



## SUPPORTING HEALTH CARE TRANSITION FROM ADOLESCENCE TO ADULTHOOD

- CHRISTOPHER PEZZULLO, DO,  
CHIEF HEALTH OFFICER, DHHS
- NANCY CRONIN, MA  
EXECUTIVE DIRECTOR, MAINE DEVELOPMENTAL  
DISABILITIES COUNCIL

APRIL 30, 2016




Maine Developmental Disabilities Council

Maine Center for Disease Control and Prevention  
An Office of the Department of Health and Human Services  
Paul E. LaPage, Governor Mary C. Mayhew, Commissioner

## Transitioning Youth to Adult Health Care

### Learning Objectives

- Transition Readiness
- Transition Planning
- Transfer of Care
- Transfer Completion



Maine Center for Disease Control and Prevention

Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care




## Transitioning Youth to Adult Health Care

### Transition Planning

Dr. Knotright

<https://www.youtube.com/watch?v=W1CVs7j5x3U>



Maine Center for Disease Control and Prevention

Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Leading the way in transitioning Youth with Special Health Care Needs (Ages 14-26) to adult Healthcare.**

What is successful transition to adult healthcare?	Parent/Guardian	Child/Doctor	Adult Medical Provider
<ul style="list-style-type: none"> <li>➤ An informed consumer</li> <li>➤ Locating a provider</li> <li>➤ Understanding their healthcare needs</li> <li>➤ Knowing how to work the system</li> <li>➤ Know what benefits are available to them</li> <li>➤ How to select a provider that meets their needs</li> <li>➤ Opportunity for choices</li> </ul>	<ul style="list-style-type: none"> <li>➤ Understanding your rights and what you no longer have access to in regards to your child's medical record</li> <li>➤ Knowing what your insurance covers for your adult child</li> <li>➤ Teach child how to be an informed consumer</li> <li>➤ Comfort level with medical provider</li> <li>➤ Support plan with medical provider "anticipatory guidance"</li> <li>➤ How to select a good fit</li> </ul>	<ul style="list-style-type: none"> <li>➤ Know where to transition to adult specialty care</li> <li>➤ List of place to refer for adult care</li> <li>➤ Provide anticipatory guidance list with tickler file</li> <li>➤ Reimbursement for extra work</li> <li>➤ Warm handshake to adult care</li> <li>➤ Understanding of health presentation of individuals with CYSHCN</li> <li>➤ Medical provider relationship</li> </ul>	<ul style="list-style-type: none"> <li>➤ Need additional medical training to understand the complex needs of patients with complex medical issues</li> <li>➤ Comprehensive history coming with the patient</li> <li>➤ Accessible equipment and skills</li> <li>➤ What do they need?</li> </ul>


Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Transition**

**Why should providers prepare patients/families to transition to adult care?**


<https://www.youtube.com/watch?v=Ecao63W84I>



Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

What Do We Know



Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**What Pediatricians Say...**

- 2/3 Reported transition planning begins between 18-20 years for *all* patients
- 4/5 Perceived there was a lack of available adult primary care providers for CYSHCNs
- 4/5 Perceived there was a lack of available specialists

Fox et al. National Alliance to Advance Adolescent Health 2008 Fact Sheet n.6

Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Adult Primary Care Providers Report**

- Lack of training in childhood-onset and congenital disorders
- Fear that they are unable to meet patient’s psychosocial needs
- Lack of social work and care coordinators in practices
- Limited knowledge about social (?community) resources
- Time / financial concerns

Pediatrics, Peter et al. (2009) *Transition From Pediatric to Adult Care: Internists’ Perspectives*, Pediatrics;123:417  
 Maine Center for Disease Control and Prevention | Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Phew – That Was In 2008...well...**

- 2012 MDDC conducted Focus Groups of Pediatricians, Adult Practitioners, and specialists identified the following barriers in Maine
  - Concern about adult practitioners knowledge of disability
  - Cost of providing transition services
  - Need to fight for adult services
  - Fragmented care
  - Aging out of systems
  - The tendency for over medicating. (Psychiatrist) “What we see is that they age out, and then where do they go? That is when I get them. And they are on a ridiculous list of meds that we spend two years trying to trim down!”
  - Most referrals to adult medical specialists come from the parents – not the provider that served the individual in their youth.

