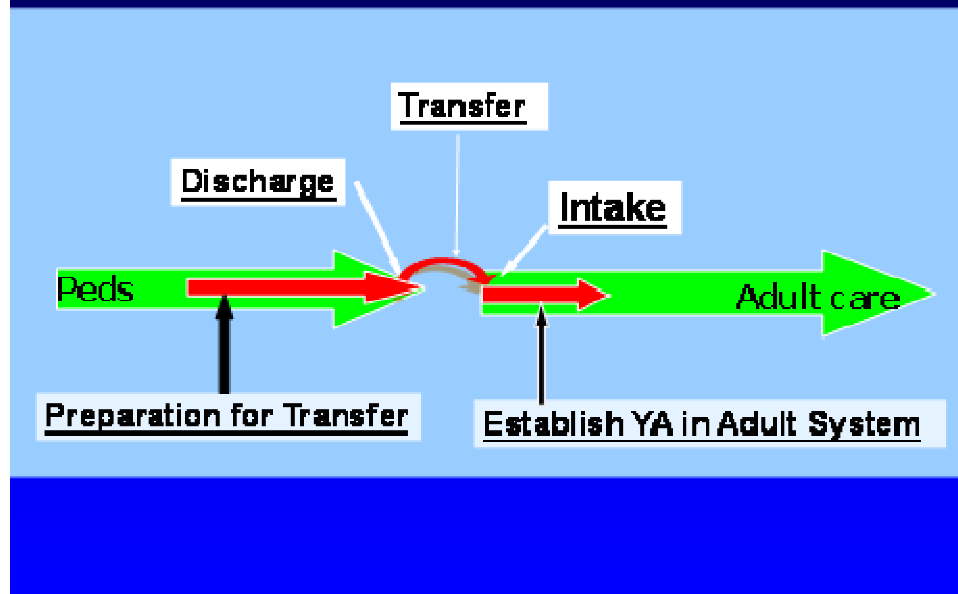
Transition Digest #2-10 (February 21, 2010)

In Digest #1 for 2010 (January, 2010) I included a brief discussion of the history of Health Care Transition (HCT) as an innovation in US health care, and observed that we are currently in the phase of innovation called “early majority” – the phase when a new practice becomes more broadly adopted – when it changes from an “unusual” to a “usual” practice – or “what it expected”. Another way of looking at this process of innovation and change is to use Gladwell’s idea of a “critical mass” or “tipping point” - the point at which the momentum for change becomes unstoppable… (see: http://en.wikipedia.org/wiki/The_Tipping_Point) – and expressed my hope that we are approaching the point where the momentum for the broad implementation of meaningful transition services and supports will be unstoppable.

I have some data to share that supports my observation (hope) that Health Care Transition is approach the tipping point.

In early January, I invested some time and effort in outreach, and shared information about the Transition Digest and the issue of HCT through several national and state health care professional organizations, including one for school health nurses. (My thanks to Gerri Harvey, a School Nurse in New Hampshire, who hosts an excellent school nurse web site -- http://snp.homestead.com/contents.html; and told me about the listserve for school nurses hosted by the National Association of School Nurses.) Over the last six weeks almost 300 individuals have asked to be added to the Digest distribution list, bring the total number of subscriber to about 2200 (internationally). Many of these new subscribers are school nurses and public health nurses; others are pediatric and adult oriented health care providers. It also appears that my invitation to subscribe to the Digest has been republished in newsletters and posted on other listserve. A warm welcome to those of you who have recently subscribed.

