

Wisconsin Integrated Transition Planning Project (WITPP): WI Transition Planning Coalition December 9 & 15, 2020



Our Agenda

- I. Welcome and Transition Bright Spot
- II. Highlights and Lessons Learned from Asset Inventory
- III. Equity Action Lab Example
- IV. Identifying Potential Communities
- V. Next Steps and Wrap Up with Poll

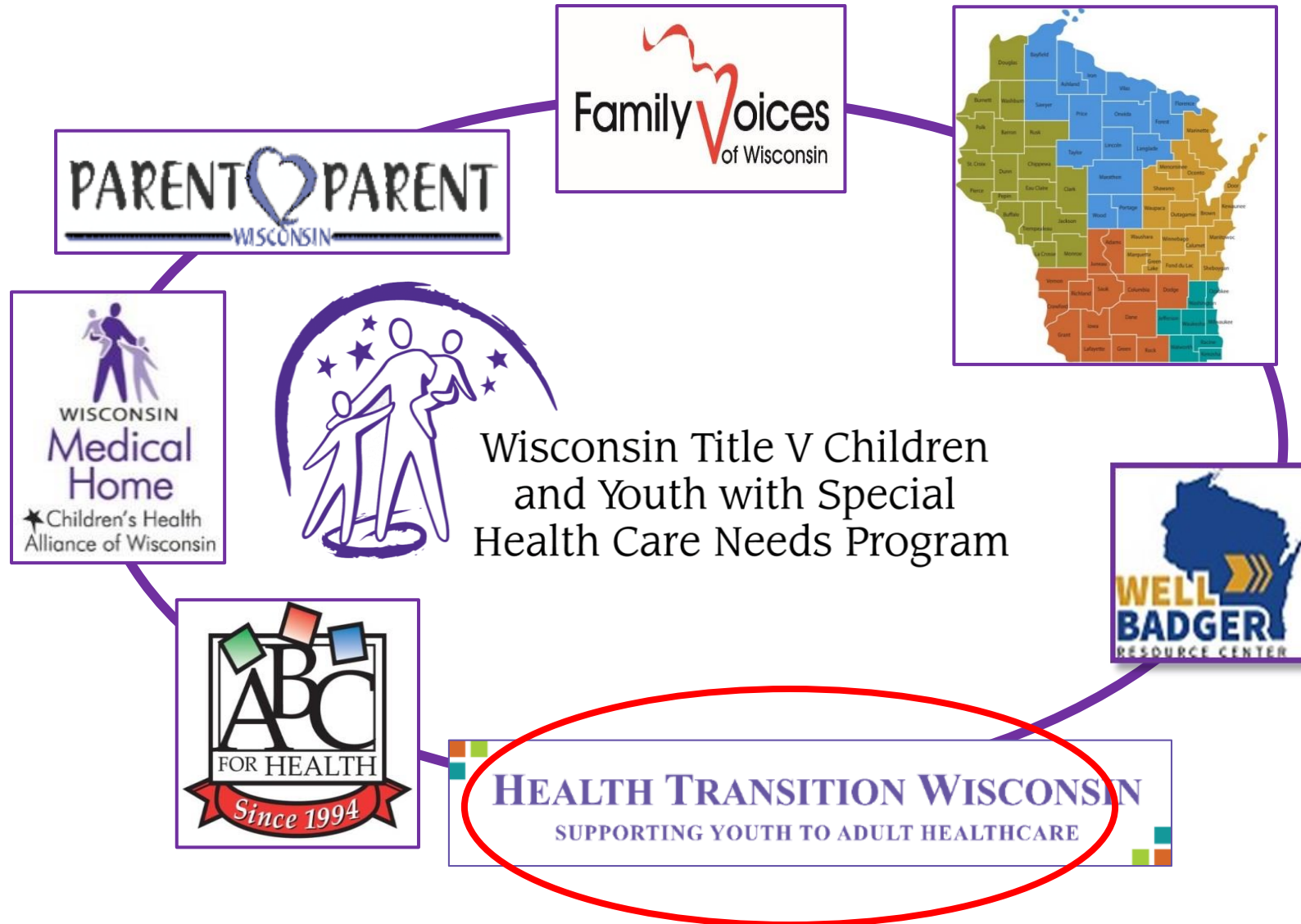


Wisconsin's Youth Health Transition Initiative

Funded by Department of Health Services contract with the



CYSHCN Network in Wisconsin



Wisconsin Youth Health Transition Initiative



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What is Health Care Transition

“The purposeful, planned movement of adolescents and young adults (AYA) with chronic physical and medical conditions from child-centered care to the adult-oriented healthcare system.”

- Society for Adolescent Health and Medicine

Nationwide



Wisconsin



Data according to the 2016 National Survey of Children with Special Health Care Needs including physical and mental health, access to quality health care, and the child's family, neighborhood and social context. Access at childhealthdata.org.

Statewide Initiative



HEALTH TRANSITION WISCONSIN

SUPPORTING YOUTH TO ADULT HEALTHCARE



Purpose

- Ensure that “high-quality, developmentally appropriate, health care services are available in an uninterrupted manner as the person moves from adolescence to adulthood”

Process

- Transition starts in early adolescence
- Transfers of care between 18 and 22 years of age

American Academy of Pediatrics, American Academy of Family Physicians, & American College of Physicians, 2011, p. 182; Human Resources & Services Administration [HRSA], 2016

Why is health so important?

Increased independence.

Success in daily life.

Access to education.

Pursuit of employment.

Video

Hunter Markle and Tim Markle

Optimal Outcomes

- **Collaborative providers:** transition is a standard of care for pediatric, adolescent, and adult health care providers
- **Engaged families:** understand the process and their role; concerns and anxieties are addressed
- **Empowered youth:** achieve autonomy, self-care management, and self-determination for their abilities
- **Enhanced lifelong health** and quality of life

