Youth Health Transition Toolkit

A Guide to Implementing Youth Health Transition Services into Clinic Workflow

Louisiana Department of Health | Office of Public Health | Bureau of Family Health

About This Toolkit

This toolkit is for health care or social service professionals working with teens and young adults (physicians, nurses, social workers, clinic managers, support staff, etc.) who want to integrate youth health transition (YHT) services into their regular clinic practice. It is based on clinical practice guidelines from national experts and lessons learned from the field.

The toolkit will guide you through 4 steps to help assess, plan, and implement YHT services tailored to your clinic needs and capacity. Some clinics may want to make small gradual changes while others may be ready to do a complete overhaul. Our care coordination experts are available to assist with any questions you may have about this process and can be reached at BFH-FamilyResourceCenter@la.gov.

About Us

The Louisiana Department of Health, Office of Public Health, Bureau of Family Health works to make Louisiana a place where all people are valued to reach their full potential, from birth through the next generation. Our Children's Special Health Services program works to ensure that children and youth with special health care needs in Louisiana have access to the services they need. These services are designed to minimize their disabilities and maximize their ability to enjoy independent and self-sufficient lives.

Part of the work of the Children's Special Health Services Program's work is to expand pediatric and other clinical practices' capacity to provide services to Louisiana families. No cost, customized technical assistance packages around medical home, youth health transition services, and developmental screening are available to support your quality improvement efforts. Call 504-568-5055 or email BFH-FamilyResourceCenter@la.gov for more information.

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Background

What is Youth Health Transition?

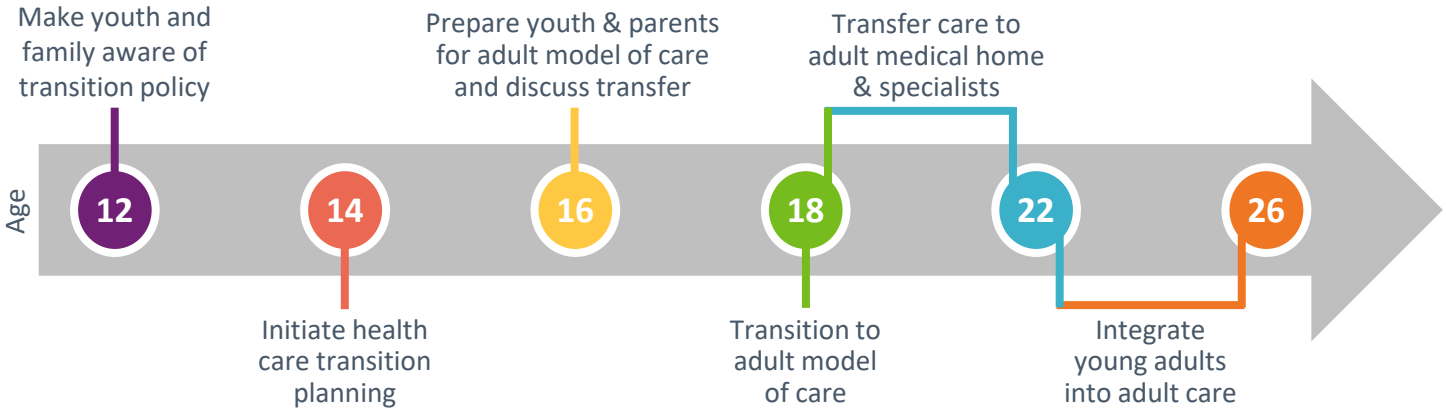
Youth health transition (YHT) is the process of shifting from a pediatric to an adult model of health care.[1] It is a specific type of care coordination that requires a gradual transfer of health care responsibility from a parent or guardian to their teenage child.[2,3] Receiving transition services improves both short and long-term health outcomes for adolescents that receive them. Pediatric providers can assist teens in this process by providing specific, transition-focused services and routinely checking in with patients as they age to get them more involved in their health care.[1,2]

YHT has been identified as extremely important by a number of leading physician groups, including the American Academy of Pediatrics (AAP), the American Academy of Family Physicians and the American Colleges of Physicians.[1] Decades of research demonstrate associations between unplanned or abrupt youth health transition and poor health outcomes.[3,4,5] Many teens don't receive transition services and, as a result, experience gaps in care that includes separation with treatment regimens. Research clearly identifies the association between failed health care transition and increased morbidity and mortality for youth with special physical or mental health care needs.[3,4,5]

Got Transition is one of the leading national organizations on youth health transition.[6] Their *Six Core Elements of Health Care Transition* are intended to be used by providers to help teens transition to an adult model of care. These elements (listed below) are included in the steps of this toolkit.

1. Create a clinic transition policy
2. Track transition progression
3. Assess transition readiness and orientation to adult practice
4. Plan for transition
5. Transfer to adult care
6. Transfer completion and ongoing care

Suggested Timeline for Transitioning Health Care



Successful transition from adolescence to adulthood is significantly influenced by social determinants of health.[7,8] Research has identified social connections, economic factors, health behaviors, and one's physical environment as drivers of health outcomes. Due to this, a holistic approach to supporting youth health care transition is essential.[1,2]

All practices serving adolescents offer some level of YHT services. For Medicaid primary care providers, many of these services are incorporated within the Early Periodic Screening Diagnosis Treatment (EPSDT) adolescent well-exam.[9]

The example below demonstrates the importance of youth health transition services and how support from a healthcare provider can be beneficial. It can be challenging for any teen to transfer to a new provider or take responsibility of their health care. This process is often more complex for teens with chronic health conditions and disabilities.[2,7] Teens with special health care needs tend to see multiple providers and require more care coordination to maintain their health.[11] Youth health transition services are an integral component of preventative care for teens both with and without special needs.[1,10]

Snapshot: Seventeen going on eighteen…

Jamal is 17 and on track to graduate from high school with honors in a few months. He has Sickle Cell Disease, and his medical home has helped coordinate his care since early childhood. He has received transfusions, oxygen therapy, immunotherapy, and is on the waiting list for a bone marrow transplant.

Jamal is leaving his hometown to attend college next fall, but before he goes, he'll need to identify new health care providers and learn how to manage his health on his own. He's been working with his pediatrician to find an adult primary care provider and sub-specialist close to his school who can take over his care once he moves. They've also talked about how he'll manage his care, use insurance, and advocate for his health care needs.

Other factors may affect Jamal's successful transition to adult health care. For example, his family doesn't have a lot of financial resources, and he is attending a small college in a rural area with limited health care and social infrastructure. In addition to health care, Jamal may need guidance related to figuring out other aspects of adult living such as employment, safe and affordable housing, legal rights, stress management, and healthy relationships. His transition will require not just clinical supports, but holistic community supports to support a successful transition to independent living.[1,2,3]

Who We Are and What We Do

The Bureau of Family Health administers the federal Maternal and Child Health Title V Program. A key goal of this program is supporting family-centered systems of coordinated care for children with and without special healthcare needs. The Bureau's Children's Special Health Services program has provided quality improvement training to help clinics implement care coordination and youth transition services. For over 15 years the team has facilitated the successful implementation of transition programs in Louisiana pediatric and family medicine practices.[11] In addition, the Office of Public Health Children's Special Health Services clinics across Louisiana have received this training and are equipped with robust transition services for patients because of it.