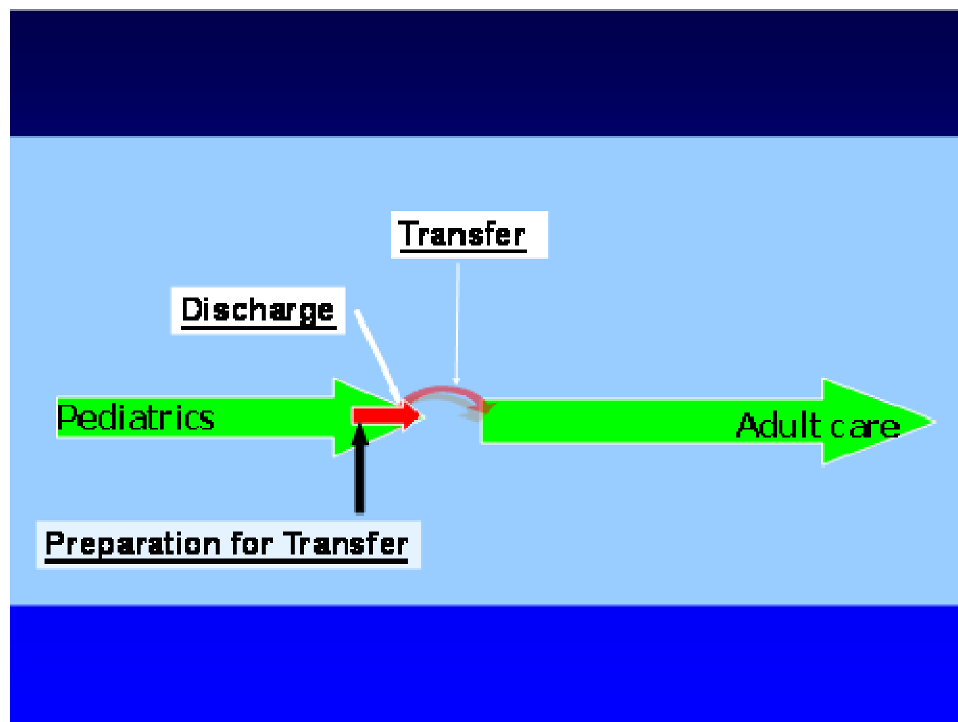
Because Digest subscribers include young adults with chronic health conditions and disabilities, parents, physicians, nurses, policy makers, teachers, therapists, psychologists and others, it is important that we use a common language when discussing the health care transition process. I offer the graphic, below, as an additional common point of reference. (AYA stands for Adolescents and Young Adults)



In this model, the process of health care transition includes activities that take place within Pediatrics that prepare the A/YA for the move to adult care AND includes activities that that take place after the transfer to adult care that help to establish the young adult in the adult health care system. The red arrow within Peds and Adult care represents the start-end-duration of transition-related services and supports.

Transfer is the move from Pediatrics to Adult care; and can also involve the transfer of medical records and other relevant information.

The graphic can be changed to depict the operational characteristics of a particular practice or clinic. The practice or clinic shown, below, does not provide transition related services and supports until shortly before the A/YA is discharged from the clinic/medical practice and does little to help connect the patient to the adult system. The adult system does nothing special to establish the new, young adult patient in the practice.



This simple graphic does not reflect the complexity of the real world health care system, where patients may receive care from several different specialty clinics and a primary care provider; and may transfer from a pediatric to an adult primary care provider while continuing to see pediatric specialists. This graphic also does not depict the role that school based nurses, classroom teachers, community-based programs, and families play in helping a young person acquire the knowledge and skills needed to successfully negotiate the adult health care system. It does, however, provide a common point of reference.

1A. A request for information

Do any physicians or Advance Practice Nurses provide transition services as a stand-alone counseling session? Services include teaching how to refill prescriptions, make appointments, present one's medical history to a new provider, or create a portable medical summary. If so, how do you document
and bill for these services?

From:
Parag Shah, MPH, MD; Medical Director, Children's Memorial Hospital Chronic Illness Transition Team

Moderators note:
Please send your responses to Parag Shah at pshah@childrensmemorial.org
Parag has promised to summarize the information he receives so I can include it in a future Digest.

1B. Summary of responses to request for information about residential transition training programs.