American Academy of Pediatrics, American Academy of Family Physicians, & American College of Physicians, 2011

WI Youth Health Transition Initiative

- Supports transition policies and practices for ***health care providers and health care organizations***
- Facilitates ***Transition Learning Community***, webinars and email communications
- Disseminates ***health transition resources*** on the website healthtransitionwi.org
- Develops and ***delivers training*** for families, community stakeholders, health professionals

WI Presentations Available

- Parents/Families
- Community Partners/Organizations
- Educators, School Nurses
- Health Care Professionals

Health Care Transition Planning

Multiple aspects to consider

- Who are and will be the health care providers?
(pediatric and/or family practice or adult internal medicine and/or specialty)
- What is the patient's...
 - health care coverage?
 - (private or public)
 - decision-making capacity?
 - (supported decision-making, Power of Attorney, limited or full guardianship)
 - health management capacity?
 - (knowledge of health condition(s), care coordination, medication management)
 - time management capacity?
 - (appointment scheduling, transportation planning, available technology resources)

Eight Health Tools



• Adult Providers



• Appointments



• Decisions



• Medications



• Health Insurance



• Medical Summary



• Emergency Contacts



• About Me

GOT TRANSITION (for health) - National Resource for Practitioners, Youth, and Families



www.gottransition.org



Six Core Elements of Health Care Transition™

THE SIX CORE ELEMENTS OF HEALTH CARE TRANSITION™ 3.0

Sample Transition Readiness Assessment for Parents/Caregivers

Please fill out this form to help us see what your child already knows about their health and the areas you think they want to learn more about. After you complete the form, you can ask your child to share their answers from their completed form, and you can compare them. Your answers may be different. Your child's doctor will help you work on steps to increase your child's health care skills.

Youth name: _____ Parent/Caregiver name: _____ Youth date of birth: _____ Today's date: _____

TRANSITION IMPORTANCE & CONFIDENCE Please circle the number that best describes how you feel now.