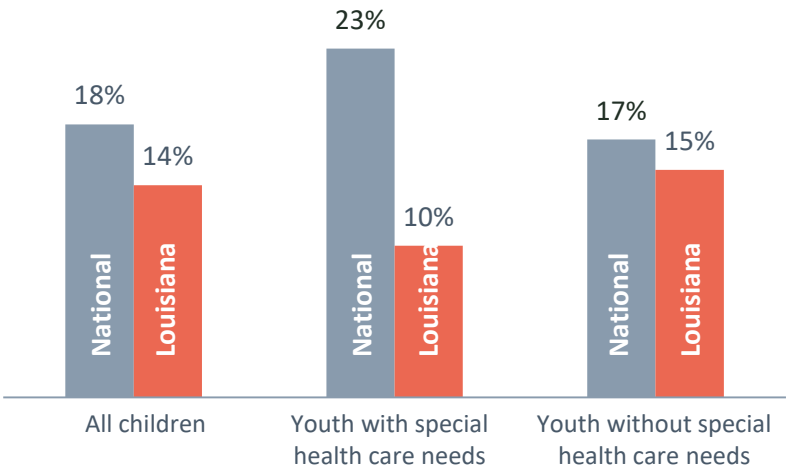
Youth Health Transition in Louisiana

Despite the efforts of the Children's Special Health Services program, findings from the *National Survey of Children's Health, 2018-19* show that overall, Louisiana providers are not consistently providing transition services. According to the report, only 14% of teens in Louisiana received the services necessary to transition to adult health care (the United States rate is 18%). [11]

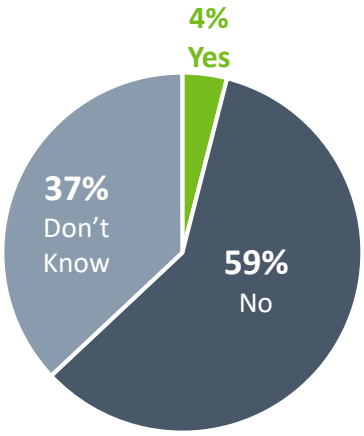
The *Louisiana Provider Survey (*implemented in 2018 by the Bureau of Family Health) found that only 4% of primary care providers (PCPs) can confidently say that their facility has a YHT policy. More than half do not have one, and close to one-third aren't sure whether they have an existing policy or not.

% Youth Receiving YHT Services

(National Survey of Children's Health, 2018-19)

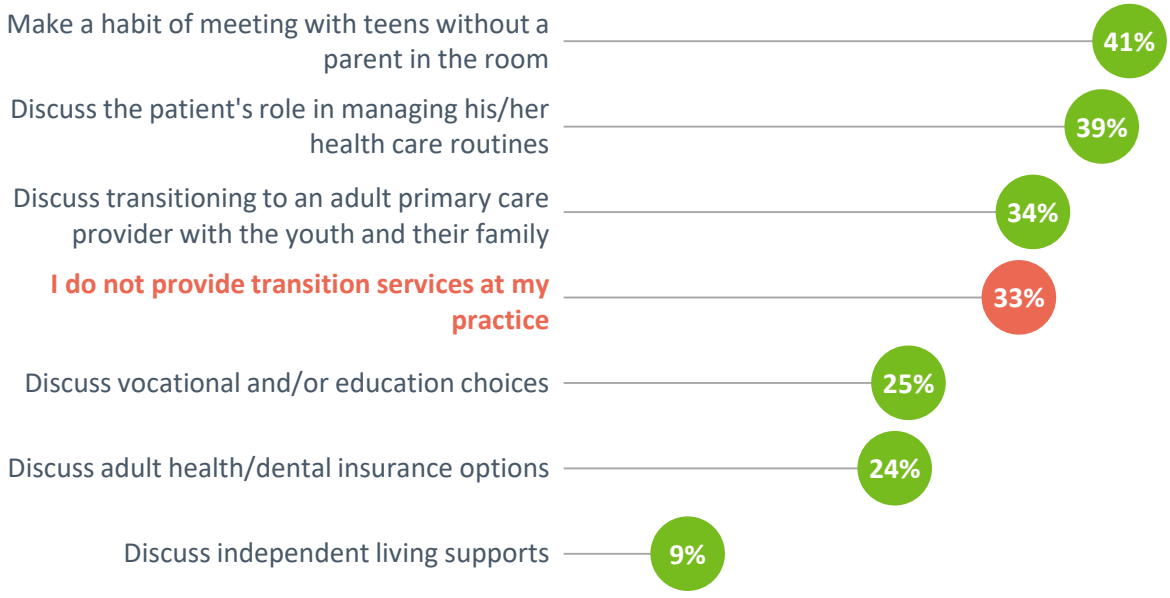


Only 4% of PCPs surveyed reported having a written YHT policy



In relation to the *Core Elements of Health Care Transition* from Got Transition, PCPs surveyed reported that they implement an average of 1.7 out of the 6 core elements. **33% of providers surveyed report that they don't provide any YHT services at their clinic.**

% of PCPs in Louisiana who provide the following YHT services



About This Toolkit

This toolkit is designed to help clinics integrate YHT services into their regular clinic practice. It is based on clinical practice guidelines from national experts and lessons learned from the field. The toolkit can be used by any health care or social service professional working with teens and young adults such as physicians, nurses, social workers, clinic managers, and support staff.

Clinics can tailor their transition programs based on clinic goals and capacity. Some clinics may want to make small gradual changes while others may be ready to do a complete overhaul. If your practice already has some transition services in place, this toolkit can help you build on what you're already doing. It is meant to be customizable based on your goals, and will help you assess, plan, and implement YHT services at your own pace.

4 Steps for YHT Implementation

This toolkit uses a 4-step framework for implementing or improving YHT services at the practice level. We have created checklists and worksheets to help you work through the steps listed below. An example of how to use each document is provided, and **blank documents are available in the appendix**. An electronic version of this toolkit with fillable PDFs is available at PartnersForFamilyHealth.org/Medical-Home.

1. **Assess your clinic's current YHT services & identify needs**
   - Inventory existing youth transition services and processes
   - Determine gaps in services and opportunities to improve workflow
   - Identify clinic-specific priorities for improvement
2. **Develop a plan for implementing new YHT services**
   - Identify processes and protocols needed to provide new or expanded services
   - Create and assign roles and responsibilities for YHT implementation
   - Train your team
3. **Implement your YHT plan**
   - Plan: Develop a test and make a prediction/hypothesis
   - Do: Conduct the test and collect data on the process and outcomes
   - Study: Analyze the data and summarize results
   - Act: Incorporate data-informed changes for the next cycle
4. **Formalize the Process**
   - Create a clinic policy
   - Integrate YHT services into your clinic's electronic health record (EHR)
   - Use CPT codes for reimbursement

Before you Begin

Before starting this process, make sure clinic leaders are willing to follow through on tasks such as approving and enforcing a YHT policy, adapting electronic health records (EHR), and utilizing YHT CPT codes. Once you have leadership on board**, form a small workgroup of 3-5 people from different areas of the clinic** (physicians, nurses, support staff, billing, etc) to help complete the steps in this toolkit. Our care coordination experts are available to assist with any questions you may have about this process and can be reached at BFH-FamilyResourceCenter@la.gov.