#1: Transitional living centre in Toronto called the GAGE run by WestPark Health Centre. They offer a transitional living program for young adults with disabilities in supported apartments. I believe the typical length of stay is less than a year.
Contact is Ginette Grewal, ginette.grewal@westpark.org.
Website for the GAGE is http://www.westpark.org/patientservices/gage.html

#2: In Georgia there is a residential program at Roosevelt Warm Springs Rehab Center www.rooseveltrehab.org . This is the same center where President Roosevelt went for Rehab. It is operated through the Georgia Department of Labor, Division of Rehabilitation Services.

#3: The Spina Bifida Association of Western Pennsylvania recently opened a transition program called Gatehouse. Information about it can be found at
http://www.sbawp.org/content.asp?sectionID=35605&SubSectionID=357584

#4: Ten Ten Sinclair here in Winnipeg, which is a transitional residential apartment building which has been operating successfully for many years now. The website has a lot of information on it.
http://www.tenten.mb.ca/

#5 Two wonderful programs in Massachusetts and one in New Hampshire.
In Lexington, Massachusetts there is the Cotting School Program, in Hanover, Mass is the New England Villages Program, and in NH, there is the Crotched Mountain Center.

#6 Courage Center has a Transitional Rehabilitation Program. (Used to be called the Courage Residence.) They focus on individuals with TBI and SCI but have also served individuals with other diagnoses.

http://staging.couragecenter.org/ContentPages/inpatientprogram.aspx

1C. Re: responses to the request for information about follow-up after patients are transferred to adult providers…

I have not completed pulling this information together. But, I would like to share the information that Catherine MacDonald provided about the maestro Project in Winnipeg, Manitoba

Maestro Project
I coordinate, a transition program called the Maestro Project in Winnipeg, Manitoba, Canada for young adults transitioning between pediatric and adult diabetes services and that is exactly what we do. We keep in phone, email contact with YA from 16-18 while in pediatric care and then when in adult care until age 25-30 (pt choice to continue after age 25), and provide support via social/educational activities. If you are not familiar with this project, I would be happy to discuss it with you further and you can also find a copy of our latest annual report with program

description and publication citations and evaluation findings on our website at www.maestroproject.com.

Currently, we have 847 young adults with type 1 diabetes and 265 young adults with type 2 diabetes between the ages of 16-30 that we follow. This serves the entire province of Manitoba, not just our city or local area. We use an administrative model and when our medical director, Dr. Heather Dean and I designed the program, the role was purposefully designed to be non-threatening to facilitate continuation of service and to provide navigation and support service delivery but not having the responsibility of providing care which would soon grow to be overwhelming for a health care provider in this role. I have attached our original job description for you for your interest, it was drafted in 2001 and as the role has remained filled, we haven't formally redrafted it since. The project has grown and shifted somewhat, but the bones remain the same. Our project was originally designed as a two-year demonstration project with 1 full-time project coordinator who provided service navigation for YA with type 1 and 1 half-time project assistant for YA with type 2.

At the time, it was completely driven by our pediatric endocrinology section with little but courtesy support from the adult section or regional funding bodies. Funding came from community foundation grants and we ran the project on about $75,000 CDN a year (now just under $100,000). An evaluation of the first two-years of the project was done showing a marked increase in number of medical and diabetes education visits and a decrease in the fall out rate of young adults the first year after transition from 25-11%. Since then, our local health authority has recognized the importance of this issue and last year 1 EFT position was designated permanent within our Department of Pediatrics.

Many of the initial "systems" challenges of transferring them have been addressed, the communication between our systems has improved (still much more work to do, but so much better!!) and services are slowly but steadily improving (we now have a specific evening young adult type 1 transition clinic). We are now currently re-evaluating the program to see whether the default rates continue to be decreased, whether we can impact more efficiently on prevention of recurrent DKA with more timely triage to education services after emergency events, and how to better meet the changing communication and social support needs of young adults.

I hope this is helpful. Please feel free to contact me anytime if you wish. My direct number is 204-789-3719.

