Supporting Pediatric to Adult Healthcare Transitions

January 16, 2026| Washington County Core Team Meeting

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Today's Presenters

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Today's Objectives

- Share best practices in pediatric to adult healthcare transitions
- Highlight innovative work to improve handoffs
- Empower interdisciplinary teams to actively collaborate with clinicians through the transition journey

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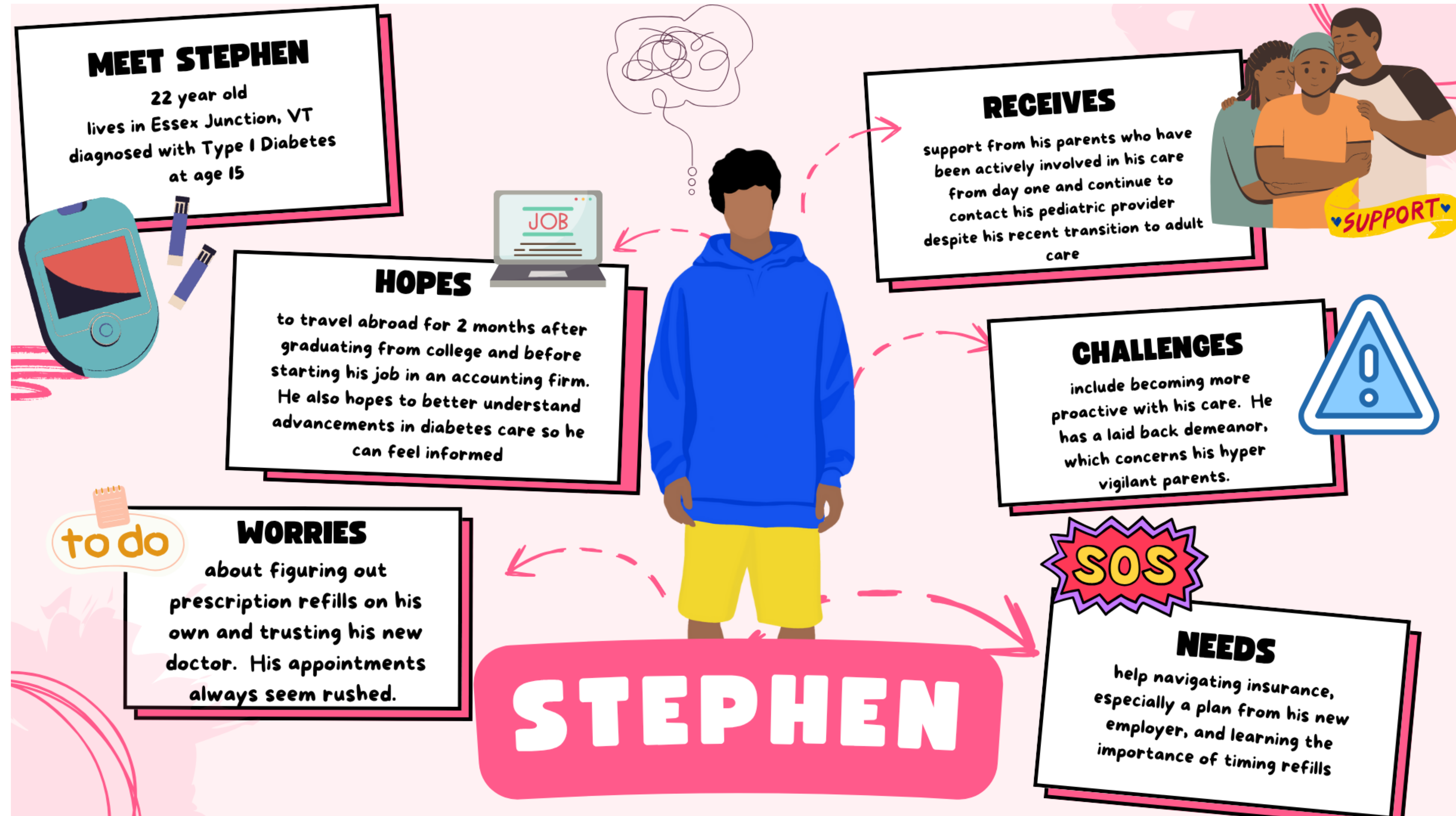
Meet Stephen