The transfer to adult health care usually takes place between the ages of 18 and 22.

How important is it to your child to move to a doctor who cares for adults before age 22?

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10
not at all very

How confident do you feel about your child's ability to move to a doctor who cares for adults before age 22?

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10
not at all very

MY CHILD'S HEALTH & HEALTH CARE Please check the answer that best applies now.

	NO	YES I WANT TO LEARN	YES
My child can explain their health needs to others.	☐	☐	☐
My child knows how to ask questions when they do not understand what their doctor says.	☐	☐	☐
My child knows their allergies to medicines.	☐	☐	☐
My child knows our family medical history.	☐	☐	☐
My child talks to the doctor instead of me talking for them.	☐	☐	☐
My child sees the doctor on their own during an appointment.	☐	☐	☐
My child knows when and how to get emergency care.	☐	☐	☐
My child knows where to get medical care when the doctor's office is closed.	☐	☐	☐
My child carries important health information with them every day (e.g., insurance card, emergency contact information).	☐	☐	☐
My child knows that when they turn 18, they have full privacy in their health care.	☐	☐	☐
My child knows at least one other person who will support them with their health needs.	☐	☐	☐
My child knows how to find their doctor's phone number.	☐	☐	☐
My child knows how to make and cancel their own doctor appointments.	☐	☐	☐
My child has a way to get to their doctor's office.	☐	☐	☐
My child knows how to get a summary of their medical information (e.g., online portal).	☐	☐	☐
My child knows how to fill out medical forms.	☐	☐	☐
My child knows how to get a referral if they need it.	☐	☐	☐
My child knows what health insurance they have.	☐	☐	☐
My child knows what they need to do to keep their health insurance.	☐	☐	☐
My child and I talk about the health care transition process.	☐	☐	☐

MY CHILD'S MEDICINES If your child does not take any medicines, please skip this section.

My child knows their own medicines.	☐	☐	☐
My child knows when they need to take their medicines without someone telling them.	☐	☐	☐
My child knows how to refill their medicines if and when they need to.	☐	☐	☐

WHICH OF THE SKILLS LISTED ABOVE DOES YOUR CHILD MOST WANT TO WORK ON?

Transitioning Youth to an Adult Health Care Clinician
Six Core Elements of Health Care Transition™ 3.0
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The logo for 'got transition' features a stylized graphic of three interlocking loops in blue and green above the text 'got transition' in a blue, sans-serif font.