Best wishes,

Catherine MacDonald
Maestro Project Coordinator

2. Training

Institute: Transitions across the continuum of care for people with complex health care challenges

DATE: June 2 & 3, 2010 *(immediately after the* Bloorview Transitions Conference 5 *)*

This two-day Institute is designed for health professionals who want to better manage the transitional care required between sectors for people with complex health care challenges. Participants will have the opportunity to learn from experts, including those working in successful interprofessional models of transitional care. Program topics and related tools will focus on:

- learning to handle shifting systems
- getting buy-in for initiatives to manage changes
- building successful transition models for patients needing complex care
- applying evolving best practices in transitions between health care sectors

More information can be found in the Preliminary Program
(http://bloomberg.nursing.utoronto.ca/Assets/CASPP/Transitions/UofT+TransitionsInstituteJune2010PreliminaryProgram1.pdf)

3. Conferences and Meetings

3A. Transitions 5 Conference

For information about the conference, which will be held on May 31 and June 1, 2010 in Toronto Canada, go to:
http://www.bloorview.ca/programsandservices/transfertoadultservices/transitionsconference.php

3B. Chronic Illness Initiative Symposium (DePaul University)

The 6th Annual Chronic Illness Initiative Symposium will be held on May 12, 2010 in Chicago, Illinois. Cost for this one day event is $25 – which includes lunch and a reception.

For more information, see:
http://www.snl.depaul.edu/WebMedia/StudentResources/CII_Symp_Flyer.pdf

Online registration is now open. Go to:
http://www.itd.depaul.edu/quickdata2/viewwebform.asp?id=5424

http://www.snl.depaul.edu/StudentResources/Chronic_Illness/index.asp#Symposium

NOTE: The CCI site has links to a number of resources that may of value to college age students with chronic medical conditions and disabilities. See:
http://www.snl.depaul.edu/StudentResources/Chronic_Illness/index.asp

4. Call for Papers

Special issue on Youth Health Care Transition
International Journal of Child and Adolescent Health 2010;3(4)

This is a call for papers dedicated to the subject of health care transition for youth and young adults that will be published in 2010. We welcome papers from a wide range of professional perspectives and clinical areas. The papers should address some aspect of the process of transition from child-centered health or habilitative systems to adult-centered health or habilitative systems. Articles are due April 1, 2010 and should be submitted to professor David Wood, MD, MPH, UF College of Medicine-

Jacksonville, Co-Director, Jacksonville Health and Transition Services (JaxHATS) (E-mail: david.wood@jax.ufl.edu) as email attachment (Rtx or doc file). The articles should comply with the requirements of the International Journal of Child and Adolescent Health (Uniform Guidelines for Biomedical Journals-Vancouver style) located in the following web-site:

http://jmerrick50.googlepages.com/IJCAH-Leaflet.pdf

David Wood, MD, MPH
Co-Director, Jacksonville Health and Transition Services (JaxHATS)
Jacksonville, FL 32209
E-mail: david.wood@jax.ufl.edu

5. Resources
NEW postings

5A. Starlight Children's Foundation

Starlight Children's Foundation has developed a number online interactive programs and games to educate seriously ill children, seriously ill teens and their family members about their medical conditions and help them cope with the social and emotional challenges that accompany illness. The programs and games encourage communication with healthcare providers and provide children with the opportunity to feel more empowered about their illness.

Each of Starlight's online programs was developed with input from children and families and guidance from leading medical professionals in order to help children:

- **Learn the purpose of medical procedures that might be invasive, painful, and/or scary**, and thereby **enable children to be less anxious and more cooperative with the treatment** team during the procedure.
- **Learn coping skills t**hey can use to tackle difficult social and emotional experiences associated with their condition or a medical procedure.
- **Experience more positive and optimistic feelings about their medical conditions** and procedures, including e**nhanced self-esteem, increased feelings of control, decreased anxiety**, and decreased feelings of being alone in their illness.
- Communicate more actively with family, friends, peers and the healthcare team about their medical condition and procedures.

