

Physician



UPSTATE Spina Bifida Center
MEDICAL UNIVERSITY

0

Overview of Workshop

Part 1: Who we are
New York State Institute for Health Transition Training

Part 2: Curriculum
Lesson Plans
Videos and Moderator guide
Continuing Education Modules

Part 3: Tools
MY PLACE personal transition site
Resource directory
Guideline grid

Part 4: Next steps
Dissemination strategies, collaboration

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Part 1: The “Institute”



healthy
transitions
Moving from Pediatric to Adult Health Care

New York State Institute for Health Transition Training

Established in 2006 at SUNY Upstate Medical University by the New York State Developmental Disabilities Planning Council

Health Transition Curriculum and Toolkit
Youths (ages 14-25 years)
Families
Service coordinators
Health care providers

Our Focus is Developmental Disabilities
Skill building
Self determination
Collaboration


Website & Workshops

Funding:
New York State Developmental Disabilities Planning Council
New York State Department of Health
SUNY Upstate Medical University
Syracuse University
Gottiano Foundation
US Department of Health and Human Services HRSA AAU grant #2 054HP05462-04-00

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Mission

To promote self-determination, to optimize health and well-being, and to improve access to health care and the quality of health care that is delivered to young people with developmental disabilities in New York State.



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Activities

2006 Transition in context

- Literature review
- Benchmark transition programs (Fla, NC, Pa)
- Focus groups: Mapping transition

2007 Curriculum and tool development

- Burton Blatt Innovation Award for video vignettes
- DOH Youth Advisory Council collaboration
- Syracuse University Center for Digital Literacy

2008 Pilot testing, Endorsements

2009 Dissemination

- High schools: Rochester, Syracuse, Albany, NYC
- Parent to Parent Chapters
- Medicaid service coordinators
- Family practitioners: AHEC, AADM, AACPD, STM
- Self Advocates


2010 Best practices

- Virtual Spina Bifida Center

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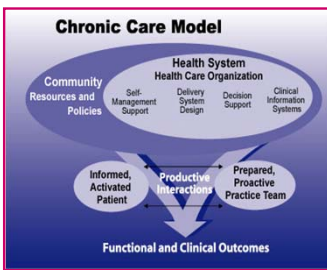
Improving Care

IOM: Crossing the Quality Chasm
 Trying harder in current system will not work
 Systems change is needed to deliver better care




6

Improving diabetes care

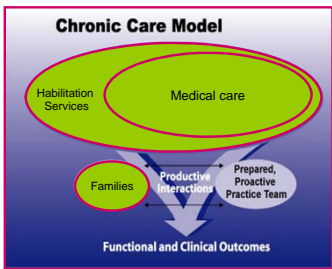


Ed Wagner [Improving Chronic Illness Care](http://www.improvingchroniccare.org/change/model/index.html) <http://www.improvingchroniccare.org/change/model/index.html>



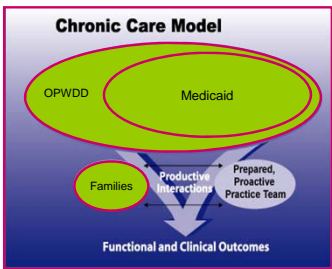
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Improving DD care



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Improving DD care



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Prevalence

Intellectual disability	30/1000
ID Requiring pervasive support	3/1000
Autism	5.2-7.6/1000
Cerebral palsy	1.2-2.8/1000
Spina Bifida	0.6/1000

Prevalence among US adults aged 18-20 years:

Developmental Disabilities	30.8/1000
Diabetes	29/1000

- Lee, 2001;
- National Diabetes Statistics, 2007


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Activities

- 2006 Transition in context**
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- 2010 Best practices**
 - Virtual Spina Bifida Center

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Family Medicine




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Activities

- 2006 Transition in context**
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 - Focus groups: *Mapping transition*
- 2007 Curriculum and tool development**
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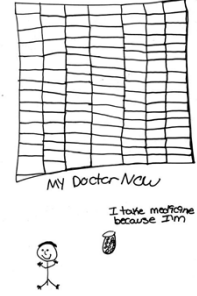
Youths



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David, 20, works at Enable. His developmental diagnosis is Autism.


Youths



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Sarah, 19, lives independently in her own apartment and is looking for work in retail. Sarah's developmental diagnosis is intellectual disability.