<https://gottransition.org/6ce/?leaving-readiness-assessment-parent>

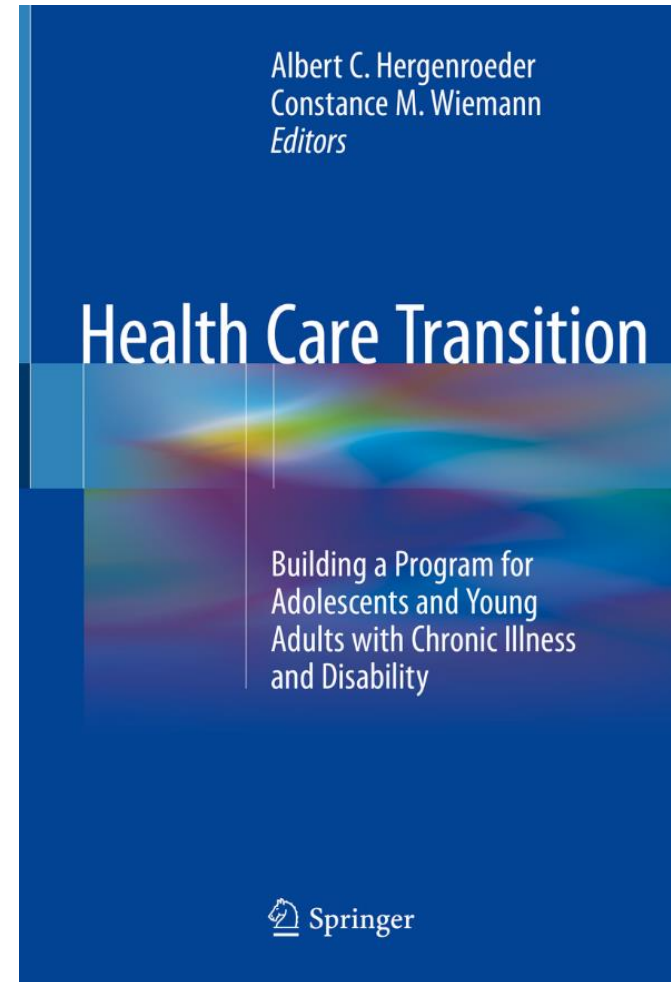
Resource

Building a Program for Adolescents and Young Adults with Chronic Illness and Disability

Also available from other sellers:
Amazon, or Barnes and Noble

ISBN-13: 978-3319728674

ISBN-10: 3319728679



<https://link-springer-com>

Wisconsin Tools & Resources

PATCH

Providers And Teens Communicate for Health

www.patch.org

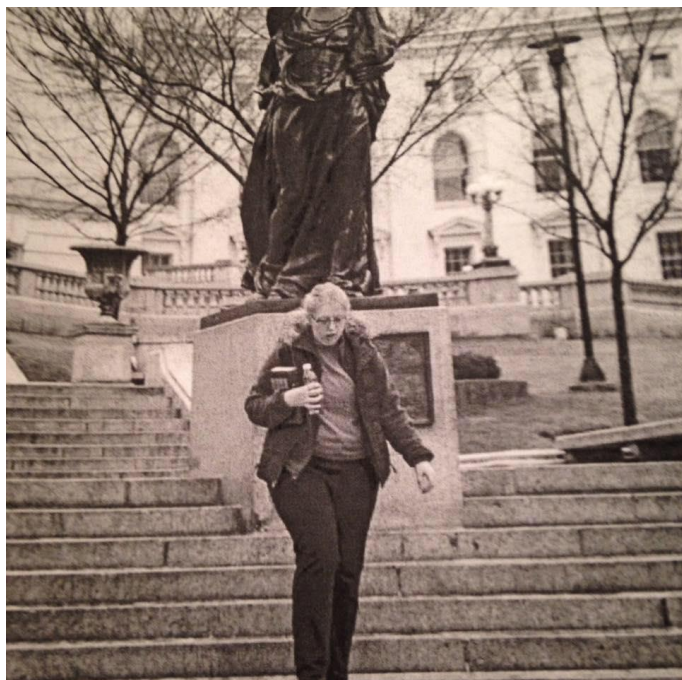
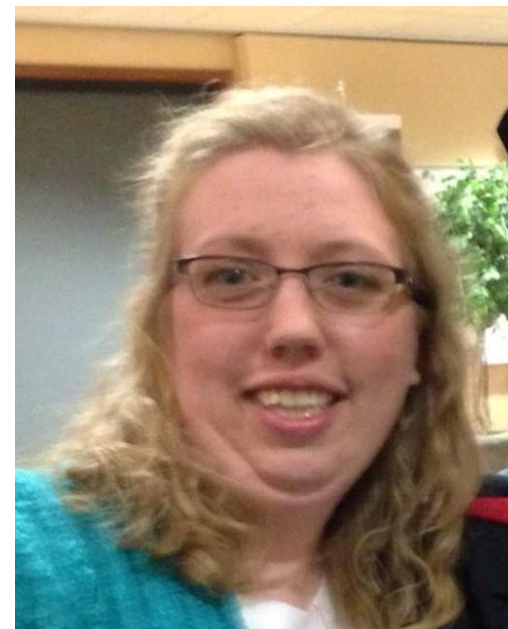
Self-Directed Health Care Kit

www.wi-bpdd.org

Partners and Consultants

- “Advisors” – group of Youth, Young Adult and Family Advocates
- State health initiatives like Aligning for Adolescent Health, PATCH
- School and Community Partners
- Health Organizations

According to
Abby....



