

Youth On The Move



Getting Ready For The Transition

Presenters:

UT Southwestern – Youth Angle

Elizabeth Cabrera, Executive Director

June Trimble, Program Coordinator



Objectives

By the end of this session participants will be able to:

- Identify at least 3 issues that contribute to failed transitions on the part of the provider and patient
- Address services gaps and integrate practical strategies to maintain retention in care after transition
- Discuss the use of tools to assess, monitor and ensure readiness for transition

Disclosures

June Trimble and Betty Cabrera has no financial interest or relationships to disclose.

- HRSA Education Committee Disclosures

HRSA Education Committee staff have no financial interest or relationships to disclose.

- CME Staff Disclosures

Professional Education Services Group staff have no financial interest or relationships to disclose.

Youth Angle Background

- ❑ Part D Adolescent Initiative established in 2001
- ❑ Administrative agency through the Department of Pediatrics at UT Southwestern Medical Center of Dallas
- ❑ An integrated network that serves HIV+ youth 13-24
- ❑ Provides medical care, support services, outreach, HIV counseling and testing and peer support
- ❑ Serves over 350 HIV+ youth and young adults
72% African American, 17% Hispanic, 10% White & 1% Other

What is Transition?

- ▶ The deliberate, coordinated provision of developmentally appropriate and cultural competent health assessments, counseling and referrals

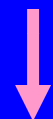




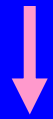
Transfer of Medical Home



Pediatric Care



Youth Care

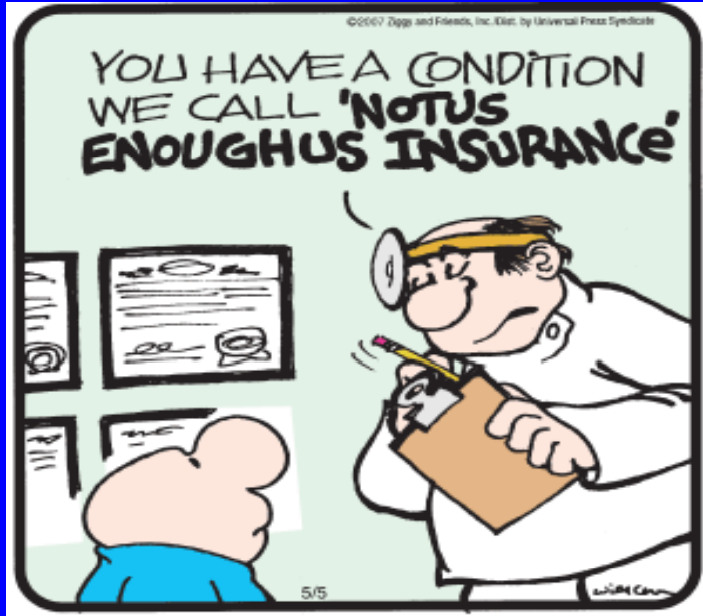


Adult Care

It's not an Option!



Moving Challenges



Adolescent sexuality



Stricter eligibility criteria



Maturity level

Moving Barriers

- Fear of “letting go” (providers and patient)
- Abrupt/late transitions
- Lack of care coordination and support
- Fragmented processes
- Lack of standardized process for quality improvement and evaluation

Small Group Activity



- Brainstorm what's going on in your area with transitioning youth/young adults to adolescent/adult care
- Use wall chart to
 - Identify 3 patient challenges
 - Identify 3 provider barriers
 - Identify ways to improve or create a coordinated transition plan

Network Coordination

- Develop a transition/monitoring process for care coordination
- Designate a staff person to oversee transition process (*both sending/receiving*)
- Develop a process for assessing patient/family/provider readiness
- Develop a sustainability management plan

Pre-Transition Planning Tips

- Determine age to begin process (13, 16, 18, 21)
- Utilize plan/tools to assess patient's knowledge and ability
- Monitor patient progress related to transition *regularly*
- Communicate with receiving site *regularly*
- Conform to target dates and timeline
- Involve Peer Advocates *(if applicable)*
- Plan a site visit/meet new provider/staff

Post-Transition Tips

- Set follow-up visit with sending clinic
- Determine barriers for unsuccessful transition (if any)
- Status report with care team
 - Relevant data
 - Financial eligibility
 - Track usage of transition skills checklist

Recommendations

1. Create written transition plan for your network/program. Review annually
2. Identify health care provider (s) who takes specific responsibility for transition
3. Identify core competencies for health literacy skills that are developmental appropriate
4. Create written transition plan in collaboration with patient, family and provider. Update annually
5. Utilize Peer Advocates in the process

Communicate, communicate, communicate!

Thank You!



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