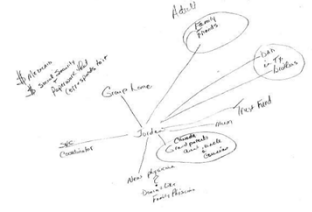
Physicians



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Family Practitioner Clinton, New York

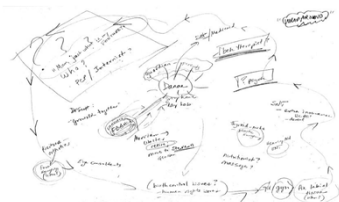
Parents



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Parent of 16-year old who has intellectual disability, Syracuse, NY

Parents



Parent of 22 year old daughter with dual diagnosis, Liverpool, NY

Focus groups

Parents were the only ones to include:

- Mental health
- Dental health
- Transportation
- Service coordination
- Pharmacy
- Insurance

Ideal system:

- Person centered
- Coordinated care
- “wrap around” services
- “Mom is key”



What we learned

Educate youth & educate physicians about systems of care for individuals with Developmental Disabilities

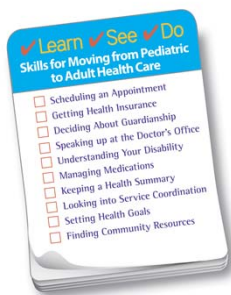
Explicitly recognize role of parents and others in the youth's Circle of Support who facilitate “wrap around” care.

Design a *shared curriculum and tools* for youths, families, service coordinators, and health care providers in order to promote collaboration

What we created



Curriculum and Toolkit




Service Coordinator




Continuing Education Modules

- For physicians, service coordinators, teachers & parents
- 10 Modules based on the skills checklist
- Content:
 - What parents and professionals can do to promote skill development**
- Format:
 - Success story
 - Information
 - Tips for collaboration
 - References and Resources
 - Quiz
- Coming soon: Free web-based education credits from SUNY Upstate Medical University





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Sample Continuing Education Module



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Introduction to Skill

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Success Story

Lisa



Lisa is a 37-year-old woman who graduated from high school with an Individualized Education Plan (IEP). She has a job in a retail store and is currently working on her high school diploma. She is also working on her college degree.

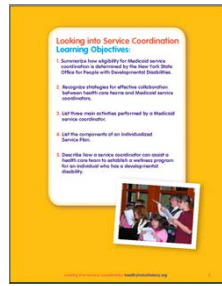
Lisa is interested in working with people and would like to become a social worker. She was able to find a job when she was in high school. She is currently working on her diploma for her school in preparation. She is interested in working and doing a job and would like to become a social worker. She has a job in a retail store and is currently working on her high school diploma.

The staff member of the school health unit is her coordinator. She has been working on her diploma for the last few years and she is currently working on her college degree.

Lisa is currently working on her diploma for her school in preparation. She is interested in working and doing a job and would like to become a social worker. She has a job in a retail store and is currently working on her high school diploma.


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Learning Objectives



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Information



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Tips for Collaboration

Planning

- Identify whether you need your health care team to collaborate with your other providers. If you need to, be sure to discuss this with your other providers. This will ensure that you are all on the same page and working together.
- Identify health care providers who are involved in your care. Add them to your collaboration team.

Family

- Identify someone in your family who can help you in your role. This will be someone who can help you with your role and who can help you with your role.
- Identify someone in your family who can help you in your role. This will be someone who can help you with your role and who can help you with your role.

Health Care

- Identify someone in your health care team who can help you in your role. This will be someone who can help you with your role and who can help you with your role.
- Identify someone in your health care team who can help you in your role. This will be someone who can help you with your role and who can help you with your role.

Support

- Identify someone in your support team who can help you in your role. This will be someone who can help you with your role and who can help you with your role.
- Identify someone in your support team who can help you in your role. This will be someone who can help you with your role and who can help you with your role.

Leading into Service Coordination | healthystarttransitions.org

References and Resources

County Work

County Work: A Guide for Health Care Providers. Available at: <http://www.healthystarttransitions.org/county-work>

Care Coordination: Helping Health and Human Services of Care for Children with Special Health Care Needs

Health Care Coordination: A Guide for Health Care Providers. Available at: <http://www.healthystarttransitions.org/care-coordination>

Quality Improvement

Quality Improvement: A Guide for Health Care Providers. Available at: <http://www.healthystarttransitions.org/quality-improvement>

Quiz

Quiz

1. Which of the following is NOT a goal of service coordination?

- Identify health care providers who are involved in your care.
- Identify someone in your family who can help you in your role.
- Identify someone in your health care team who can help you in your role.
- Identify someone in your support team who can help you in your role.