Adult Provider and Appointments, About ME

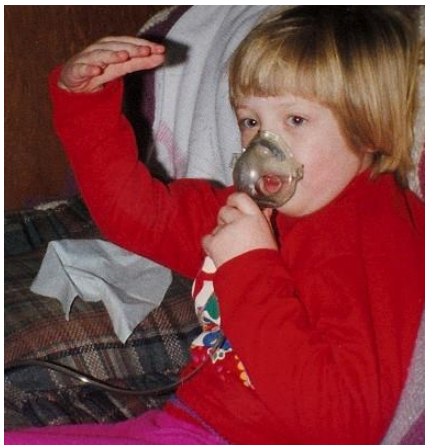


According to Abby.....

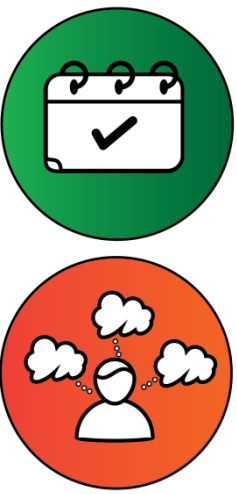
When did you start to see a doctor for adults?

What do you like about your doctor?

How do you prepare to go to an appointment?



Bring someone you trust to the appointment



Ideas to make an appointment more comfortable:

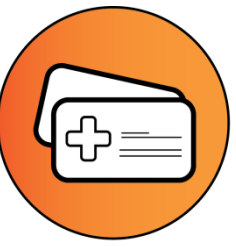
- Bring a trusted person
- Bring a security fidget

To help remember questions:

Face time or speaker phone will work if mom or dad can't come with you



Insurance and Emergency



Where is your insurance card?

How about emergency contacts?

Decision-Making



SUPPORTERS

Who are your supporters?

How did you find them?



WI Resources for Families and Health Professionals

STAY A STEP AHEAD

Healthcare Transition is the change from a PEDIATRIC model of care (parents and caregivers make most decisions) to an ADULT model of care (most adults make their own healthcare decisions).

Step 1: Start talking transition
Age 12-14

- Know the names of doctors and reasons for seeing them.
- Allow time for the youth patient to meet with the physician alone.
- Fill out a checklist to prepare for adult healthcare.

Step 2: Be In the know
Age 15-17

- Youth, families, and doctor need to know youth's
 - unique medical needs
 - communication style
 - disability
 - diagnosis
- Youth and family need to learn about privacy and consent before age 18.

Step 3: Transition to adult care
Age 18 & up

- Ask current doctor to recommend doctors who care for adults.
- Check on insurance coverage.
- Be sure medical records are sent to adult doctor(s).

Health Transition Wisconsin: healthtransitionwi.org
Wisconsin Regional Centers for Children and Youth with Special Healthcare Needs:
www.dhs.wisconsin.gov/cyshcn/regionalcenters.htm

Decisions Need To Be Made Before 18th Birthday

<https://healthtransitionwi.org/wp-content/uploads/sites/178/2020/02/StayAStep-Ahead.pdf>

HEALTH TRANSITION WISCONSIN
SUPPORTING YOUTH TO ADULT HEALTHCARE

<https://healthtransitionwi.org/>



<https://www2.waisman.wisc.edu/cedd/pdfs/products/health/PG.pdf>



Health Transition Resources



www.gottransition.org



HEALTH TRANSITION WISCONSIN

SUPPORTING YOUTH TO ADULT HEALTHCARE



www.healthtransitionwi.org

Thank you!