Maine Center for Disease Control and Prevention | Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**WHAT ADULT PRIMARY CARE PROVIDERS SAY THEY NEED / WANT....**

- 95% Written transfer summary
- 95% “Support” from a specialist
- 84% Written information about condition impacting patient
- 91% Conversation with prior provider – AKA Warm handshake

Maine Center for Disease Control and Prevention | Maine Developmental Disabilities Council

**Side-by-Side Version**  
Six Core Elements of Health Care Transition 2.0

The Six Core Elements of Health Care Transition 2.0 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-oriented care. They are aligned with the AHA/AAFP/ACIP Clinical Report on Transition.<sup>1</sup>  
 Sample clinical tools and measurement resources are available for quality improvement purposes at [www.GotTransition.org](http://www.GotTransition.org)

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)
<p><b>1. Transition Policy</b></p> <ul style="list-style-type: none"> <li>• Develop a transition plan/protocol with input from youth and families that describes the provider’s approach to transitioning to an adult approach to care at 18, including process and contact information.</li> <li>• Discuss all staff about the provider’s approach to transition, the pediatric team, the Six Core Elements, and desired roles of the youth, family, and adult health care team in the transition process, taking into account cultural preferences.</li> <li>• Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care.</li> </ul>	<p><b>1. Transition Policy</b></p> <ul style="list-style-type: none"> <li>• Develop a transition plan/protocol with input from youth/family and staff that describes the provider’s approach to transitioning to an adult approach to care at 18, including process and contact information.</li> <li>• Discuss all staff about the provider’s approach to transition, the pediatric team, the Six Core Elements, and desired roles of the youth, family, and health care team in the transition process, taking into account cultural preferences.</li> <li>• Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care.</li> </ul>	<p><b>1. Young Adult Transition and Care Policy</b></p> <ul style="list-style-type: none"> <li>• Develop a transition plan/protocol with input from young adults that describes the provider’s approach to transitioning to an adult approach to care at 18, including process and contact information.</li> <li>• Discuss all staff about the provider’s approach to transition, the pediatric team, the Six Core Elements, and desired roles of the young adult, family, and health care team in the transition process, taking into account cultural preferences.</li> <li>• Post policy and share/discuss with young adults at first visit and regularly review as part of ongoing care.</li> </ul>
<p><b>2. Transition Tracking and Monitoring</b></p> <ul style="list-style-type: none"> <li>• Establish policies and process for identifying transitioning youth and adult health care team members.</li> <li>• Utilize individual flow sheet or registry to track youth’s transition progress with the Six Core Elements.</li> <li>• Incorporate the Six Core Elements into clinical care process, using ICD-9 procedure.</li> </ul>	<p><b>2. Transition Tracking and Monitoring</b></p> <ul style="list-style-type: none"> <li>• Establish policies and process for identifying transitioning youth/family and adult health care team members.</li> <li>• Utilize individual flow sheet or registry to track youth/family/ adult’s transition progress with the Six Core Elements.</li> <li>• Incorporate the Six Core Elements into clinical care process, using ICD-9 procedure.</li> </ul>	<p><b>2. Young Adult Tracking and Monitoring</b></p> <ul style="list-style-type: none"> <li>• Establish policies and process for identifying transitioning young adults and adult health care team members.</li> <li>• Utilize individual flow sheet or registry to track young adults’ completion of the Six Core Elements.</li> <li>• Incorporate the Six Core Elements into clinical care process, using ICD-9 procedure.</li> </ul>
<p><b>3. Transition Readiness</b></p> <ul style="list-style-type: none"> <li>• Conduct regular transition readiness assessments, beginning at age 14 to 16, to identify and discuss with youth and parent/caregiver their needs and goals for adult care.</li> <li>• Jointly develop goals and pathways to address with youth and parent/caregiver and document regularly in plan of care.</li> </ul>	<p><b>3. Transition Readiness</b></p> <ul style="list-style-type: none"> <li>• Conduct regular transition readiness assessments, beginning at age 14 to 16, to identify and discuss with youth and parent/caregiver their needs and goals for adult care.</li> <li>• Jointly develop goals and pathways to address with youth and parent/caregiver and document regularly in plan of care.</li> </ul>	<p><b>3. Transition Readiness/Orientation to Adult Practice</b></p> <ul style="list-style-type: none"> <li>• Identify and be adult practices willing and practice interested in seeing the young adults.</li> <li>• Establish a process to welcome and assist new young adults into practice, including a description of available services.</li> <li>• Develop youth-friendly intake or welcome information about the practice and offer a “got transition” appointment, if feasible.</li> </ul>