There are two programs in particular that I believe you might be interested in.

IBDU: Graduating to Independence

Starlight Children's Foundation and the Children's Digestive Health & Nutrition Foundation (CDHNF) have launched *IBDU: Graduating to Independence*– a fairly new resource for young adults with Inflammatory Bowel Disease (IBD) who are preparing for college, vocational training, entrance into the workforce or living independently. The site provides answers for older teens and young adults to real life challenges and educational resources. The website includes a multitude of interactive features such

as group discussions in the community, polls, and coming soon will be video stories related to IBD and coping skills. Support for the IBDU website was provided by an unrestricted education grant from UCB, Inc. If you haven't had a chance to explore the site yet, we encourage you to do so today! You also might like to read the press release for more information.

Starbright World

Having a serious or life-threatening medical condition can make it even harder to cope with already-difficult realities of being a teenager. Supporting a brother or sister who has an illness can be daunting as well. With this in mind, Starlight Children's Foundation created *Starbright World,* an online social network exclusively for sick teens, 13-20, and their teenaged siblings. With help from a generous six-figure grant from signature sponsor Vivendi, Starlight unveiled the next generation of *Starbright World* in December of last year. The new-and-improved site leverages the latest in social networking technology to keep up with the ever-changing and more sophisticated expectations of today's teens. To learn more, visit www.starlight.org/starbrightworld for all of the details. Check out the multimedia news release page for the new Starbright World here, which includes a press release about the site's launch, an informative video, helpful links, and related documents that provide more information about *Starbright World*, its proven efficacy, and answers to FAQs for parents, hospitals and organizations.

To check out more of Starlight's programs—for illnesses like asthma, sickle cell, cancer, and more—visit www.starlight.org/programs.

Melanie Parga
Communications Assistant
Starlight Children's Foundation
323.556.3315 (p)
310.479.1235 (f)

5757 Wilshire Blvd., Suite M100
Los Angeles, CA 90036
www.starlight.org

Helping seriously ill children and their families cope with their pain, fear and isolation through entertainment, education and family activities.

5B. DVD on doing skin self-exam for individuals who have loss of sensation
Gillette Children's Hospital has developed a DVD for adults and another for children on how to examine skin for those at risk of developing wounds due to loss of sensation.   Follow up research by

Laura Gueron, PT, MS (Submitted for publication) shows that for patients with cognitive impairment the DVDs should not be considered a one-time, stand alone intervention for teaching. It is a nice augment to the spoken instruction or written word. Here's a link to the adult video on-line

http://www.gillettechildrens.org/default.cfm?PID=1.17.6.3

(contributed by Ronna Linroth)

5C. Reality Check

(**Editor's note:** While this e-bulletin does not focus directly on the topic of health care transition, it is a useful resource for leaders of community-based organizations who strive to work effectively with other stakeholders to bring about real change in the organization and delivery of transition and related services and supports for youth and young adults and their families).

Reality Check is a monthly e-bulletin that is dedicated to programs, organizations, and their leadership; promoting partnerships and leaders with capacity, intuition, and collaborative skills that can transform systems, change lives, and maximize resources. This month we discuss **The Partnership Factor: Building Partnerships between Systems, Programs, and the People**. Partnering on behalf of systems change, service delivery, and community development is no longer in its infancy. As efforts and "random acts of partnership" occur across the country we move forward with heightened confidence and recognition of how far we have really come in such a short timeframe. The January issue of Reality Check discusses the intentional factors that influence the outcomes of partnerships and challenges partners to continue building their capacity in the interest of common goals for the people they serve, represent, and love.