Health Care Transitions (HCT)

Process of moving from a child/family centered model of healthcare to an adult/patient centered model of health care…

Goals:

- Improve the ability of youth to manage their own health care and effectively use health services
- Ensure an organized process in pediatric and adult health care practices to facilitate transition preparation, transfer of care, and integration into adult centered health care

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Problems Encountered without coordinated HCT

- Medication/treatment adherence
- Medical complications
- Discontinuity of care
- Patient dissatisfaction
- Expensive health care utilization
  (Emergency Dept.; Urgent Care)
- Reduced quality of care
- Medical errors

Barriers to Transition

Patient Based

- Anxiety & fear
- Negative belief about adult health care
- Lack of interest in healthcare
- Competing priorities & other life transitions
- Socioeconomic status

System Based

- Lack of communication and coordination
- Access issues & finding a provider
- Insurance issues (loss of coverage)
- Provider knowledge & comfort gaps
- Inadequate prep and clinical support

Got Transitions

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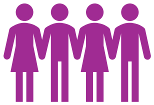
Got Transition https://www.gottransition.org/

Our Approach



Youth & Family Engagement

Build skills and knowledge to support self management

Training and Education

Build workforce knowledgeable on how to provide high quality youth supported care

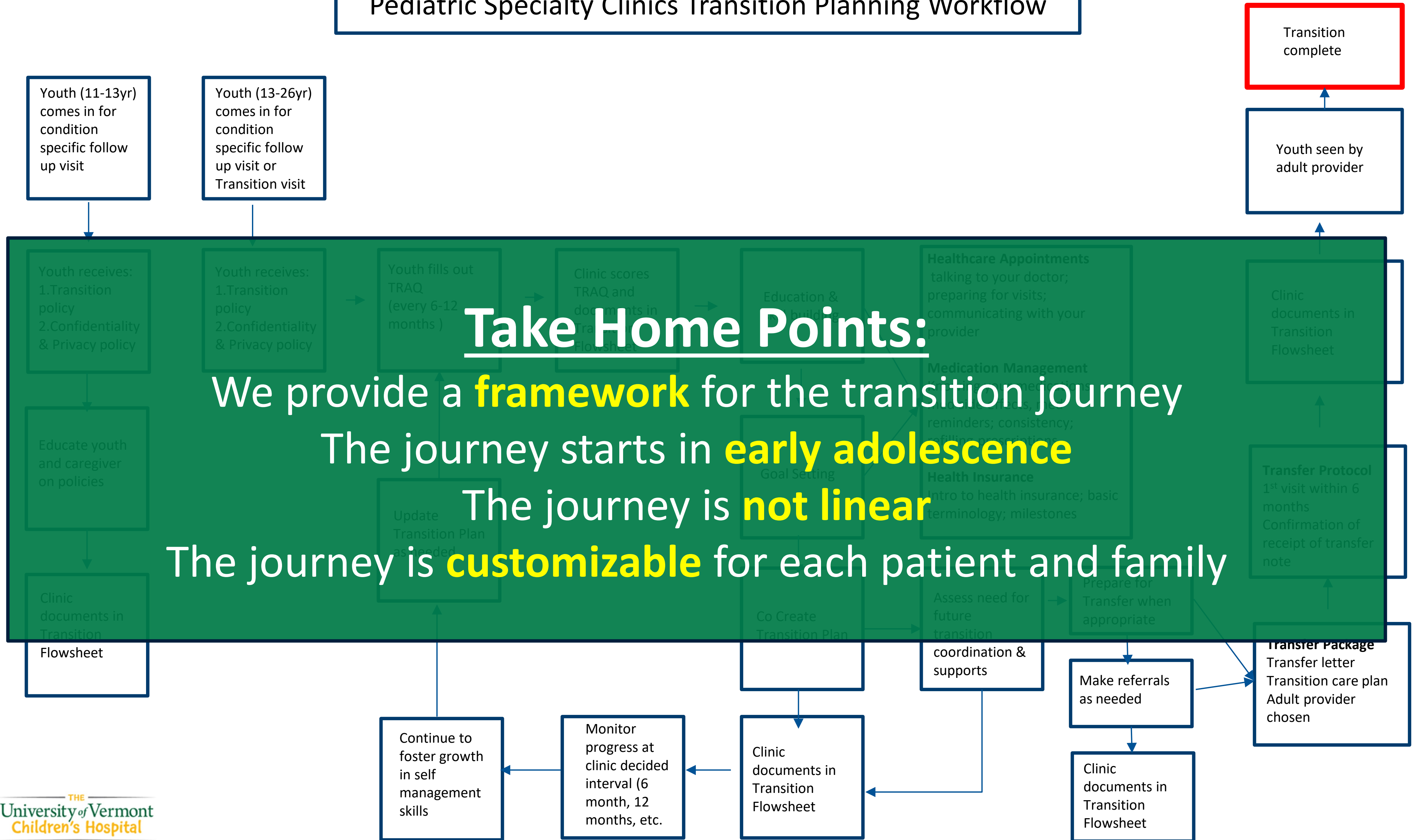
Strengthening partnerships

Supporting Pediatric and Adult collaboration to improve coordination and communication

Clinical implementation of Got Transitions

Interdisciplinary teams utilizing quality improvement methodology to implement transition improvements

Process Mapping



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Youth Engagement Strategy

- Motivational Interviewing
  - Guiding style of communication
  - Empowers people to make change
  - Be curious, not judgmental

- Utilize technology when possible

Image from https://slate.com/culture/2023/06/ted-lasso-finale-season-3-defense-depression.html

Motivationalinterviewing.org
https://link.springer.com/article/10.1007/s40272-020-00414-2

Transition **R**eadiness **A**ssessment **Q**uestionnaire