2. Which of the following is NOT a tip for collaboration?

- Identify whether you need your health care team to collaborate with your other providers.
- Identify health care providers who are involved in your care.
- Identify someone in your family who can help you in your role.
- Identify someone in your health care team who can help you in your role.

3. Which of the following is NOT a tip for collaboration?

- Identify whether you need your health care team to collaborate with your other providers.
- Identify health care providers who are involved in your care.
- Identify someone in your family who can help you in your role.
- Identify someone in your health care team who can help you in your role.

4. Which of the following is NOT a tip for collaboration?

- Identify whether you need your health care team to collaborate with your other providers.
- Identify health care providers who are involved in your care.
- Identify someone in your family who can help you in your role.
- Identify someone in your health care team who can help you in your role.

Leading into Service Coordination | healthystarttransitions.org

Part 3: Tools

healthy transitions
Moving from Pediatric to Adult Health Care

Circle of Support

A grid of nine photos of people. The photo of a woman in the top right corner is circled in pink.

MY PLACE Transition Site


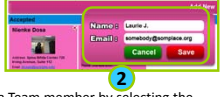

healthy transitions
Moving from Pediatric to Adult Health Care

My Place Darcy Smith

Forms, Goals, Calendar, My Place Handbook, My Place Hand-book, Profile, My Place Handbook, Logout.

Team

The Team tool is a space where you can assemble a team of people to help with transition planning. Team members are able to view and update health forms, keep track of appointments on a shared calendar, set goals, and share information in a private area for team discussions.


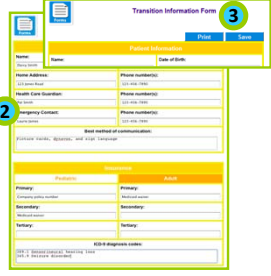
1. Click the **Add New** button.
2. Enter the team member's name and email address.
3. The person is added to the team on your MY PLACE site.

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Forms

1. In the Forms area you can create and store interactive documents. These forms can be updated by anyone on the team by clicking on the edit icon.

2. The **Transition Information Form** is a personal health summary.






1. Click the **edit** icon.
2. The **Transition Information Form** is a personal health summary.
3. Click on the **Save** icon to archive the form. Click on the **Print** icon to make a hard copy.

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Goals

1. The **Goals** tool is an area where you can create and track progress on goals. Click the **Add** icon to create individualized action plans for your goals.

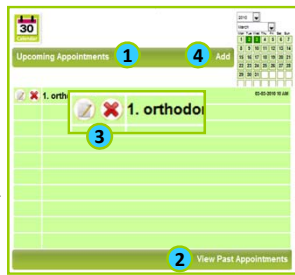



1. Click the **Add** icon.
2. Enter your goal and list the steps you will take to achieve your goal on the yellow table.

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Calendar

1. **MY PLACE** includes a Calendar where team members can track appointments and events. The Calendar opens with a list of all **Upcoming Appointments**.

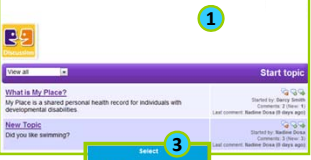


1. **Upcoming Appointments**
2. **View Past Appointments**
3. Appointment information from either list can be viewed and edited by clicking on the **edit** icon. Appointments can be deleted by clicking on the **delete** icon.
4. Click on **Add** to create a new appointment. A text box appears.

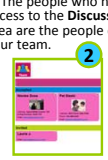
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Discussion

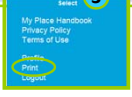
1. The **Discussion Area** is a space for sharing information and talking about ideas.



2. The people who have access to the **Discussion** area are the people on your team.



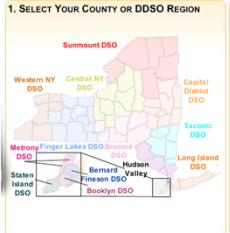
3. The team discussions are automatically saved and can be printed from the blue navigation bar on the left side of the screen.