Please feel free to share the bulletin with others that may benefit from understanding and building their capacity to better serve or represent populations in need. You can also download the latest and previous Reality Check e-bulletins at: www.axisgroup1.net

Conni Wells – Author of Reality Check
(423) 768-0476
cjwells@axisgroup1.net
www.axisgroup1.net

5D. Moving on up

http://www.health.nsw.gov.au/gmct/transition/ezine.asp

Moving on up is created by the GMCT Transition Care team in New South Wales (Australia) for health professionals managing young people with chronic illness/disability. Moving on up aims to provide a forum for sharing of ideas about transition issues for young people with chronic illness/disability moving from paediatric to adult health care. We want to hear from anyone interested in transition.

Also see the section of the New South Wales Department of Health web site that focuses on health care transition:

http://www.health.nsw.gov.au/gmct/transition/index.asp

Reposting

5E. Youth Leadership Toolkit

The Becoming Leaders for Tomorrow Project at Utah State University has developed a toolkit that is designed to increase understanding of the importance of the perspectives that youth and young adults bring and to provide information and tools that help to effectively include them in addressing the challenges of transitioning to adulthood and increased independence.

The toolkit consists of a guidebook and a DVD. The DVD includes nearly 2 hours of young adults sharing their hints and tips for other youth and young adults; parents; doctors; and other professionals. The guide book is for facilitators and provides some background and several discussion points and questions to use during training event..

More information about this project is available at:
http://blt.cpd.usu.edu/Leadership_Toolkit.html

The guidebook can be downloaded
http://blt.cpd.usu.edu/Youth_Leadership_Toolkit_Guide.pdf

Or you can request a copy of the guidebook and the DVD by contacting Al Romeo

Alfred N. Romeo, R.N., PhD.
Becoming Leaders for Tomorrow http://blt.cpd.usu.edu/
UT Dept. of Health, CSHCN
PO Box 144610 (44 Mario Capecchi Dr.)
Salt Lake City, UT 84114-4610
Office 801-584-8535
Fax 801-584-8488
alromeo@utah.gov

5F. Embedding Health Outcomes in the Individualized Education Program

"Embedding Health Outcomes in the Individualized Education Program" is a video recording of a 40 minute teleconference that provides information and specific examples of health related goals for an IEP. This recording is available, at no cost, from the Wisconsin Department of Public Instruction web site.

http://dpimedia.wi.gov/main/Viewer/?peid=f44dfa70439241dd85e99cce0cb70e26

5G. Health and the IEP

The Wisconsin Community on Transition Health Practice Group has developed health-related training materials that can be used with schools, health providers, families and directly with youth to help youth with disabilities learn to more effectively manage their health care concerns.

The health care training kit is available for $35, which includes shipping and handling.
All materials are available to download for free at
http://www.waisman.wisc.edu/wrc/pub.html

Order Form: **http://www.waisman.wisc.edu/wrc/pdf/cyshcn_orderform.pdf**

5H. Healthy and Ready to Work (HRTW) National Resource Center:
http://www.hrtw.org/

5I. National Center for Medical Home Implementation - Section on Transition
http://www.medicalhomeinfo.org/health/trans.html

5J. Good 2 Go Transition Program at the Hospital for Sick Children (Toronto, Canada)
http://www.sickkids.ca/good2go/

5K. Transition @ RCH (Royal Children's Hospital, Melbourne, Australia)
http://www.rch.org.au/transition/index.cfm?doc_id=8143

5L. Young People's Health Special Interest Group (UK) – Section on Transition
http://sites.google.com/site/yphsig/transition

6. New HCT-related articles

6A. G. Sawicki et al. Measuring the Transition Readiness of Youth with Special Healthcare Needs: Validation of the TRAQ—Transition Readiness Assessment Questionnaire. Journal of Pediatric Psychology (in press)
Advance Access published on December 29, 2009

All correspondence concerning this article should be addressed to Gregory Sawicki, MD, MPH, Division of Respiratory Diseases, Children's Hospital Boston, E-mail: gregory.sawicki@childrens.harvard.edu

