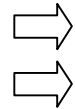


Transition Model

Pre-Transition

- Clinical Team and Transition Coordinator initiate developmentally appropriate Transition planning
- Provider initiates use of Transition Intake form
- Patient and family are provided educational materials about transition process
 - “Transitions: A Guide to Getting Older at Children’s Hospital”
 - “Transitions: Parent Tips”
 - “Information about Transitions for Youth with Chronic Illness and Disability”
- Patient increases knowledge of illness and responsibility for health care
 - “Managing My Own Health Care” checklist
 - Uses “Patient Wallet Card”
- Providers/Transition Coordinator work with patient to assess readiness to transition and health care skills
 - “Health Care Skills Checklist”
 - “Transition Role Plays”
- Transition Coordinator updates new members of the team on Transition issues
- Transition Coordinator meets periodically with the family, patient and care team to identify
 - Stressors and assets
 - Barriers and facilitators of transition
 - Family role



Transition Process

- Clinical Team/Transition Coordinator assess family/patient readiness for transition
- Patient and family are provided educational materials to enhance dialogue. Difference of adult/pediatric care system are discussed
 - “Transitioning: A Guide to Finding a Primary Health Care Provider”
- Tempo for completion of transition discussed by patient, family and team
- Adult health care providers identified and contacted
- Case management and psychosocial services provided
- Transition Coordinator provide support and assistance with appointments and accompanies patient to appointments as needed
- Transfer of pediatric medical records/summaries to new team
- Communication between providers, stepwise transition as appropriate
- Insurance issues clarified



Post Transition

- Success of patient focused transition stressed by new Team
- Family role clarified and social support emphasized
- Access to multidisciplinary services clarified
- Case management at new site initiated
- Providers at new site communicate with pediatric care team
- Transition Coordinator contacts patient and family for follow-up assessment after one year

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