MOC-4 Points

This toolkit can be used to receive American Board of Pediatrics Maintenance of Certification 4 (MOC-4) credits. See the Quality Improvement section on page 17 for more information.

Step 1: Assess Your Clinic's Current YHT Services and Identify Needs

The first step is to evaluate what you're already doing. This step will utilize the Quick Scan Checklist. A blank version of the Quick Scan Checklist can be found in the Appendix.

The goal of this step is to identify 1-3 tasks or services that will make it easier (or possible) for your clinic to successfully provide youth health transition services to your patients.

1. Inventory existing youth transition services and processes

Fill out the Quick Scan Checklist (a blank template is in the Appendix) to help assess what you're already doing to help your patients transition to adult care. As you work your way through the list, consider how consistently these tasks are performed. If an item isn't performed with the majority of patients, don't check it off.

2. Determine gaps in services and opportunities to improve workflows

Take a look at your **Quick Scan Checklist**. How does it look? Sections that have a lot of unchecked boxes are the areas you may want to focus on. These will be your priority tasks for improvement. If a lot of the boxes are checked, great job! Your clinic already has a lot of services in place to help teens shift to an adult model of care. You may still find this toolkit helpful for improving service delivery or establishing a formal process to make service delivery more consistent across providers.

3. Identify specific priorities for improvement

Based on where your gaps in services are, **identify 1-3 tasks related to YHT that could be improved and write them in the spaces below**. When choosing priorities, make sure you consider the feasibility of making changes. Potential YHT Priority Tasks could be to:

- Create a process or timeline for identifying youth who are ready to receive transition services from a provider, and tracking their progress.
- Establish a consistent practice of meeting with teen patients without their parents at some point during their visit.
- Create a list of talking points about health care management for providers to discuss with their patients to prepare them for transition.
- Provide referrals to adult providers and communicate with the selected provider to begin transfer of care.
- Follow up with patients 3-6 months after transferring care to confirm the transition was successful.
- Add YHT services to your clinic's Electronic Health Records (EHR).
- Use CPT codes to bill for YHT services.

1. _____

2. _____

3. _____

Need Help?

Our experts can provide technical assistance to you through this process. See the Implementation Training and Support Request Form in the Appendix and contact us at **BFH-FamilyResourceCenter@la.gov** or 504-568-3405 for more information.

Quick Scan Checklist

Youth Health Transition Implementation

Fill out your own checklist using the template in the Appendix!

Use this tool for Step 1 of the Youth Health Transition Implementation to assess what your clinic is already doing. Many YHT services are embedded within wellness exams. Some practices may realize that they already have a lot of youth health transition services in place. Check the boxes below to identify what your clinic is already doing. Check the box in the upper right hand corner of each topic to identify it as a priority for improvement.

Priority Task

Anticipatory Guidance & Coaching for Adolescents [X]

Check the boxes for the following topics that are regularly discussed with patients during well-visits:

- ☑ Self-care
- ☑ Personal safety
- ☑ Sexual health *inconsistent*
- ☑ Chronic condition management *comprehensive*
- ☑ Mental & emotional health *inconsistent screening*
- ☐ Social health
- ☐ Health insurance access
- ☐ Independent living
- ☐ Academic performance and career goals
- ☐ Identification of adult provider(s)
- ☑ Transfer to adult provider(s)
- ☑ Privacy laws- age of majority *HIPPA forms*
- ☐ Supported decision making (for patients with developmental disabilities)

Staff Involved: *RN self-care coach, screenings. MD/DO sexual health - MH. MA coordinates record transfers.*

Average age topics discussed: *Chronic care management starts as early as 9 -10, usually start MH screens at 12. Well checks include sexual health guidance 13 and over.*

Transfer of Responsibility [X]

- ☐ Time without parents during visit
- ☑ Talk directly to teen, rather than parent, during visit
- ☐ Legal changes (privacy, consent, etc) discussed with family before patient turns 18

Staff Involved: *NP/MD, nurse, clinic team overall.*

Average age private visits begin: *At this time, private visits occur only when teens come alone to the appointment, usually 16 or over – not the norm*

Referrals & Resources [ ]

- ☑ Referrals to YHT supports and resources *some*
- ☑ Referral to adult provider discussed at visit
- ☑ Referral to adult provider made
- ☐ Patient contacted after transfer of care

Staff Involved: *Check-out clerk provides a list of local providers if family requests a referral.*

Clinic Policy [ ]

- ☐ Written YHT clinic policy established
- ☐ Policy disseminated to staff
- ☐ Policy disseminated to patients

Staff Involved: *No YHT clinic policy at this time. PCP and clinic management need to explore.*

Documentation of YHT Services [X]

- ☐ Conduct periodic transition readiness assessments
- ☑ Transition services documented in patient chart
- ☐ Designated field for YHT in EHR
- ☐ YHT codes used for billing *check with billing*

Staff Involved: *PCP/RN – adolescent assessment, explore adding YHT reportable fields and system prompts*

Step 2: Develop a Plan for Implementing YHT Services

Once you identify your priority tasks in Step 1, you'll need to start strategizing about what is needed to implement them. Use the Project Planning Worksheet to help you think through this process. Consider how you can use the resources you already have, and what new things you'll need. You may need to develop new processes and protocols to ensure services are provided consistently across all providers. Consider the staff capacity of the clinic as well. Identify roles that need to be filled to carry out tasks and determine who the best person to fill them would be. Identify staff members who will lead YHT efforts and disseminate information to the rest of the team.

The goal of this step is to assess the capacity of your clinic by identifying the processes and staff you have, and considering what you'll need to add or change in order to successfully implement your YHT priority tasks.

1. Identify processes, protocols, staff, and training needed to implement your priority tasks

Write your YHT priority tasks at the top of the Project Planning Worksheet and answer the questions that follow. For questions you answer "No" or "Some/Sometimes" to, consider how your clinic can make changes in those focus areas. Use the notes to guide your brainstorming and review YHT tools and resources listed towards the end of this toolkit (or through your own online search) to figure out what will work for your team.

2. Create and assign roles and responsibilities for YHT implementation

Based on your YHT priorities, **decide what tasks need to be fulfilled and which staff members will need to do them. Identify staff who are essential to implementing YHT services.** You will need to determine who will be the main point people and leaders of YHT implementation. There are opportunities for everyone to get involved – MD/DO, NP, PA, MA, Nurse, Pharmacists, Clinic Managers, etc. Approach leaders and those you think may be interested in youth health transition or overall quality improvement.

3. Train your team

Once roles are assigned, you'll want to **train your YHT leaders and clinic team members** involved in carrying out the tasks. Determine specific training needs and explore training materials and resources online.