Objective The aim of this study was to develop the Transition Readiness Assessment Questionnaire (TRAQ), a measure of readiness for transition from pediatric to adult healthcare for youth with special health care needs (YSHCN). Methods We administered TRAQ to 192 YSHCN aged 16–26 years in three primary diagnostic categories, conducted factor analysis, and assessed differences in TRAQ scores by age, gender, race, and primary diagnosis type. Results Factor analysis identified two TRAQ domains with high internal consistency: Skills for Self-Management and Skills for Self-Advocacy. Each domain had high internal consistency. In multivariate regression models, older age and a primary diagnosis of an activity limiting physical condition were associated with higher scores in Self-Management, and female gender and a primary diagnosis of an activity limiting physical condition were associated with higher scores in Self-Advocacy. Conclusions Our initial validation study suggests the TRAQ is a useful tool to assess transition readiness in YSHCN and to guide educational interventions by providers to support transition.

6B P Rapley and PM Davidson Enough of the problem: a review of time for health care transition solutions for young adults with a chronic illness
Journal of Clinical Nursing. Volume 19: Issue 3-4, Pages 313 - 323
Published Online: 12 Jan 2010
ABSTRACT
Aims and objectives. In this article, we critically assess the state of the science of transition care in chronic conditions using diabetes care as an exemplar and provide a case for the adoption of the

principles of the Chronic Care Model in driving health care reform. Background. Globally, there is an increasing burden of chronic conditions including among adolescents and young adults. As a consequence adolescents are transitioning, at an increasing rate, from paediatric services into mainstream adult services, which are often ill equipped to meet their needs. Design. Integrative literature review. Methods. An integrative literature review method was used to summarize key issues facing adolescents with chronic illness and generate strategies for improving health care services. Conclusion. Strengthening the capacity for transitioning from a service that is family focused to one with an individual orientation requires a paradigmatic shift and clear identification of roles and responsibilities in the health care system. The absence of empirically developed models of care, in a context of growing need, signals the importance of ongoing discussion, debate and research.
Implications for clinical practice. There is a need for a change in philosophical orientation to promote service provision on the basis of need, rather than a model based on diagnosis and chronology. Nurses and other health professionals need to increase their awareness of issues facing adolescents with chronic conditions making the transition to adult health services.

6C. S. Jain. Building a Medical Home for Patients with Disabilities: Our Blueprint by Sweety Jain, MD in
Keystone Physician Fall/Winter/2009 (the online journal of the Pennsylvania Academy of Family Physicians magazine
Available online. Go to:
http://www.nxtbook.com/nxtbooks/pafp/keystonephysician_2009fallwinter_v2/#/20

7. Comments from Digest subscribers

7A The following was a recent article in our newsletter. It is becoming a major issue here in Texas.

TRANSITION TO ADULTHOOD ACCOMPANIED BY LOST BENEFITS, MEDICAL CRISIS
There are different kinds of transitions: Transition from early childhood to school; transition from school to work; and transition from work to retirement. However, there is one “transition” that traumatically changes people’s lives for the worse and that is “medical transition”, the transfer from children’s healthcare to adult healthcare when children may lose many of the health care and nursing services they currently receive.

In an article by Emily Ramshaw in the Texas Tribune (12/8/09), she described “a team of doctors and social workers at Houston’s Baylor College of Medicine who are pioneering ‘transition medicine’, a field designed to help severely disabled juveniles make the leap into adulthood”. She quotes Dr. Tamiko Kido, one of Baylor Clinic’s transition medicine specialists as saying “This transition – it’s a rude awakening for a lot of families & patients. It’s not logical to them, nor to us. We help bridge that gap”. As the child transitions to adult Medicaid, many of the supports and services covered by Medicaid simply are no longer covered and the families are forced to either forgo necessary treatment or pay out of pocket. Some lose in-home nursing care while others lose dental care. Some actually must consider institutional care and are faced with placing their child outside the home to receive the supports and services they require. Ramshaw reports that “That’s not the only bad news families face as their disabled children age. Once young adult patients age out of pediatrics, finding adult primary care doctors is incredibly difficult. These doctors are already in short supply in Texas. Getting them to

accept patients with complex conditions … is tough enough. Finding primary care doctors with any kind of expertise in congenital heart defects, cystic fibrosis, or rare genetic disorders is next to impossible." While some lucky families have pediatricians who continue to see their adult child for some years into adulthood, most are not so lucky.