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Resource directory


1. SELECT YOUR COUNTY OR DDSO REGION



2. SELECT SERVICE(S)

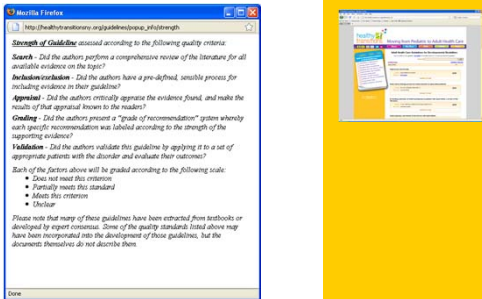
- Advocacy
- Assistive Technology
- Benefits Counseling
- Counseling
- Day Habilitation
- Education/Training
- Employment
- Family Care Program
- Future Planning/Guardianship
- Hearing and Vision
- Home & Environmental Modifications
- United Financial Support
- Recreation/Leisure
- Residential Habilitation
- Residential/Respite Services
- Respite
- Service Coordination
- Therapy/PT/OT/ST
- Transportation
- Vocational Assessment

3. VIEW LIST OF AGENCIES AND SERVICES IN YOUR AREA



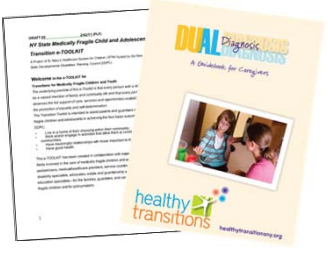
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Guideline Grid



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Transition Topics



Dual Diagnosis
Medically Fragile

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Part 4: Next Steps



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Dissemination

Youths: High Schools
Educator Workshops
Rochester, Syracuse, Albany, New York City
Regional Special Education Technical Assistance Centers
(RSE- TASC) - Resource Directory
Self Advocates

Parents: Parent to Parent of New York State:
Transition workshops
Newsletter
Listserve

Service Coordinators: Office for People with Disabilities
Medicaid Service Coordinator Trainings in Rochester and Syracuse

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Dissemination: Family Practitioners

Free web-based continuing education credits
Center for Excellence in Primary Care
Department of Family Medicine, SUNY Upstate Medical University

Academic detailing: rural primary care sites
•Area Health Education Center System (AHEC)
•American Academy of Developmental Medicine and Dentistry (AADMD)
•American Academy of Cerebral Palsy and Developmental Medicine (AACPDMD)
•Society of Teachers of Family Medicine (STFM)

Medical student and resident training programs
SUNY Upstate Medical University
New York Mid Atlantic Consortium
COGME

Virtual spina bifida center

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Recap of Workshop

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Parent



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1



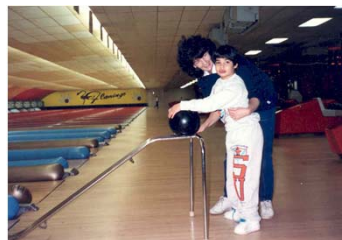
2



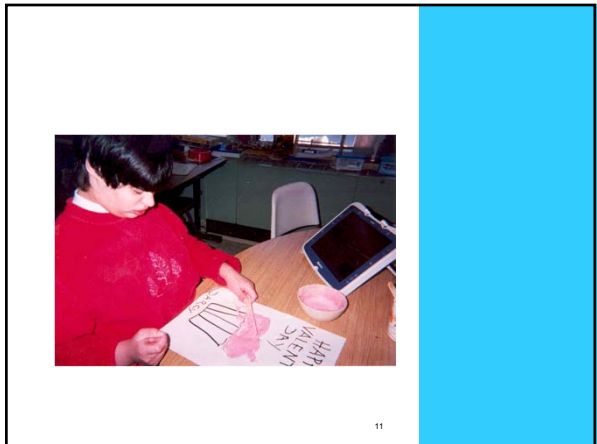
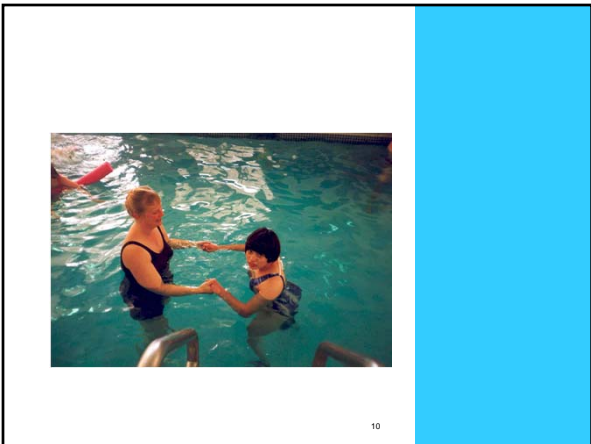
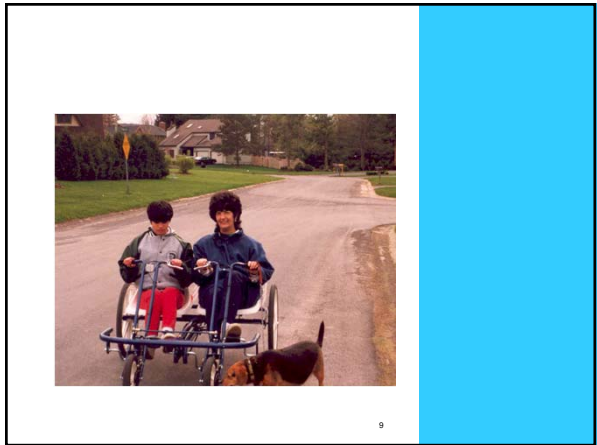
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Delta Omega Sorority honors three outstanding Rome seniors