WITP Project Timeline

Goal: To develop an Integrated Transition Pilot Plan for youth and adults with ID/DD

Nov-Dec

**Complete
Asset Inventory**

For the
Comprehensive
Review and
Analysis

January

**Identify
Community(ies)**

For the
Equity Action
Lab(s)

March

**Launch Equity
Action Lab(s)**

Advancing an
equity goal in
a measurable
way over 100
days

July

**Draft Integrated
Transition Plan**

Based on
Equity Action
Labs with
feedback from
the coalition

August

**Plan
Finalized**

Celebrate with
final WITPC
meeting

Asset Inventory Highlights

1. Health
2. Employment
3. Education

Leadership skills that create Communities of Solutions



Leading from within

Leading together

Leading for outcomes

Leading for equity

Leading for sustainability

<https://www.communitycommons.org/collections/Leadership-Skills-that-Create-Communities-of-Solutions>



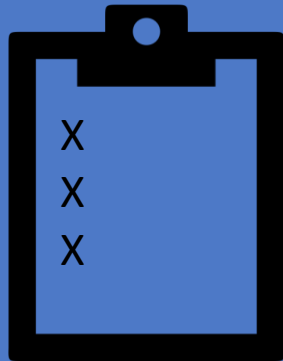
Stories from Waterville, Maine

Our overall aim is to improve the health of 16,000 Waterville residents by 2020 by increasing community connections and access to nutritious food for all.

- In the beginning, all we could see were the problems.**
- Something needed to change.**
- It was rocky, at first.**
- Things shifted when we understood that “We are all in this together.”**
- How did we do it? By Connecting, Growing Emerging Leaders, and Celebrating Together.**

<https://www.communitycommons.org/collections/Stories-from-Waterville-Maine>

Identifying Potential Communities

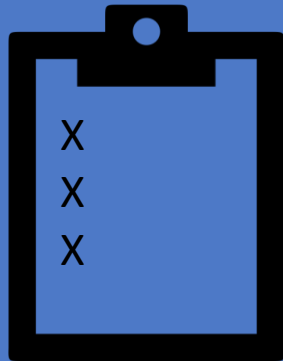


Created by Thomas Helbig
from Noun Project

We are looking to partner with up to 3 communities that meet the following criteria:

- ☐ History of addressing transition (education, employment and/or health) and a desire to build on existing assets;
- ☐ Existing partnerships with many sectors: schools, healthcare, large employers, ADRC, individuals with disabilities and/or their families, etc.;
- ☐ Interest in a transition model using evidence-based practices (when available) that integrate transition from youth to adult health care, educational, vocational, and other services to support community living;
- ☐ Small team of individuals committed to the work and a desire to diversify team;

Identifying Potential Communities



Created by Thomas Helbig
from Noun Project

- ☐ Commitment to improve transition for those struggling the most (equity lens);
- ☐ Relationships and trust built with at least some medically underserved individuals with disabilities and/or their families of transition age (12-26 years);
- ☐ Willingness to engage more individuals with disabilities and their families as leaders (not just participants) with shared power/voice in the project;
- ☐ Willingness to commit to a ~6-9 month relatively time intense quality improvement project that tests actions determined to be feasible and important by your community;
- ☐ Agency that is willing to be a fiscal and organizational lead;
- ☐ Transition Coordinator necessary...?

Questions or
Comments?



Breakout Discussion

- Goal is to generate ideas of potential communities
- Two activities:
 1. Analyze the “community criteria.” Is it clear...anything missing...what is most important....are there too many on the list?”
 2. Do you know any potential communities to approach or people who could help us identify communities for the Equity Action Lab?

Next Steps

1. Continue building asset inventory and organizing into a usable format
2. Goal to have it complete by January for vetting based on project goals
3. Provide feedback on outreach/"marketing" tool for potential communities
4. Begin approaching potential communities to have 2-3 identified by the end of January
5. Next meeting: January 12, 2021 at 9-10:30am **-OR-** January 13, 2021 at 1-2:30pm

Thank you!

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