<sup>1</sup> American Academy of Pediatrics, Section on Academy of Family Physicians, American College of Physicians. Transition Clinical Report: Addressing Gaps Supporting the Youth Care Transition from Adolescence to Adulthood in the Health System. Pediatrics 121:132-137

Continued >


www.gottransition.org

Maine Center for Disease Control and Prevention | Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

### Transition Readiness

- Begins at age 14
- Conduct regular assessments
- Jointly develop goals
- Prioritize actions



Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

### 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 that	I need to learn	Someone needs to do this... like?
I know my medical needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can explain my medical needs to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my symptoms including ones that I quickly need to see a doctor for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what to do in case I have a medical emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my own medicines, what they are for, and when I need to take them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my allergies to medicines and medicines I should not take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand how health care privacy changes at age 18 when legally an adult.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Using Health Care**

I know or I can find my doctor's phone number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I make my own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, I think about questions to ask.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


www.gottransition.org

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

### Transition Planning

- Develop and update the plan of care
- Prepare youth and parent for adult approach to care
- Determine need for decision-making supports
- Plan with youth and family optimal time of transfer
- Obtain consent for release of medical information
- Assist youth in identifying an adult provider
- Provide linkages to insurance resources, self-care information and culturally appropriate community supports.



Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

### Sample Individual Transition Flow Sheet

Six Core Elements of Health Care Transition 2.0

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Primary Diagnosis: \_\_\_\_\_ Transition Complexity: \_\_\_\_\_  
(Low, moderate, or high)

**Transition Policy**

-Practice policy on transition discussed/shared with youth and parent caregiver \_\_\_\_\_ Date \_\_\_\_\_

**Transition Readiness Assessment**

-Conducted transition readiness assessment \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

-Included transition goals and prioritized actions in plan of care \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

**Medical Summary and Emergency Plan**

-Updated and Shared medical summary and emergency plan \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

**Adult Model of Care**

-Decision-making changes, privacy, and consent in adult care discussed with youth and parent/caregiver (if needed, discussed plans for supported decision-making) \_\_\_\_\_ Date \_\_\_\_\_

-Timing of transfer discussed with youth and parent/caregiver \_\_\_\_\_ Date \_\_\_\_\_

-Selected Adult Provider \_\_\_\_\_

Name \_\_\_\_\_ Clinic \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ First Appointment Completed \_\_\_\_\_

**Transfer of Care**

-Prepared transfer package including:  
 - Transfer letter, including effective date of transfer of care to adult provider

www.gottransition.org

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Transition: Up Close**

- Competency for independent decision making
- Insurance coverage
- Guardianship/Supported Decision Making
- Connection to community supports

Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Ongoing At Every Visit**

- Developmentally appropriate education / discussions on:
  - Sexuality / relationships
  - Nutrition and fitness
  - Substance use/abuse
  - Participation in health care decision making

Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Implementing A Standard Of Care**

- Transition Plans
  - Individualized to meet unique needs and goals of youth and family
  - Appropriate to youth's developmental level
  - Reviewed / updated regularly – changed when needed (may warrant increased # of visits or new assessments of abilities to successfully transition)