Directions to Youth and Young Adults: Please check the box that best describes your skill level in the following areas that are important for transition to adult health care. There is no right or wrong answer and your answers will remain confidential and private. Directions to Caregivers/Parents: If your youth or young adult is unable to complete the tasks below on their own, please check the box that best describes your skill level.	No, I **do not know** how	No, but I **want to learn**	No, but I am **learning** to do this	Yes, I have **started** doing this	Yes, I **always** do this when I need to
MANAGING MEDICATIONS					
1. Do you fill a prescription if you need to?					
2. Do you know what to do if you are having a bad reaction to your medications?					
3. Do you reorder medications before they run out?					
4. Do you explain any medications (name and dose) you are taking to healthcare providers?					
5. Do you speak with the pharmacist about drug interactions or other concerns related to your medications?					
APPOINTMENT KEEPING					
1. Do you call the doctor's office to make an appointment?					
How **important** is it to you to manage your own health care?					
How **confident** do you feel about your ability to manage your own health care?					

Please check this box if you are the person completing this form ☐

Take Home Points:

Readiness to change

Strength based

Dynamic and longitudinal

Patient centered

Johnson K, McBee M, Reiss J, Livingood W, Wood D. TRAQ Changes: Improving the Measurement of Transition Readiness by the Transition Readiness Assessment Questionnaire. J Pediatr Nurs. 2021 Jul-Aug;59:188-195. doi: 10.1016/j.pedn.2021.04.019. Epub 2021 May 18. PMID: 34020387.

Importance and Confidence

Please circle how you feel about the following statements					
	Not at all important	Not too important	Somewhat important	Important	Very Important
How important is it to you to manage your own health care?	1	2	3	4	5
How confident do you feel about your ability to manage your own health care?	1	2	3	4	5

Your Connections to HCT

- Inter-disciplinary collaborations are just beginning to be recognized
- Special educators and transition coordinators are vital contributors to care teams
- Your involvement improves outcomes in **independent living**, employment, and post secondary education