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Transitioning



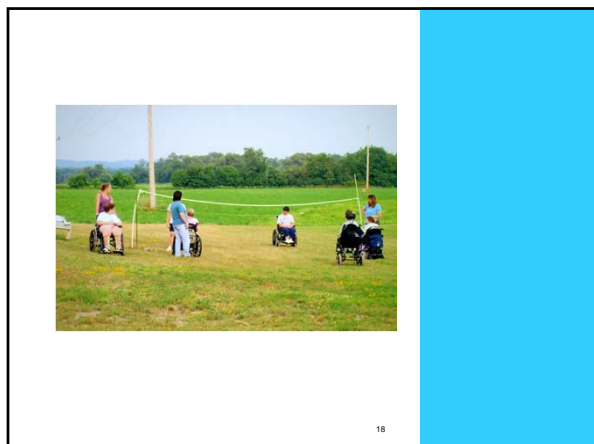
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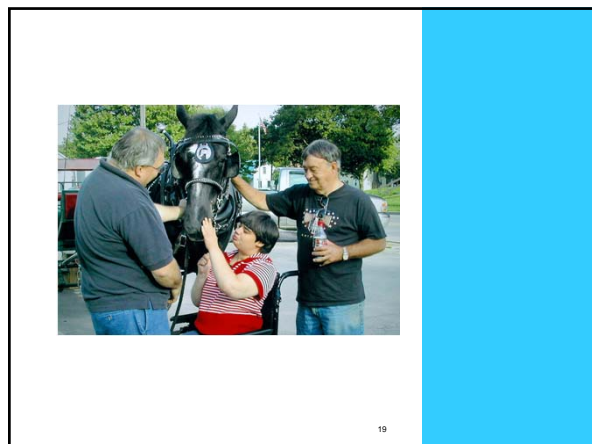
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19



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Circle of Support

A collage of nine small, square portrait photographs of various people, likely representing a support network or community members. The photos are arranged in a roughly circular pattern.

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Part 2: Curriculum

The logo for 'healthy transitions' features the words 'healthy' in blue and 'transitions' in orange, with a colorful graphic of dots and lines to the right. Below the logo is the tagline 'Moving from Pediatric to Adult Health Care'.

Healthy Transitions Curriculum

A graphic of a booklet titled 'Learn See Do Skills for Moving from Pediatric to Adult Health Care'. The cover lists several skills with checkboxes:

- Scheduling an Appointment
- Getting Health Insurance
- Deciding About Guardianship
- Speaking up at the Doctor's Office
- Understanding Your Disability
- Managing Medications
- Keeping a Health Summary
- Keeping into Service Coordination
- Looking into Health Goals
- Setting Health Goals
- Finding Community Resources

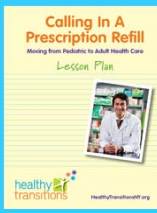
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Lesson Plans

- Developed by Pat Slaski, MEd, special educator & parent
- Designed for group settings with 5-15 young adults
- Offers a menu of activities for range of learning styles
- Can be used as a stand alone unit or as 6-part curriculum
- Focus is on interactions with **people**:

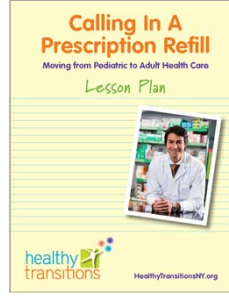
Scheduling an appointment
Scheduling transportation
Paperwork at the sign in desk
Speaking Up at the doctor's office
Calling in a prescription refill
Setting health goals

office secretary
taxi scheduler
receptionist
doctor or nurse
pharmacist
service coordinator