AAP Clinical Report 2011: Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home

## Transitioning Youth to Adult Health Care

**Implementing A Standard Of Care**

- For all....
  - Direct communication between pediatric and adult providers (primary and specialists)
  - Transfer of medical record (with “portable” summary that is also provided to patient and family)
  - “Pre-transfer” visit during the year before actual transfer

AAP Clinical Report 2011: Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home  
Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Critical Steps**

- Adaptive and Cognitive Functioning – if relevant -(Pediatric Sub-specialist / Schools / Referral to psychologist)
- Insurance coverage
- Confirm, connect and follow up with new provider

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Critical Questions For Families To Consider, When your child reach adulthood, what are your expectations for:**

- Living arrangements
- Nutritional requirements
- Employment or post secondary education
- Physical/cardiovascular expectations
- Recreational/leisure activities
- Spiritual life
- Behavioral health/health care
- Guardianship
- Transportation
- Financial planning
- Social skill activities
- Health and Life Benefits
- Sexual expression
- Types of services needed
- Personal Hygiene and grooming

32nd Institute on Rehabilitation Issues (2007) Rehabilitation of Individuals with Autism Spectrum Disorders [www.autism-info.org/2007\\_employment\\_&\\_ASD\\_report.pdf](http://www.autism-info.org/2007_employment_&_ASD_report.pdf)

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

[www.medicalhomeportal.org](http://www.medicalhomeportal.org)

Home > For Parents & Families

**School Transitions**

Transition to Adulthood

- Overview
- After High School Options
- Employment/Daytime Activities
- Education
- Leading Adult Health Care
- Genetic Counseling
- Guardianship/Estate Planning
- Health
- Insurance/Financial Aids
- Healthy Relationships
- Independent Living
- Living Arrangements
- Tools & Checklists
- Self-Advocacy
- Transportation - Where's My Ride
- Assistive Technology

The following "For Parents and Families" areas focus on various points in the journey and aspects of assuring the best outcomes for your child.

**Before a Diagnosis**  
This page provides an introduction to the processes involved in recognizing a problem and then seeking to cause or diagnosis.

**After a Diagnosis or Problem is Identified**  
This section of the Portal has content for families of children with a new diagnosis. We hope to help with information, including knowing you are not alone, working with healthcare providers and Medical Homes, and Caring for Children with Special Health Care Needs. Filing prescriptions, working with the insurance company, or simply keeping up with your child—dealing with daily life is often overwhelming. Find tools and suggestions for getting organized and Managing and Coordinating Care, advocating for your child, planning for the future, and taking an occasional break from it all. This section also includes information on adoption, foster care, complementary and alternative medicine, and advocacy.

**Responding to a Diagnosis**  
Whether your child has been recently diagnosed, or you are looking for the latest information about your child's care, this page will help you find reliable resources and information.

**Early Services, 0-3 Years**  
Research shows that early discovery, diagnosis, and treatment of children with developmental delays or disabilities lead to improved outcomes in developmental skills, academic performance, and social skills. This section provides information on the Early Intervention Part C program and services, additional government and private services, and home visiting programs for children 0-5 years with special health care needs.

**Education and Schools**  
Schools can provide necessary services and support for children with special health care needs. Learn the terms, laws, and processes so you can work more effectively with schools to provide the best educational experience for your child.

**Navigating Transitions with Your Child**  
Children, youth, teens, young adults, and their families will find answers to some of their questions about insurance and behavioral independence, as well as transportation for recreation for their children, & school

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Checklist For Families**

Transitions - Changing Role For Families

Health & Wellness 101 The Basics	Yes	No	I need more info	I need more info	I need more info	I need more info	I need more info
1. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
2. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
3. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
4. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
5. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
6. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
7. Before a doctor's recommendation, my child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
8. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
9. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
10. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
11. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
12. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
13. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
14. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
15. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
16. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							
17. My child/young person/adolescent has a health care provider, and that provider will continue to provide care for them as they transition to adulthood.							