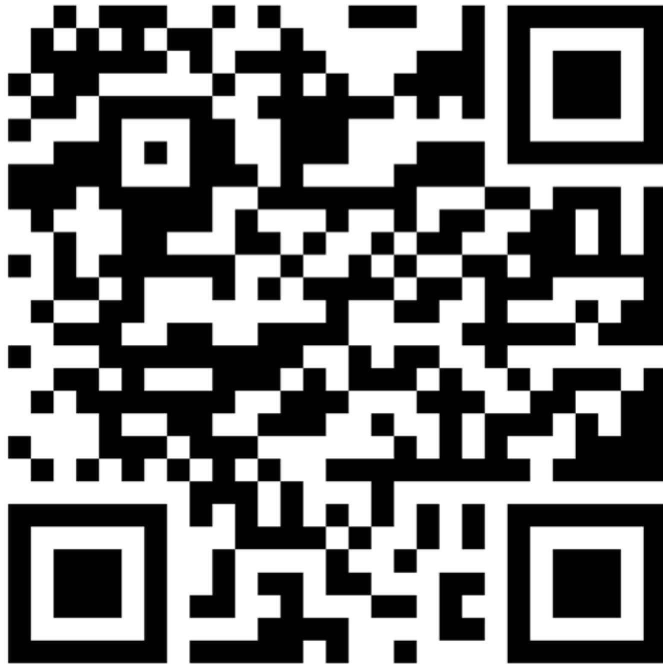
How YOU Can Contribute to HCT

- Integrate HCT into IEP Planning
- Promote person centered planning
- Foster interagency collaboration
- Embed skill building into academic and career development
- Engage families in transition planning

Got Transitions Tools

- Health Care Transition Readiness Assessment for Students with an IEP
- Health Care Transition Sample Goals

HCT Readiness Assessement for Students with an IEP



Pediatric to Adult Health Care Transition Tool | **Health Care Transition Readiness Assessment** *for Students*

This health care transition readiness assessment is intended for students and their family/caregivers to compete as part of IEP transition planning meetings. If a student is unable to fill out this form, the student can complete it with the help of their family/caregiver.

Directions: Please check the box next to the answer that best applies to you right now. This helps us see what you already know about your health and using health care and areas that you need to learn more about.

Student Name: Student Date of Birth:

Completed By: Date Completed:

Personal Care *(related to dressing, eating, bathing, and moving)*
- ☐ I am able to care for all my needs
- ☐ I need a little bit of help to care for my needs
- ☐ I need a lot of help to care for my needs
- ☐ I need help to care for all my needs

Use of Communication Supports
- ☐ Text-to-speech technology
- ☐ Assistive Listening Systems
- ☐ ASL/Interpretation technology
- ☐ Other technology:
- ☐ I do not use communication supports

Transition Importance & Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*
**The transition to a doctor who cares for adults usually occurs between ages 18-22.*

How important is it to you to move to a doctor who cares for adults by age 22*?

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

How confident do you feel about your ability move to a doctor who cares for adults by age 22*?

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

My Health *Please check the box that applies to you right now.*	Yes	I want to learn	No
I can name my learning differences, disability, medical, or mental health diagnosis (e.g. diabetes, depression).	☐	☐	☐
I can name 2-3 people who can help me with my intellectual differences, disability, medical, or mental health needs in an emergency.	☐	☐	☐
Before a doctor's visit, I prepare questions to ask.	☐	☐	☐
I know to ask the doctor's office for accommodations, if needed.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know the name(s) of my doctor(s).	☐	☐	☐
I know or I can find my doctor's phone number.	☐	☐	☐
I know how to make my doctor's appointments.	☐	☐	☐
I carry my health information with me every day (e.g. insurance card, emergency phone numbers).	☐	☐	☐
I know my food allergies.	☐	☐	☐

My Medicines *Please check the box that applies to you right now.*	Yes	I want to learn	No
I know the name of the medicines I take.	☐	☐	☐
I know the amount of the medicines I take.	☐	☐	☐
I know when I need to take my medicines.	☐	☐	☐
I know how to read and follow the direction labels on my medicines.	☐	☐	☐
I know what to do when I run out of my medicines.	☐	☐	☐
I know my medicine allergies.	☐	☐	☐

