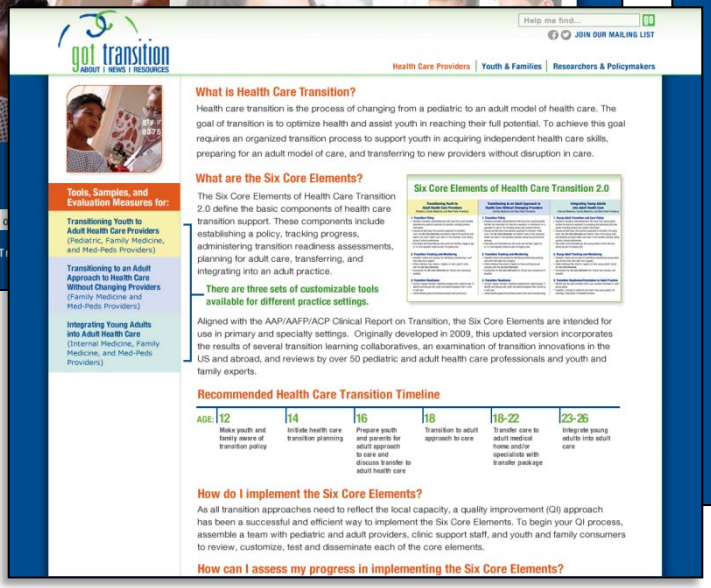
- ACP Council on Subspecialty Societies and GT Transition Project:
  - 11 subspecialty societies signed up to (at a minimum) customize three of the Six Core Elements tools, Readiness and Self Care Assessment and Medical Summary, for several of their diseases
  - SGIM/SAHM customizing for youth with ID.DD and Physical Disability
  - Products will be reviewed by AAP
  - ACP will launch all the specialty Societies' tools at the IM meeting in 5/2016
- Updating the 2011 Clinical Report for AAP/AAFP/ACP
- Support States Title V Maternal and Child Health programs on statewide HCT efforts who have chosen transition as one of their focuses for their block grant

Examples of Got Transition's National Efforts

- Develop HCT payment strategies
- Building Young Adult/Family/nursing leaders for HCT
- Tip Sheets available at Gottransition.org
  - Starting a Transition Improvement Process
  - Coding and Reimbursement Strategies
  - Incorporating Transition into EPIC HER
  - Integrating Young Adults with Intellectual and Developmental Disabilities into Your Practice: Tips for Adult Health Care Providers

Website: www.gottransition.org





Presentation Learning Objectives

After this presentation, you will be able to:

- Discuss the background need and national context for Health Care Transition from Pediatric to Adult Health Care
- Review the AAP/AAFP/ACP Clinical Report and the ***Six Core Elements of Health Care Transition*** through the lens of a pediatric practice transitioning youth to an Adult Practice
- Discuss the resources available at Gottransition.org and the current national activities of the Got Transition

Thank You and Questions

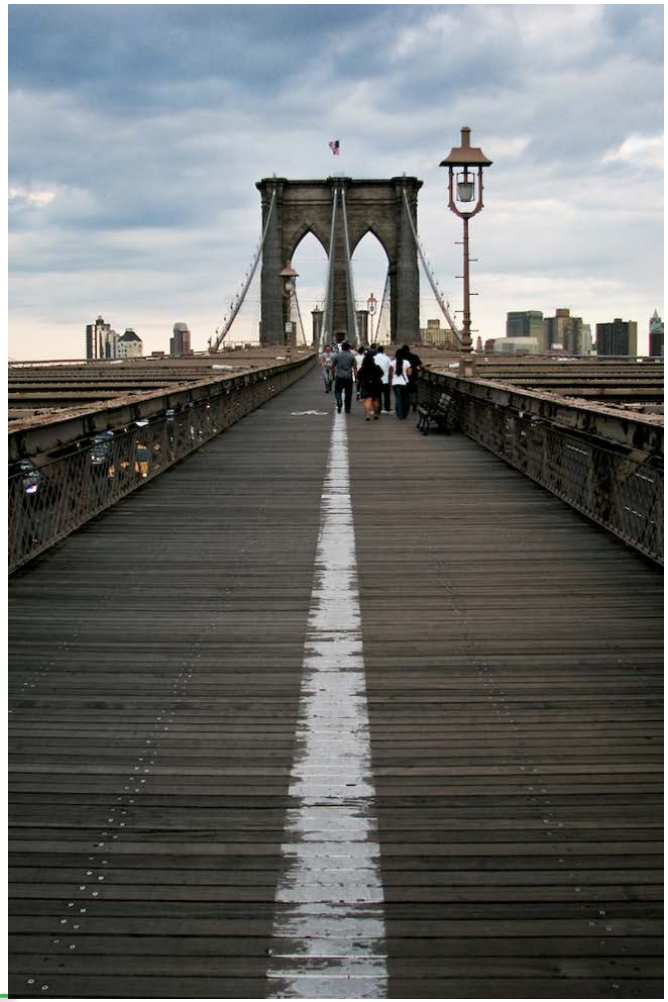


Photo by [illegible]
Used under Creative Commons License (CC BY-NC-SA 2.0)

gottransition.org

See link to new Transition CME sponsored by HSCSN, download the *Six Core Element 2.0* packages and start making HCT quality improvements in your practice

pwhite@thenationalalliance.org

Please provide us with your contact information so that we can add you to our mailing list.

HealthCareTransition

@gottransition2