Need Help?

Our experts can provide technical assistance to you through this process. See the Implementation Training and Support Request Form in the Appendix and contact us at **BFH-FamilyResourceCenter@la.gov** or 504-568-3405 for more information.

Project Planning Worksheet

Youth Health Transition Implementation

Fill out your own worksheet using the template in the Appendix!

Use this worksheet for Step 2 of Youth Health Transition Implementation to assess clinic capacity and begin to consider what your next steps are. Identify the processes and staff you have, and those that you will need to add or modify in order to successfully implement your YHT priority tasks. The checkboxes below indicate Y for Yes, S for Some/ Sometimes, and N for No.

My Clinic's YHT Priority Tasks

1. Select a single adolescent depression screener and implement across all providers.
2. Work with IT to identify an EHR reportable field for documentation/tracking.
3. Establish protocol for meeting with patients 14 and above without caregiver in room.

Processes & Protocols

Does your clinic have a protocol for one-on-one visits for patients over age 14? Y ☐ S ☐ N ■

Notes Clinic manager to request technical assistance with process mapping

Experts recommend introducing transition services when patients are ages 12-14. Meeting with patients one-on-one without a parent in the room is a great first step toward getting youth to take control of their health. Have the providers at your clinic meet and decide on the age when this service should start.

Does your clinic use a form to document YHT services (paper or electronic)? Y ☐ S ■ N ☐

Notes Some items yes, need to assess EHR adolescent visit screen for report fields

Adding fields or making edits to an EHR can be costly, so we recommend using existing reportable fields in your EHR system that could be used to document YHT tasks. Most EHR systems have age-specific assessment screens that include many of the recommended YHT services. Use these to build your form for YHT documentation.

Does your clinic bill for YHT services? Y ☐ S ■ N ☐

Notes Not sure, team will check in with billing. Well visits are usually bundled.

The American Academy of Pediatrics' latest version of *Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care* includes a listing of transition-related CPT codes, corresponding Medicaid fees, and relative value units (RVUs). Work with your clinic's billing team to establish which codes to use.

Do clinic staff meet on a regular basis to talk about quality improvement opportunities and projects? Y ■ S ☐ N ☐

Notes All team staff meetings are held monthly. QI projects are tracked/discussed.

New processes will likely need to be established to implement your new YHT services. It's important to establish a process and teach it to staff across the clinic to ensure everyone is well-trained. Check in regularly with staff to answer questions, keep everyone on track, and explore ways to continuously improve the clinic. You can add YHT as a topic to existing clinic meeting agendas, or schedule a regular time for YHT leaders to meet.

Staff Capacity & Training

	Y	S	N
Does your clinic have a designated care coordinator responsible for patient referrals and follow up?	☐	☐	■
Does your clinic have quality improvement (QI) team/staff?	■	☐	☐

Notes Nurses and MAs support care coordination activities. Clinic manager directs QI project activities, pulls in appropriate staff prn

Staff capacity and roles vary clinic to clinic. If your clinic has staff members who are responsible for QI and care coordination, they can likely help implement new YHT services. If these roles don't exist, you may want to consider creating a new position or evaluating which current positions have the capacity to carry out your needs. Someone will need to be the point person for implementing your priority tasks and evaluating their effectiveness.

	Y	S	N
Are all staff familiar with YHT clinical guidelines?	☐	■	☐
Are all staff familiar with Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements?	☐	■	☐

Notes Providers familiar with guidelines, will review with team at all staff meeting.

Staff will likely need to be trained in order to effectively provide YHT services. Check out the resources listed at the end of this toolkit for our recommended trainings on YHT and QI. It's important to establish a process and teach it to staff across the clinic to ensure everyone is well-trained.

Assigning Roles

Gather your team and work together to decide who should be responsible for carrying out your priority tasks. Use the table below as a starting point to begin brainstorming which position(s) and specific people would be a good fit for what your clinic needs. You only need to think these through for the tasks you selected. If your priority tasks aren't listed, add them at the bottom.

Task	Have?	Position(s) Responsible *(PCP, RN, SW, Clinic Staff, etc)*	Lead Person(s) for Task - Notes
Provide anticipatory guidance and coaching for adolescents	Y ■ N ☐	PCP, LPN, RN	PCP provides guidance, nurses coaching and teaching. Need to implement additional YHT topics.
Coordinate community referrals	Y ■ N ☐	MA, LPN	MA-resources, RN/LPN referrals.. Need additional YHT referral information.
Develop a clinic policy	Y ☐ N ■		Clinic managers and PCPs –determine YHT services first.
Integrate YHT services in EHR	Y ☐ N ■	Clinic Manager/IT	PCPs – Clinic Manager and IT. Need to add reportable fields/standardize documentation.
Code for billing of YHT services	Y ☐ N ■	Clinic Manager Coding Specialist – billing	Sending coding guide to billing, not sure if we are capturing these codes.
Standardize adolescent depression screens	Y ☐ N ■	LPN, RN, PCP, MA	Nurses screen, PCPs discuss finings - makes referrals as needed, MA coordinates
Establish effective workflow for private visit time	Y ☐ N ■	Clinic Manager with BFH, RN, LPN and MA	Manager scheduled BFH technical assistance to develop workflow options for private visit times.

Step 3: Implement Your YHT Plan

Once you identify the processes and staff needed to implement your priority tasks, you'll want to perform the quality improvement by implementing the tasks into your clinic workflow. Quality improvement (QI) is the framework used to systematically improve the way health care is delivered to patients. It refers to the process of planning and testing changes on a small scale, with the goal of implementing them across the entire practice. This toolkit utilizes the Plan-Do-Study-Act (PDSA) method of QI to help you figure out which strategies work best. The PDSA provides a systematic framework for working through tasks and will help you document the process, communicate with staff, and work through issues that may arise.

The PDSA Worksheet will help you plan and test different ways to implement your priority tasks in hopes of finding a strategy that works. You'll need to complete a new worksheet for each test of each priority task. Start with the priority task that seems the easiest to implement. For additional instruction on how to complete a PDSA, check out the resources listed in the Quality Improvement section on page 17 of this toolkit.

The goal of this step is to test different strategies for implementing your priority tasks. Once you determine what works best, you can establish a system that allows you to successfully integrate YHT services into your workflow.

1. Plan: Develop a test and make a prediction

Select one of the priority tasks you chose in Step 1. Create a plan for how you are going to implement that task. Answer the following questions in the box, then make a prediction about what you think will happen.

- Who will be performing the task?
- What specific things will they be doing?
- Where will the task be performed?
- When will it happen?

2. Do: Conduct the test and collect data

Carry out the plan you created. Start small. You can test out your tasks on a few patients, with a few providers, or over a short period of time. **Document what happens**, including any data you are able to gather. Note any barriers you encounter, as well as what goes well.

3. Study: Analyze the data and summarize results

How did it go? Look at the data you collected and **summarize the results**. Are there any trends in the data? Compare the actual results to the prediction you made in the Plan phase of the PDSA cycle. How do they compare?

