Implementation Toolkit Resource Guidance

Indiana Center for Youth and Adults with Conditions of Childhood Supports: Transition Resources

Section I: Resource Overview

Summary
Indiana Center for Youth and Adults with Conditions of Childhood Supports (CYACC) is a statewide transition support center that provides a transition consult for youth ages 11-22 who have transition needs which extend beyond the available services in their current health care team. A multidisciplinary consult assessment is performed by nursing, social work and medicine professionals. The resources featured in this toolkit (brochure, medical summary, and transition plan) are informed by the 6 Core Element Approach, and provide examples of how 6 Core Element tools can be adapted and used in practice.

Resource Description

The **brochure** is a handout which includes introduction to the transition domains, the CYACC team, and the general CYACC transition processes. The brochure functions as Core Element 1 of the 6 Core Elements approach (developing a policy).

The **medical summary** is a form used to collect demographics, care team, diagnoses, treatment plans, and critical components of past medical history. The form was created to provide succinct and effective education for the youth himself or herself, as well as effective summarization for other potential users, including all health care providers. The medical summary functions within Core Element 5, focused on transfer of care.

The **transition plan** is a form completed by the transition team to identify, summarize and address key transition domains and planning. The transition plan aligns with Core Element 4, transition planning.

Purpose

The purpose of the brochure is to activate youth and families to consider the topics and potential needs which will be assessed at CYACC intake, as well as the format for the CYACC team process. The program brochure is shared with each youth and family prior to the intake visit.

The purpose of the medical summary is to create a succinct yet complete history and outline a current healthcare and services team for each youth. The transition plan encourages youth and families to describe their current state and identify actionable goals in each of the high-yielding transition domains where transitioning youth commonly have need.

A chart review and intake assessment inform the completion of a medical summary and transition plan which is shared with youth and their families so that they can prioritize key needs. The CYACC team then assists in achievement of identified goals based on how much help each youth and family unit may need.

Intended User

The users of these resources include youth, families, and referring providers, as well as any other individuals whom the youth or family want to inform about their transition process.

Intended Beneficiaries/Target Population

CYACC receives referrals for a complex population of youth ages 11-22 who typically have health care needs across an average of three of the following four categories of chronic health concerns: chronic medical conditions, physical disability, intellectual disability and serious mental illness.

Materials Required

Tools are hyperlinked above. These tools are regularly adapted by the CYACC team through a continuous quality improvement process. Through this process, the CYACC attempts to ensure that information provided to transitioning youth and caregivers is educational, succinct, and effective in ongoing care delivery, and activates and supports them in achieving actionable transition goals.

Section II: Using the Resource

How to Use this Resource

A transition brochure can be used by adapting the language to fit one's existing program.

A medical summary form can be used to import information from multiple sources. It is important to represent the person's conditions, the team member currently providing care for each condition, and the treatment plan for each condition.

A transition plan can be used to demonstrate the current state and current next step plan for each transition domain.

Internal Capacity (Staff Needed to Implement this Resource)

The CYACC transition team includes nursing, social work, and medical personnel. Typically, an intake visit is two hours in length. The CYACC team has acquired a complex skill set to meet transition needs and provide services for youth with complex health conditions.

Each nurse and social worker participates in two half-day clinic intake sessions per week for two to four patients. For the remainder of the workweek, they deliver follow up care, including completing the forms, disseminating forms and information to all relevant participants, and supporting youth and families in achieving identified goals.

The CYACC team is supported by funding from Indiana Title V, with matching funds as supports from the Indiana University School of Medicine Department of Pediatrics and the Marion County Eskenazi Health system.

Collaboration/Partners (External Partners who Help to Implement the Resource)

CYACC has an advisory board which helps with ongoing skill maintenance and development of transition skills. Included are the following key partners:

- Indiana Title V
- Indiana's Centers for Independent Living
- Indiana Vocational Rehabilitation
- Indiana Institute on Disability and Community (UCEDD)
- Indiana Disability Rights (PAS)
- Indiana Legal Services
- Indiana Bureau of Developmental Disability Services
- ARC of Indiana
- Down Syndrome Indiana
- Three Indiana family to family organizations – Family Voices Indiana, About Special Kids and Insource.
- Individual youth and family advocates

Lessons Learned

The brochure has helped activate youth and families to be prepared for their comprehensive intake visits. It includes topics which are not typical in healthcare settings and therefore pre-reflection by the participants helps them get more out of the visit.

Youth and families and care teams are all very appreciative of the medical summary and use it in a variety of ways, across health care organizations, schools, and with state agencies. CYACC developed satisfaction surveys, which often offer specific suggestions regarding how to modify the tools.

Youth and families and care teams are all very appreciative of the transition plan which CYACC uses as a communication tool for anyone engaged in supporting the family in achieving their goals.

Next Steps

CYACC will continue to modify the tools to meet the needs of the youth and young adult population in Indiana.