Download at [www.medicalhomeportal.org](http://www.medicalhomeportal.org)

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**College Bound? Some Tips To Practice Well Before Orientation**

- Unstructured time
  - Unlike the typical college student's schedules many youth's schedules are highly structured so youth may struggle knowing how to fill the time up.
- Medications
  - Use only verbal/alarm prompts for medication
- Personal hygiene
- Know how to travel alone and use public transportation
- Appropriate coping strategies that can be utilized in most places
- Know how to do laundry
- Know how to manage money

College Support Program for Students with ASD (2011) Autism Training Center at Marshall University web source: <http://msucollegesupport.blogspot.com/> accessed 4/27/2016

Maine Center for Disease Control and Prevention      Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Skills They Need To Transition**

- Calling in a prescription refill
- Scheduling appointments
- Speaking up at the Doctor's Office
- Managing medication
- Make and keep follow-up visits
- Determine methods to track health progress
- Work with your doctor to set health goals
  - Personal Hygiene
  - Self Care (i.e. taking medications on schedule)
  - Preventing secondary conditions
  - Managing medications
  - What to do when there is an "emergency"
  - Wellness
  - Sexuality

## Transitioning Youth to Adult Health Care

## Transitioning Youth to Adult Health Care

**Suggested Adult Service Application Timeline For Families**

- Age 16 - Contact VR (Services will begin at age 18 but the transition plan and assessments should be done earlier)
- Age 17 - Identify and meet with adult health practitioner
- Age 17.5 - Apply for adult services through DHHS Office of Adults with Cognitive and Physical Disabilities (Even if the intent is to stay in children's services until the youth's 21 birthday.)
- Age 18 - If appropriate:
  - Apply for SSI.
  - Apply for MaineCare
    - Note: Even if individual was eligible for SSI and/or Mainecare as a child they must re-apply as an adult.
  - Consider guardianship or supportive decision making

Maine Center for Disease Control and Prevention      Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

### Adult Services


- Adult Developmental Services through the Office of Cognitive and Physical Disabilities
  - Waiver Services – Non Entitlement Program
  - Must be >2 standard deviations on a adaptive scale such as the Vineland to be eligible
  - All Waiver services are closed to a waitlist
- Vocational Rehabilitation
  - Eligibility guidelines
  - For many to access must also have the waiver for long term support
- Mental Health System

Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

### Transfer of Care

- Confirm date of first adult visit
- Transfer young adult when condition is stable
- Complete transfer package, including final transition readiness assessment, plan of care
- Prepare letter of transfer




Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

### Transfer Completion

- Contact young adult 3 to 6 months after last visit to confirm transfer
- Communicate with adult provider on transfer and offer consultation assistance, if needed
- Build ongoing and collaborative partnerships with adult primary and specialty care providers.




Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care

**Dr. Right**

<https://www.youtube.com/watch?v=6EJkOYmkxmE>



Maine Center for Disease Control and Prevention Maine Developmental Disabilities Council



## Transitioning Youth to Adult Health Care

**Quality Improvement, Make The Change**

- Review (create) office policy on transition
- Discuss assigning roles within practice (resources – in community / within practice, create a data base
- Network with adult providers
- In services with community support agencies / schools

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council

## Transitioning Youth to Adult Health Care


**EMMC Pediatric Primary Care - Transition Pilot**

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council


## Questions?

**Christopher Pezzullo, DO**  
 Chief Health Officer, DHHS  
[christopher.pezzullo@maine.gov](mailto:christopher.pezzullo@maine.gov)  
 207-287-5044

**Nancy Cronin, MA**  
 Executive Director, MDDC  
[nancy.e.Cronin@maine.gov](mailto:nancy.e.Cronin@maine.gov)  
 207-287-4214



**Maine Developmental Disabilities Council**



Department of Health and Human Services  
*Maine People Living Safe, Healthy and Productive Lives!*

Paul E. LaPage, Governor      Mary C. Mayhew, Commissioner

Maine Center for Disease Control and Prevention
Maine Developmental Disabilities Council