4. Act: Refine changes for the next cycle

Based on the results, **decide what to do next**. The 3 options are:

- **Adapt**: Consider what changes could be made to improve the way your task was implemented. Get a new PDSA worksheet and go through these steps again with those modifications. Continue making small changes and working through the PDSA cycle until you find a strategy that works well.
- **Adopt**: If you are satisfied with how the test went and want to implement it across the clinic, create a timeline for bringing it up to full scale and execute it.
- **Abandon**: If your plan was unsuccessful or you've gone through this cycle a few times and nothing seems to be working, you may want to abandon the idea. If you decide to abandon this plan, consider other strategies or services that could be implemented.

Plan-Do-Study-Act (PDSA) Worksheet

Youth Health Transition Implementation

Fill out your own PDSA using the template in the Appendix!

Use this worksheet for Step 3 of Youth Health Transition Implementation to implement your priority tasks. A Plan-Do-Study-Act (PDSA) cycle is a simple scientific method for accelerating quality improvement (QI).[14] Use this worksheet to test a change you wish to implement or improve in your facility.

Title: YHT 1-QI - Implementing universal adolescent depression screens for all patient well visits age 12-20

Planned Test Date(s): May 1, 2025 **PDSA Cycle #:** 1 **Today's Date:** April 25, 2025

1: PLAN Develop a test and make a prediction

DESCRIPTION OF TEST/TASK

Who: Clinic nurses and PCP (Dr. Russo)

What: Administer and scores depression screen. Provide referrals if needed.

Where: Exam room

When: Nurses distribute screens before leaving exam room. PCP scores and discusses results while in room.

PREDICTION

We predict all adolescent well-child visit patients will be screened for depression.

2: DO Conduct the test and collect data

STEPS TAKEN

- After nurse takes vitals in exam room, they hand the patient the screen and a pen.
- Nurse explains what the screen is and how to complete. Tells patient that the doctor will review the results with them.
- Nurse asks patient if they have any questions. Once questions are answered nurse leaves the room.
- Patient completes screen alone in exam room.
- Doctor reviews and scores the screen with the patient in the exam room.
- If needed, doctor asks nurse to coordinate a referral for the patient.

COLLECT DATA

- # well-child visit seen/scheduled: 15/17
- # screens given: 11
- Reasons for not giving screen: forgot, no blank copy, no time

3: STUDY Analyze the data and summarize results

ANALYZE DATA

- 11/15 well-child visit patients received a screen
- Feedback from staff showed that nurses remembered to give patients the screen in the morning, but had forgotten a few later in the afternoon.

RESULTS

- 73% of patients received a screen
- Based on feedback from staff, we need a way to remind nurses to give the screen.

COMPARE RESULTS TO PREDICTED OUTCOME

- Goal: 100%
- Reality: 73%

4: ACT Refine changes for the next cycle

☑ **ADAPT** (write out changes to be made next time)

Request that an alert be added to the EHR for all well-child visits. Place printed copies of blank depression screener in all exam rooms. Will make changes and do another cycle on June 1.

❑ **ADOPT** (create a timeline for full implementation)

❑ **ABANDON**

Step 4: Formalize the Process

Once you establish a successful strategy for integrating YHT services into your clinic's workflow, you can formalize the process to ensure consistency across all patients.

1. Create a clinic policy

After a few months of fully implementing your priority tasks, create a YHT clinic policy. A written youth transition policy can serve as a useful education tool for both staff and patients, and helps establish consistent service delivery. Use the *Sample Clinic Policy* in the Appendix as an example for writing one for your clinic. The policy should include the following:

- The age transition services begin at your practice (typically between 12-14 years old)
- The expected age of transfer to adult services (typically between 18-22 years old)
- The transition services your clinic offers (helping to identify an adult provider, sending medical records, communicating with the new adult provider about the unique needs of your patients)
- The teen's role in transition and managing their health and health care (scheduling appointments, understanding their insurance)

2. Integrate YHT services into your clinic's electronic health record (EHR)

Fully integrating YHT services into your clinic's EHR will make it easier to ensure consistency and track data. [14] Establishing standardized documentation for transition services will help minimize service redundancy. Document topics covered at each visit to cue topics for subsequent visits. The EHR case management module may be useful for documenting transition referral coordination and follow-up. We also suggest using screenings and assessments to guide any anticipatory guidance you provide.

Look for overlap between recommended transition services and existing quality measures (HEDIS, PCMH, Child Core Measures) reported by the clinic. If the clinic EHR includes an age-specific encounter screen for documentation of adolescent health assessments, review the assessment screen for transition service items and explore the social history section for items related to the social determinants of health. Items to look for include:

- ❑ Self-care management
- ❑ Insurance maintenance
- ❑ Education/vocation
- ❑ Health promotion/exercise
- ❑ Nutrition/food security
- ❑ Safety/risk assessments
- ❑ Sexual health
- ❑ Depression/mental health
- ❑ Dental/oral health
- ❑ Independent living support
- ❑ Adult provider referrals/transfers
- ❑ Age of majority – privacy laws

If your practice's EHR system supports an online patient portal, consider using it to relay supplemental information. An online patient portal can be used as an important communication channel for transition-aged youth, as teens often prefer electronic communication. See the Readiness Assessment Checklist and Patient Planning Worksheet in the Appendix.

3. Use CPT codes for reimbursement

A major benefit to implementing YHT services into a clinic's regular practice is that they are reimbursable. The American Academy of Pediatrics' latest version of *Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care* includes a list of transition-related CPT codes, corresponding fees, and relative value units (RVUs).[15] The tip sheet also includes a set of clinical vignettes with recommended coding for transition-related services to help you understand which codes to use and when. See an example on the next page and find the latest version of this document at GotTransition.org under "Resources" → "Payment and Transition". Note that for Louisiana Medicaid patients, some YHT services are bundled into the EPSDT adolescent well-exam.

Snapshot: An example of coding for transition services

This clinical vignette was developed by Got Transition to illustrate how to code for youth health transition services.[14]

A preventive medicine visit with an established 18-year-old female patient is scheduled for her final pediatric visit before she goes off to college. The patient wants to see a new physician who treats adults, and she asks the physician for suggestions. She has been treated for major depressive disorder (mild) since she was 14. During the visit, the patient describes high levels of stress associated with all the changes that are happening in her life and persistent sadness.