The Arc is a growing voice of advocacy in Texas to promote transition medical doctors in additional areas of the state, but the process of change will be long and hard. Add your voice to the effort by calling for medical schools, state agencies, and the legislature to look for solutions to this tragic problem. Planners must consider two separate challenges. The first is the basic healthcare for juveniles transitioning into adulthood. The second (and in many ways the more complicated challenge) is to consider the complex and poorly understood needs of people with intellectual and developmental disabilities who may or may not also have medical issues.
This piece quotes from an article by Emily Ramshaw, Aging Out The Texas Tribune, 12/8/9
http://www.texastribune.org/stories/2009/dec/08/aging-out/ *Other sources*
http://www.bcm.edu/medpeds/transitional.html
http://www.rcpe.ac.uk/clinical-standards/guidance/transition-medicine.php

Richard Garnett, PhD, Executive Director, The Arc of Greater Tarrant County
Fort Worth, Texas 76107
817/877-1474 Richard.Garnett@arcgtc.org www.arcgtc.org

(Editor's note: I believe that there is an ongoing need to make families aware of the challenges that they may face when their child reaches adulthood; and to inform the general public about the issue of health care transition.)

7B. I'm wondering why the field of ephebiatrics, aka adolescent medicine, isn't more prominent in the health care transition discussion, specifically as the bridge between child and adult medicine. There are pitifully few doctors who specialize in ephebiatrics, but perhaps the reason for that should be part of the discussion, too.
On a historical note, some innovators appeared well before the 1988-1989 period. My father, Dr. Frederick C. Biehusen, was the first Army physician to start an adolescent clinic. It began around 1961 at Letterman General Hospital at the Presidio of San Francisco. The clinic provided a place for teens to learn to take responsibility for their health care, as well as a parent-free, baby-free location for confidential discussions of health, sexuality, sports injuries (another of my Dad's professional interests), and other topics. I don't know how the legal issues were dealt with, but I do remember that the clinic was held on a Saturday morning in my Dad's office with my mother, an RN, as his nurse--and there was no shortage of patients. (I was too young to attend the clinic myself, but I remember it vividly since it gave my siblings and me a parent-free Saturday morning!)
Mary Podmostko
maryp@gwmail.gwu.edu
Project 10: Transition Education Network

8. Final Words
Please send me items that you would like to have included in a future issue of the Transition Digest.

Please feel free to forward the Digest to others, and let them know that they can be added to the Digest distribution list by sending me an e-mail.

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If you want to be removed from the Transition Digest distribution list, send a request to be removed to jgr@ichp.ufl.edu .

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About the "Transition Digest". This free e-mail monthly newsletter typically includes information about emerging trends in health care transition of adolescents and young adults with chronic medical conditions and disabilities, promising health care transition practices, lessons learned, materials for youth and parents, new transition related articles (from a broad range of journals), websites, meetings, and questions from subscribers. It does NOT address medical management, but rather focuses on issues like improving systems of care, promoting teen's autonomy and medical decision making skills, assessing transition readiness and facilitating the transfer between pediatric and adult providers.

If you are interested in receiving the Digest (at no cost) send a request by e-mail to jgr@ichp.ufl.edu .

Past issues of the Transition Digest (from 2010, 2009 and 2008) are available, as PDFs at http://hctransitions.ichp.ufl.edu/listserv.html

Health care materials developed by the Institute for Child Health Policy can be seen at: http://hctransitions.ichp.ufl.edu/hct-promo/