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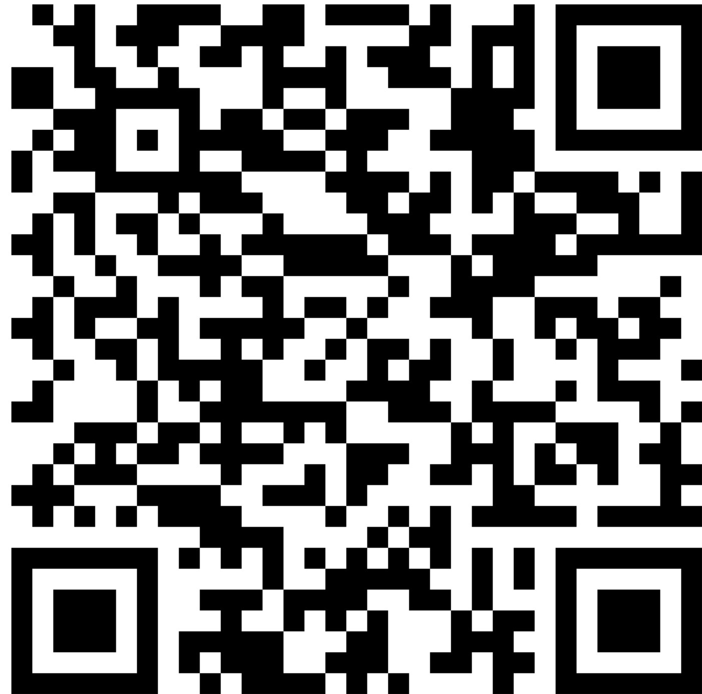
Source: Health Care Transition Skill Building in School: Tools for Students ...

Sample HCT Goals for Students with an IEP



Sample Goals for the Health Care Transition Readiness Assessment for Students with an IEP

If a student has responded "No" or "I want to learn" to any of the items on the Health Care Transition Readiness Assessment, please use the following sample goals as a guide when creating goals in the IEP transition plan.

HCT READINESS ASSESSMENT ITEM	*SAMPLE GOAL*
MY HEALTH	
I can name my learning differences, disability, medical, or mental health diagnosis (e.g. diabetes, depression).	By the end of the IEP cycle, student will say aloud and/or spell out and/or enter into their cell phone the name(s) of their medical or mental health diagnosis(es), with __% accuracy.
I can name 2-3 people who can help with my intellectual differences, disability, medical, or mental health needs in an emergency.	By the end of the IEP cycle, student will input their emergency contacts' information on their phone and name and identify the contacts in their phone when asked, with __% accuracy.
Before a doctor's visit, I prepare questions to ask.	By the end of the IEP cycle, student will prepare and practice asking a few questions to their doctor before their next appointment, with __% accuracy.
I know to ask the doctor's office for accommodations, if needed.	By the end of the IEP cycle, student will identify which accommodations they need to request at a doctor's office, with __% accuracy.
I have a way to get to my doctor's office.	By the end of the IEP cycle, student will plan transportation to their doctor's office ahead of time, with __% accuracy.
I know the name(s) of my doctor(s).	By the end of the IEP cycle, student will input their doctor's contact information on their phone and name and identify their doctor in their phone when asked, with __% accuracy.
I know or I can find my doctor's phone number.	By the end of the IEP cycle, student will name and identify their doctor in their phone when asked, with __% accuracy.
I know how to make my doctor's appointments.	By the end of the IEP cycle, student will know how to call their doctor's office or use an online portal to schedule a future appointment, with __% accuracy.
I carry my health information with me every day (e.g. insurance card, emergency phone numbers).	By the end of the IEP cycle, student will keep their insurance card safely in their wallet/backpack or take a photo of it and store it on their phone and be able to retrieve the insurance card when asked, with __% accuracy.
I know my food allergies.	By the end of the IEP cycle, student will be able to say aloud and/or spell out and/or enter into their cell phone the name(s) of the foods they are allergic to, with __% accuracy.