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Sample Lesson Plan




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Learning objectives




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Overview




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Assessment



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Video and discussion

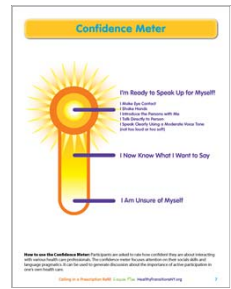


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Mind Map: Group Activity



Social skills/language pragmatics



Role play script

Role Play Example: Calling in a Prescription Refill

YOU: Hello pharmacist, my name is [Name]. I need a refill for my [Medication].

PHARMACIST: Yes, I have your record. How many refills do you need?

YOU: I need [Number] refills. Can you check that for me?

PHARMACIST: Yes, I can do that. How many refills do you need?

YOU: I need [Number] refills. Can you check that for me?

PHARMACIST: Yes, I can do that. How many refills do you need?

YOU: Thank you very much.

Props for Role Play



Rap

RAP

Looks like the prescription is getting low
 Need to call in a refill, that I know
 Get through to pharmacist, say all I need to tell
 When pharmacist asked me for my name
 Pick up questions for me to fully understand

I pick up or delivery, decide which one is best
 Get my prescription, get the medication I need
 I'm feeling great, I'm feeling good
 for me to stay healthy and feeling really great

Now I'm the Master
 Using my skills on a Rappert!

Chant

Chant

Remember a patient's name
 For you and your patient's name
 Choose your name
 Say your name to the pharmacist
 Say your name to the pharmacist
 My pharmacist says, "Hello!"
 My pharmacist says, "Hello!"
 My pharmacist says, "Hello!"

Group energizers

Group Energizers

- 1. Standing Ovation
- 2. Hand on Heart
- 3. Singing Ovation
- 4. Clap Clap
- 5. 2 Finger Clap - Open Apples
- 6. One Finger Clap - Rock On
- 7. High Five
- 8. High Five & Squiggle Shakes
- 9. Wave for Joy
- 10. Clap Hands
- 11. Round of Applause
- 12. Tap on the Chest
- 13. One Foot Tap
- 14. Shoulder Clap
- 15. Head of Approval
- 16. YES, YES, Y-E-E-E, Cheer
- 17. Backward - Squiggle Shakes
- 18. Tap, Thank You
- 19. Knock on - 2 Fingers - 1 Hand on Heart, Y-E-E, 2 Fingers
- 20. Touch, Knock
- 21. Round, Knock with Clapping

How to use this Group Energizer: In a room with 20 or more people, choose an energizer to lead and have everyone participate. You can also use these energizers for smaller groups. These energizers can be used in a variety of settings. They are most useful when used in a group setting. They are most useful when used in a group setting.

Copy and Distribute

KWL Chart

Topic	What I Know	What I Want to Know	What I Learned

How to use this KWL Chart: This tool has columns and rows and is designed to be used by students. The tool is designed to be used by students. The tool is designed to be used by students. The tool is designed to be used by students.

Copy and Distribute

How to Say Thank You: Calling in a Prescription Refill

You Will Need:

- 1. A blank card
- 2. A pen or pencil
- 3. A name of your friend

YOU _____

YOU _____

YOU _____

Make sure to say thank you!

How to use this Thank You Card: This card is designed to be used by students. The card is designed to be used by students. The card is designed to be used by students. The card is designed to be used by students.

Copy and Distribute

Prescription Label

How to use this Prescription Label: This label is designed to be used by students. The label is designed to be used by students. The label is designed to be used by students. The label is designed to be used by students.

Copy and Distribute

Mind Map - How You Try

How to use this Mind Map: This map is designed to be used by students. The map is designed to be used by students. The map is designed to be used by students. The map is designed to be used by students.

Certificate of Completion

CONGRATULATIONS!

Has Successfully Learned Skills for
Calling in a Prescription Refill

healthy transitions
Moving from Pediatric to Adult Health Care

How to use this Certificate of Completion: This certificate is designed to be used by students. The certificate is designed to be used by students. The certificate is designed to be used by students. The certificate is designed to be used by students.

Videos and Moderator Guide

- Rationale: Social Learning Theory
- 40 brief (2-3 minute) vignettes
- Actors are youths with developmental disabilities
- Questions for group discussion for each video
- Can be viewed individually or as 10-part curriculum



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Sample Video



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