The physician takes an extra 15 minutes to re-assesses the patient's depression and determines that a different medication is required. The physician reviews the last scorable transition readiness assessment conducted when the patient was 17, updates the medical summary, and recommends an adult physician who can accept her as a new patient. She also recommends that she schedule a visit with her child/adolescent psychiatrist to discuss her depression and plans to transfer to an adult psychiatrist. Following the visit, the physician takes an extra 30 minutes of non-face-to-face time to prepare a transfer letter for the patient to take to her new adult providers. The transfer letter includes an updated medical summary, plan of care, and scorable transition readiness assessment.[6]

Coding:

- ICD-10-CM: Z00.121 (Encounter for routine child health examination with abnormal findings)
- ICD-10-CM: F41.8 (Other specified anxiety disorders)
- CPT 99395 (Preventive medicine visit, established visit, ages 18-39)
- CPT 99213-25 (Office visit, established patient, low to moderate severity, 15 minutes, with significant, separately identifiable E/M service above and beyond the service performed by the same physician)
- CPT 99358 (Prolonged E/M services before and/or after direct patient contact; first hour)

The latest Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care can be found at GotTransition.org under "Resources" → "Payment and Transition"

Quality Improvement (QI)

Quality improvement (QI) is the framework used to systematically improve the way health care is delivered to patients. It refers to the process of planning and testing changes on a small scale, with the goal of implementing them across the entire practice. Plan-Do-Study-Act (Step 3 of Implementing YHT Services in this toolkit) is a popular QI framework. Using evidence-based QI strategies while implementing your YHT initiative will strengthen your clinic's services and provide staff with the tools to improve efficiency, patient safety, and clinical outcomes.[12, 13, 15]

Building clinic QI capacity does not have to be costly or overwhelming. Evidence tells us that selecting a QI method and using it consistently is key to success. There are many no and low cost, evidence-based QI trainings that provide the framework needed to get started. The resources listed below can be used to better understand QI and how to use the PDSA framework.

Quality Improvement Resources

- **American Academy of Pediatrics (AAP) Quality Improvement in the Pediatric Practice - Tutorial**
  rb.gy/ronr5f
  An introduction to QI and the PDSA framework. Topics covered include the basics of QI, creating a QI team, and how to complete a PDSA.

- **The National Institute for Children's Health Quality (NICHQ) Quality Improvement 101/102 - Virtual Training**
  nichq.org/resource/quality-improvement-101 **&** nichq.org/resource/quality-improvement-102
  Self-directed courses that introduce quality improvement science concepts. QI 102 provides lessons, exercises, and examples of best practices and offers direction on moving from one PDSA cycle to the next.

American Board of Pediatrics Maintenance of Certification 4 (MOC-4) Credits

This toolkit can be used as an American Board of Pediatrics MOC-4 project for providers who are heavily involved in leading the QI efforts. Review the checklist, application questions, and project examples at abp.org/content/your-own-qi-project so you know what you'll need to submit to qualify for credits. For more information about American Board of Pediatrics MOC-4 credits, visit abp.org/content/quality-improvement-part-4.

Create a culture of quality improvement in your practice

- Educate staff on QI and provide opportunities for all staff to participate.
  - Encourage all staff to share ideas on what could be improved.
  - Designate a staff member as the point person for QI ideas.
- Use QI methods for small improvement projects and embed continuous QI into the framework of your practice.
  - Include QI in regular staff meetings and set a schedule for routine monitoring and review of data.
- Articulate the value of QI
  - Communicate results from improvement projects to the clinic and community at large.
- Celebrate successes
  - Recognize staff members' efforts by including their QI contributions in performance evaluations.

Additional YHT Resources

Below are additional resources related to youth health transition and supporting children and youth with special health care needs. Review these resources to get a better understanding of the supports available to the patients you serve. Share these resources with your patients to help them prepare for transitioning their health care.

Youth Health Transition Resources

Got Transition | GotTransition.org

The national center for youth transition, and a virtual one-stop-shop for transition resources. The site hosts a library of resources for providers, educators, researchers, youth and their families, and policymakers. Resources include:

- Current research
- The 6 Core Elements of Transition
- Tools to help providers/practices implement medical home and promote preventative health
- Toolkits to support the implementation of comprehensive transition programs.

Smooth Moves | SmoothMovesYHT.org

An online resource for adolescents and young adults. The site covers all topics related to transition and hosts a library of youth-friendly tools developed by content experts. We encourage you to share this resource with the young adults your practice serves.

Louisiana State Bar Association | lsba.org/ChildrensLaw/BecomingAnAdult.aspx

The Louisiana State Bar Association maintains an online, teen-friendly resource called Becoming an Adult: Legal Rights in Louisiana. The site covers topics such as voting, housing, driving, alcohol, and employment rights.

Local Resources for People with Special Health Care Needs

Louisiana Children's Special Healthcare Services | ldh.la.gov/cshs

Find information on key support services for pediatric patients with special health needs. Regional Resource Guides are available for download to provide clinics with a quick list of key community programs and state agency services. Each of the guides include basic service information, eligibility criteria, and contact information.

Family Resource Center | BFH-FamilyResourceCenter@la.gov

This virtual resource center supports Louisiana families and pediatric providers by providing community referrals, resource linkage, help navigating health and social systems, and transition supports. Contact the center at (504) 896-1340 or send email requests to BFH-FamilyResourceCenter@la.gov.

Exceptional Lives Louisiana | ExceptionalLives.org/Louisiana

Resource guides and directories can help users find services in their area and walk them through the process of applying for disability benefits.

Disability Rights Louisiana | DisabilityRightsLA.org

Legal supports are available for individuals with a developmental disability who require supported decision making for health care, finances or independent living as an adult.

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Appendix

This toolkit is available online with fillable PDFs for the following documents at ldh.la.gov/cshs.

- **Implementation Training and Support Request Form**: Our team of experts is available to meet in-person or virtually to provide technical assistance in youth health transition, developmental screening, and care coordination. Use this form to request trainings and resources in these topic areas.
- **Quick Scan Tool**: Follow the example in Step 1 to fill out your own Quick Scan Checklist using this blank template.
- **Project Planning Checklist:** Follow the example in Step 2 to fill out your own Project Planning Checklist using this blank template.
- **Plan-Do-Study-Act (PDSA) Worksheet:** Follow the example in Step 3 to fill out your own PDSA using this blank template.
- **YHT Clinic Policy Creation Guide:** An overview of youth health transition and template for creating a clinic transition policy.
- **Readiness Assessment & Planning Checklist:** Give these worksheets to your patients to get them thinking about what they already know about their health and what they should learn more about in order to successfully transition to an adult model of care.

Louisiana Department of Health ● Office of Public Health ● Bureau of Family Health

Implementation Training & Support

The Bureau of Family Health offers trainings and resources to Louisiana providers that can help enhance and expand their clinical services. Our team of experts is available to develop a tailored plan to fulfill your clinic's needs, and can meet in-person or virtually to provide technical assistance. We use a quality improvement framework that helps embed continuous improvement into your practice. We provide trainings on the following topics:

- Developmental screening
- Care coordination
- Youth health transition

These trainings and resources are available at no cost. If you're interested in learning more, please complete the information below and email it to DevScreen@la.gov. We will contact you to provide more information and schedule a training.

Step 1: Tell Us Your Interests

Check the following services you are interested in for each of the topic areas.

	Referral Resources	Tools to Use in Clinic	Implementation Training*
Developmental Screening	☐	☐	☐
Care Coordination	☐	☐	☐
Youth Health Transition	☐	☐	☐

*Implementation Training can be done in-person or virtually. Training includes:

- Project planning
- Staff training
- Process mapping
- Implementation Assistance

Step 2: Tell Us About Your Practice

Provide the following information about your clinic. We will contact you using your preferred method of communication.