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[Source: Health Care Transition Skill Building in School: Tools for Students ...]

Resources for Families

Got Transition
https://www.gottransition.org/

American College of Physicians
https://www.acponline.org
(navigate to Pediatric to Adult Care Transitions Initiative)

Resources & Research

YOUTH & FAMILIES

Decision-Making and Guardianship

- National Resource Center for Supported Decision-Making
- Center on Youth Voice, Youth Choice (CYVYC)
- Understanding Supported Decision-Making and Alternatives to Guardianship *by Quality Trust*
- Charting the Life Course Tool for Exploring Decision Making Supports *by the University of Missouri-Kansas City Institute for Human Development*
- Supported Decision-Making Resource Library *from the American Civil Liberties Union*
- The Right to Make Choices: International Laws and Decision-Making by People with Disabilities *by the Autistic Self Advocacy Network*

Got Transition Resources

- Turning 18: What it Means for Your Health [En Español]

Finding and Using Adult Health Care

- Finding Adult Providers *by the American Academy of Pediatrics' Illinois Chapter*
- Transition to Adult Care *from PACER's National Parent Center on Transition and Employment*

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ACP Pediatric to Adult Care Transitions Initiative

About This Project

Condition-Specific Tools

HOME > CLINICAL INFORMATION > HIGH VALUE CARE > RESOURCES FOR CLINICIANS > PEDIATRIC TO ADULT CARE TRANSITIONS INITIATIVE > CONDITION-SPECIFIC TOOLS

Condition-Specific Tools

The ACP Pediatric to Adult Care Transitions Toolkit contains disease-specific tools that are critical for the young adult in transition to be aware of and understand in order to successfully achieve optimal self-care as an emerging adult.

Each set of tools was required to include at least the three minimum elements described below, which have been customized to include disease/condition-specific elements that are an important part of the transition process for emerging adults in learning self-care. Practices utilizing these tools should also consider incorporating some of the generic tools from the Got Transition Six Core Elements in establishing a process and procedures for pediatric patient transitioning to adult care. The disease/condition-specific sets of tools found below on this page contain the following customized elements, at a minimum:

- **Transition Readiness Assessment** – an assessment tool intended to be utilized by the pediatric care team or other clinicians caring for youth to begin the conversation about the youth's needed skills to manage their health and health care. The tool is used to evaluate the youth's current knowledge about and ability to manage his/her health condition. This tool indicates the elements specifically related to the clinical condition that should be assessed and documented by the transferring pediatric practice. This tool can be revisited and utilized as a teaching and training aid to ensure that these items have been mastered by the time the young adult is ready to transfer to adult care.
- **Medical Summary/Transfer Record** – a summary of the key medical record elements that contains the essential information needed for communication between pediatric and adult clinicians for the specific patient including pertinent disease-specific information. This is to be completed by the pediatric or other sending clinician, shared with

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Takeaways

- The healthcare system is **complex**
- Young adults are a **unique** patient population with established care team relationships
- Transition is an **individualized** journey
- **Education** and **coaching** are key components
- **Collaboration** across sectors is essential

Acknowledgements

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- Vermont Dept. of Health

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References

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- McDonagh JE, Kelly DA. Transitioning care of the pediatric recipient to adult caregivers. Pediatr Clin North Am 2003;50(6):1561-1583.
- Health Care Transition Skill Building in School: Tools for Students ...
- Bridging the Gap: Supporting Healthcare Transitions for Students with ...
- Supporting Students with Disabilities in Transitioning to Adulthood
- Promoting Successful Transitions for Students with Disabilities - ed

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https://www.uvm.edu/larnermed/vchip/transitions-care-pediatric-adult-focused-care

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Questions for Consideration

- What roles do special educators, Vocational rehab professionals, and other supporters currently play in supporting healthcare transitions? What tools or strategies are you using?
- Where do you see gaps in communication or coordination between education, rehab, and healthcare providers? Where do you see redundancies?
- What training do educators and other health care professionals need to feel confident supporting healthcare transitions?
- What does successful collaboration across sectors look like in your experience? Any examples?