Clinic: _____ Contact Name: _____

Address: _____ Contact's Role: _____

City: _____ Phone: _____

EHR System: _____ Email: _____

Clinic Owner: _____ Preference: ☐ Phone ☐ Email

Quick Scan Checklist

Youth Health Transition Implementation

Use this tool for Step 1 of the Youth Health Transition Implementation to assess what your clinic is already doing. Many YHT services are embedded within wellness exams. Some practices may realize that they already have a lot of youth health transition services in place. Check the boxes below to identify what your clinic is already doing. Check the box in the upper right hand corner of each topic to identify it as a priority for improvement.

Priority Task

Anticipatory Guidance & Coaching for Adolescents ☐

Check the boxes for the following topics that are regularly discussed with patients during well-visits:

- ☐ Self-care
- ☐ Personal safety
- ☐ Sexual health
- ☐ Chronic condition management
- ☐ Mental & emotional health
- ☐ Social health
- ☐ Health insurance access
- ☐ Independent living
- ☐ Academic performance and career goals
- ☐ Identification of adult provider(s)
- ☐ Transfer to adult provider(s)
- ☐ Privacy laws- age of majority
- ☐ Supported decision making (for patients with developmental disabilities)

Staff Involved: _____

Average age topics discussed: _____

Transfer of Responsibility ☐

- ☐ Time without parents during visit
- ☐ Talk directly to teen, rather than parent, during visit
- ☐ Legal changes (privacy, consent, etc) discussed with family before patient turns 18

Staff Involved: _____

Average age private visits begin: _____

Referrals & Resources ☐

- ☐ Referrals to YHT supports and resources
- ☐ Referral to adult provider discussed at visit
- ☐ Referral to adult provider made
- ☐ Patient contacted after transfer of care

Staff Involved: _____

Clinic Policy ☐

- ☐ Written YHT clinic policy established
- ☐ Policy disseminated to staff
- ☐ Policy disseminated to patients

Staff Involved: _____

Documentation of YHT Services ☐

- ☐ Conduct periodic transition readiness assessments
- ☐ Transition services documented in patient chart
- ☐ Designated field for YHT in EHR
- ☐ YHT codes used for billing

Staff Involved: _____

Project Planning Worksheet

Youth Health Transition Implementation

Use this worksheet for Step 2 of Youth Health Transition Implementation to assess clinic capacity and begin to consider what your next steps are. Identify the processes and staff you have, and those that you will need to add or modify in order to successfully implement your YHT priority tasks. The checkboxes below indicate Y for Yes, S for Some/ Sometimes, and N for No.

My Clinic's YHT Priority Tasks

1. _____

2. _____

3. _____

Processes & Protocols

Does your clinic have a protocol for one-on-one visits for patients over age 14? Y ☐ S ☐ N ☐

Notes

Experts recommend introducing transition services when patients are ages 12-14. Meeting with patients one-on-one without a parent in the room is a great first step toward getting youth to take control of their health. Have the providers at your clinic meet and decide on the age when this service should start.

Does your clinic use a form to document YHT services (paper or electronic)? Y ☐ S ☐ N ☐

Notes

Adding fields or making edits to an EHR can be costly, so we recommend using existing reportable fields in your EHR system that could be used to document YHT tasks. Most EHR systems have age-specific assessment screens that include many of the recommended YHT services. Use these to build your form for YHT documentation.

Does your clinic bill for YHT services? Y ☐ S ☐ N ☐

Notes

The American Academy of Pediatrics' latest version of *Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care* includes a listing of transition-related CPT codes, corresponding Medicaid fees, and relative value units (RVUs). Work with your clinic's billing team to establish which codes to use.

Do clinic staff meet on a regular basis to talk about quality improvement opportunities and projects? Y ☐ S ☐ N ☐

Notes

New processes will likely need to be established to implement your new YHT services. It's important to establish a process and teach it to staff across the clinic to ensure everyone is well-trained. Check in regularly with staff to answer questions, keep everyone on track, and explore ways to continuously improve the clinic. You can add YHT as a topic to existing clinic meeting agendas, or schedule a regular time for YHT leaders to meet.

Staff Capacity & Training

Does your clinic have a care coordinator responsible for referring patients to other clinics and services? Y ☐ S ☐ N ☐

Does your clinic have quality improvement (QI) team/staff? ☐ ☐ ☐

Notes

Staff capacity and roles vary clinic to clinic. If your clinic has staff members who are responsible for QI and care coordination, they can likely help implement new YHT services. If these roles don't exist, you may want to consider creating a new position or evaluating which current positions have the capacity to carry out your needs. Someone will need to be the point person for implementing your priority tasks and evaluating their effectiveness.

Are all staff familiar with YHT clinical guidelines? Y ☐ S ☐ N ☐

Are all staff familiar with Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements? ☐ ☐ ☐

Notes

Staff will likely need to be trained in order to effectively provide YHT services. Check out the resources listed at the end of this toolkit for our recommended trainings on YHT and QI. It's important to establish a process and teach it to staff across the clinic to ensure everyone is well-trained.

Assigning Roles

Gather your team and work together to decide who should be responsible for carrying out your priority tasks. Use the table below as a starting point to begin brainstorming which position(s) and specific people would be a good fit for what your clinic needs. You only need to think these through for the tasks you selected. If your priority tasks aren't listed, add them at the bottom.

Task	Have?	Position(s) Responsible *(PCP, RN, SW, Clinic Staff, etc)*	Lead Person(s) for Task - Notes
Provide anticipatory guidance and coaching for adolescents	Y ☐ N ☐		
Coordinate community referrals	Y ☐ N ☐		
Develop a clinic policy	Y ☐ N ☐		
Integrate YHT services in EHR	Y ☐ N ☐		
Code for billing of YHT services	Y ☐ N ☐		
	Y ☐ N ☐		
	Y ☐ N ☐		

Plan-Do-Study-Act (PDSA) Worksheet

Youth Health Transition Implementation

Use this worksheet for Step 3 of Youth Health Transition Implementation to implement your priority tasks. A Plan-Do-Study-Act (PDSA) cycle is a simple scientific method for accelerating quality improvement (QI). Use this worksheet to test a change you wish to implement or improve in your facility.

Title: _____

Planned Test Date(s): _____ **Today's Date:** _____

1: PLAN Develop a test and make a prediction

DESCRIPTION OF TEST/TASK

Who:_____

What: _____

Where: _____

When: _____

PREDICTION

2: DO Conduct the test and collect data

STEPS TAKEN

COLLECT DATA

3: STUDY Analyze the data and summarize results

ANALYZE DATA

RESULTS

COMPARE RESULTS TO PREDICTED OUTCOME

4: ACT Refine changes for the next cycle

☐ **ADAPT** (write out changes to be made next time)

☐ **ADOPT** (create a timeline for full implementation)

☐ **ABANDON**

Introducing Youth Health Transition

A guide for incorporating practices to help teens transition into an adult model of care

WHAT IS YOUTH HEALTH TRANSITION?

Youth Health Transition (YHT) is the process of changing from a **pediatric to an adult model of care**. Health care transition services help to assist teens in reaching their full potential and ensure their best possible health.

Transition can be a difficult task for any teen, but it's especially challenging for teens with disabilities.

To transition to an adult model of care successfully, teens and young adults should be supported in the following:

- Acquiring independent life skills
- Preparing for the kinds of health care they'll need as adults
- Transferring to new providers without disruption of care

When teens are not transitioned to adult care, consequences can include:

- Difficulty accessing health care
- Increased impairment, morbidity, or mortality
- Decreased function or mobility
- Increased health care costs
- Decreased likelihood that the individual will reach social milestones

November 2019

WHAT ARE TRANSITION SERVICES?

- Providers should become familiar with the **Six Core Elements** that serve as benchmarks for transition services provided in primary or specialty care settings. The Core Elements are:
  - ✓ Establish a clinic policy
  - ✓ Track transition progression
  - ✓ Assess transition readiness
  - ✓ Plan for transition
  - ✓ Transfer to adult care
  - ✓ Transfer completion

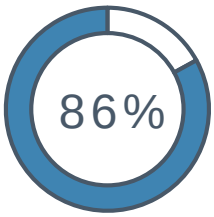
  Learn more at gottransition.org/providers.

- **Transition services should start when the patient is 12 to 14 years old.** While the legal age of transition to adulthood is 18, the American Academy of Pediatrics recommends that preparation for youth health transition (YHT) start much earlier.

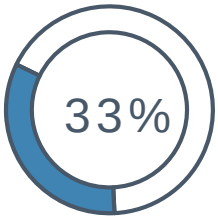
- **Develop a clinic transition policy.** Outlining transition services offered in the practice can formalize and standardize YHT services. A basic policy provides a framework for youth transition services (see sample policy on next page). Sharing the policy with teens, families and staff can serve as an education tool!

TRANSITION SERVICES IN LOUISIANA

Youth Health Transition has been identified as an extremely important component of the medical home by a number of leading physician groups, including the American Academy of Pediatrics (AAP). However, recent findings show that **Louisiana providers are not consistently providing transition services:**



86% of teens in Louisiana **did not receive** necessary transition services (National Survey of Children's Health 2018-2019).



33% of Louisiana providers reported that they **do not provide** transition services at their practice (2018 Louisiana Provider Survey).

For more information, visit us at PartnersForFamilyHealth.org/cshs

Sample Transition Policy

A clinic transition policy is key to integrating youth transition services into your practice.

A basic clinic policy statement formalizes and adds consistency to clinic processes and workflow for youth transition services. The policy should articulate how the practice defines youth transition and transition age, the changes that occur at the age of majority, and the required age of transfer to adult care. When disseminated it can serve to engage teens and families with the transition process. Please feel free to modify and use this sample policy below for your practice. It's been adapted from evidence-based tools at gottransition.org:

"[**Pediatric Practice Name**] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with teens, 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, teens 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 teen 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 teens 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. For teens with disabilities or chronic diseases, we will also link families to programs that can assist with planning for other transition issues, such as **adult insurance, education, jobs, independent living, legal issues/decision making,** and so on."

Additional Resources

- **GotTransition.org:** A program of the National Alliance to Advance Adolescent Health that provides youth health transition resources for providers, families, and policymakers.
- **SmoothMovesYHT.org:** A website intended for teens with activities and tools to help them build the skills they need to be independent.
- American Academy of Pediatrics Clinical Report. **Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home.** White PH, Cooley WC; Transitions Clinical Report Authoring Group; AAP; AAFP; ACP. Pediatrics. 2018;142(5) – Feb 1, 2019.

Who We Are

The Louisiana Department of Health, Office of Public Health, Bureau of Family Health's Children's Special Health Services program works to ensure that children and youth with special health care needs in Louisiana have access to health care services. These services are designed to minimize their disabilities and maximize their ability to enjoy independent and self sufficient lives.
Visit us at **partnersforfamilyhealth.org/cshs**

LOUISIANA DEPARTMENT OF HEALTH

PARTNERS FOR FAMILY HEALTH LOUISIANA

Readiness Assessment Checklist

Youth Health Transition

Youth health transition is the time to get ready for the move from pediatric care to adult health care, work, and independence. Learning to manage your health and health care takes time. Experts recommend you start planning for this transition around age 14. This gives you enough time to develop the skills you will need. A **readiness assessment** is a list of questions about taking care of you and your health care. Filling one helps you figure out which skills you need to work on to do things on your own. If you need help, ask a family member for assistance.

Youth Health Transition Readiness Assessment (Adapted from Got Transition 2.0)

Fill out the checklist below to see what you already know and what you may need to learn more about when it comes to managing your health and health care.

My Health *(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 which symptoms mean I need to see a doctor quickly	☐	☐	☐ _____
I know what to do in case I have a medical emergency	☐	☐	☐ _____
I know my medicines, what they are for, and when I need to take them	☐	☐	☐ _____
I know my allergies to medicines and which 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 know how health care privacy changes at age 18, when I am legally an adult	☐	☐	☐ _____

Using Health Care *(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, 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 with 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 I turn 18	☐	☐	☐ _____
My family and I have talked about my ability to make my own health care decisions at age 18	☐	☐	☐ _____

Create Your Own Plan

Youth Health Transition

A transition plan is all about you, your health, and preparing to do things on your own. The most important thing to remember is that there is no wrong way to do a transition plan! If you need help, get a family member or friend to give you a hand. A transition plan can help you come up with do-able steps to help you transition to independence. Remember, your input is very important. Let your doctors and other providers know what works for you and what doesn't. Share your transition plan with your providers. Experts recommend starting transition plans at age 14!

Use the checklist below to start making a transition plan. Use it to keep notes and contact information for referrals. Add more pages as needed.

I will begin to take charge of my health

- ❑ I will learn more about my health condition(s) by talking to my health care providers and family.
- ❑ I will go to smoothmovesYHT.org and gottransition.org for information on transition.
- ❑ I will begin to take charge of my health. These are the skills I need to work on:
  - **Manage my medications**
  - **Order medicine from the pharmacy**
  - **Fill out medical forms**
  - **Schedule appointments**
  - **Learn how to do my own medical treatments**
  - **Learn how to stay healthy**
- ❑ I will ask my health care providers about meeting with them privately for part of my visit.
- ❑ At age 16-18, I will talk to my doctors about the transfer to adult health care providers (I will ask them when this should happen and what providers they recommend)

  _____
- ❑ My personal transition goals and notes:

  _____

  _____

  _____
- ❑ For youth with disabilities or special health care needs - I will talk with my health care providers, IEP transition coordinator at school, and local resource organizations for transition guidance on:
  - **Health insurance and SSI**
  - **independent or supported living**
  - **Education/job training after high school**
  - **Medical/legal decisions at age 18**

Additional Resources

For additional resources and information, connect with a family peer-support organization in your region such as **Families Helping Families** or **Family Voices**. **ExceptionalLives.org** offers personalized resource guides and an online resource directory. For legal info, check with the Louisiana State Bar Association or your local legal advocacy center.