A Collaborative Interdisciplinary, Interagency Approach to Transition from Adolescence to Adulthood

October 30, 2013

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ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES
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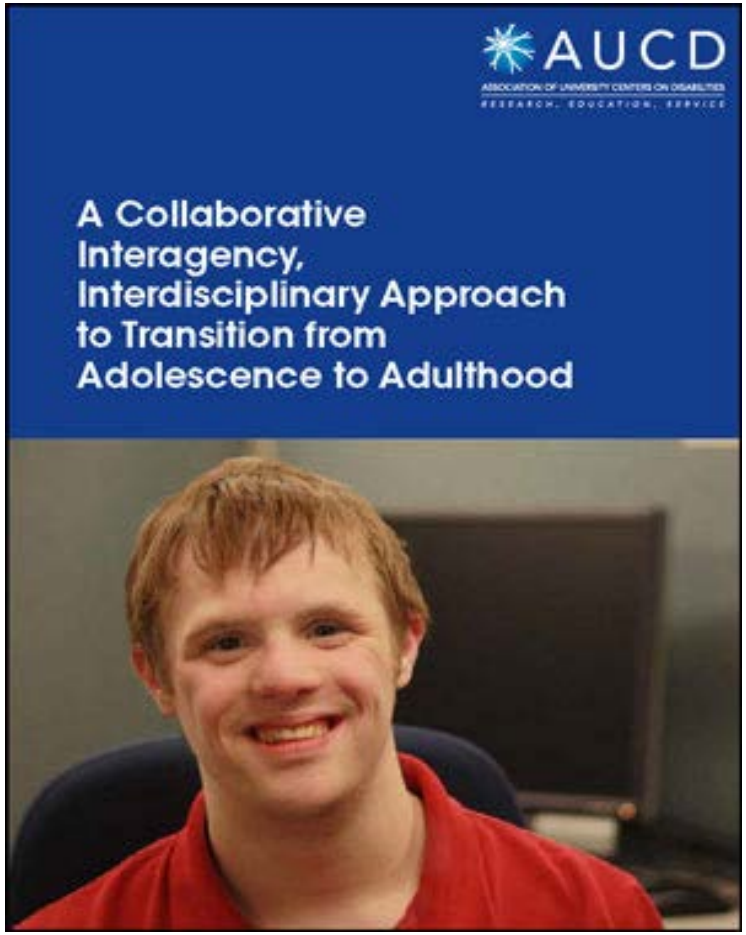
UCEDD Resource Center
A project of AUCD, in partnership with AIDD, to strengthen and support the network of UCEDDs

Webinar Overview

- Introductions
- Presentation
- Q & A after presentation
  - You can ask a question by pressing the * then # key to request the floor. Questions will be answered in the order they are received.
  - You can also submit any questions throughout the webinar via the ‘Chat’ box below the slides.
  - The moderator will read the questions after the presentations.
- Survey
  - Please complete our short survey to give us feedback for the next webinar!

Panelists

- **Tony Antosh**, Ed.D.; Director,
  Sherlock Center, Rhode Island College
- **Tawara Goode**, Ph.D.; Associate Director,
  Georgetown University
- **Ilka Riddle**, Ph.D; Director,
  University of Cincinnati UCEDD
- **Olivia Raynor**, Ph.D.; Director.
  Tarjan Center, UCLA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A Collaborative Interagency, Interdisciplinary Approach to Transition from Adolescence to Adulthood

Agenda

1. Introduction (*Antosh)*
2. Self Determination (*Antosh)*
3. Perspectives on Transition
   - Individual & Family Perspective (*Antosh)*
   - Healthcare Perspective (*Riddle)*
   - Employment and Post Secondary Education Perspective (*Raynor)*
   - Community Living Perspective (*Antosh)*
4. Transition Through a Cultural Lens (*Goode)*
5. Interagency Collaboration (*Raynor)*
6. Resources (*Antosh)*
7. Discussion and Questions

Genesis of the Monograph

- **Office of Special Education and Rehabilitation Services** (Education), **Administration on Community Living** (HHS) and other federal agencies are promoting a more comprehensive integrated approach to transition. Those agencies have reviewed this monograph.
- **AUCD Board of Directors** identified transition as a critical issue and decided to use the breadth and depth of the network to create a national focus on that issue.
- **Interdisciplinary Practice** is one of the foundation concepts of the AUCD network. Applying the concepts of interdisciplinary, interagency collaboration to transition is an extension of that concept.

The Issue

Youth with IDD should be able to expect **self-determined transitions** with **coordinated support** from family, community, professionals, and agencies.

But they and their families often experience very **little coordination and collaboration** from the myriad of systems involved in the transition process

Why

Failure to support self-determination as the central element of the person-centered process of transition

Why

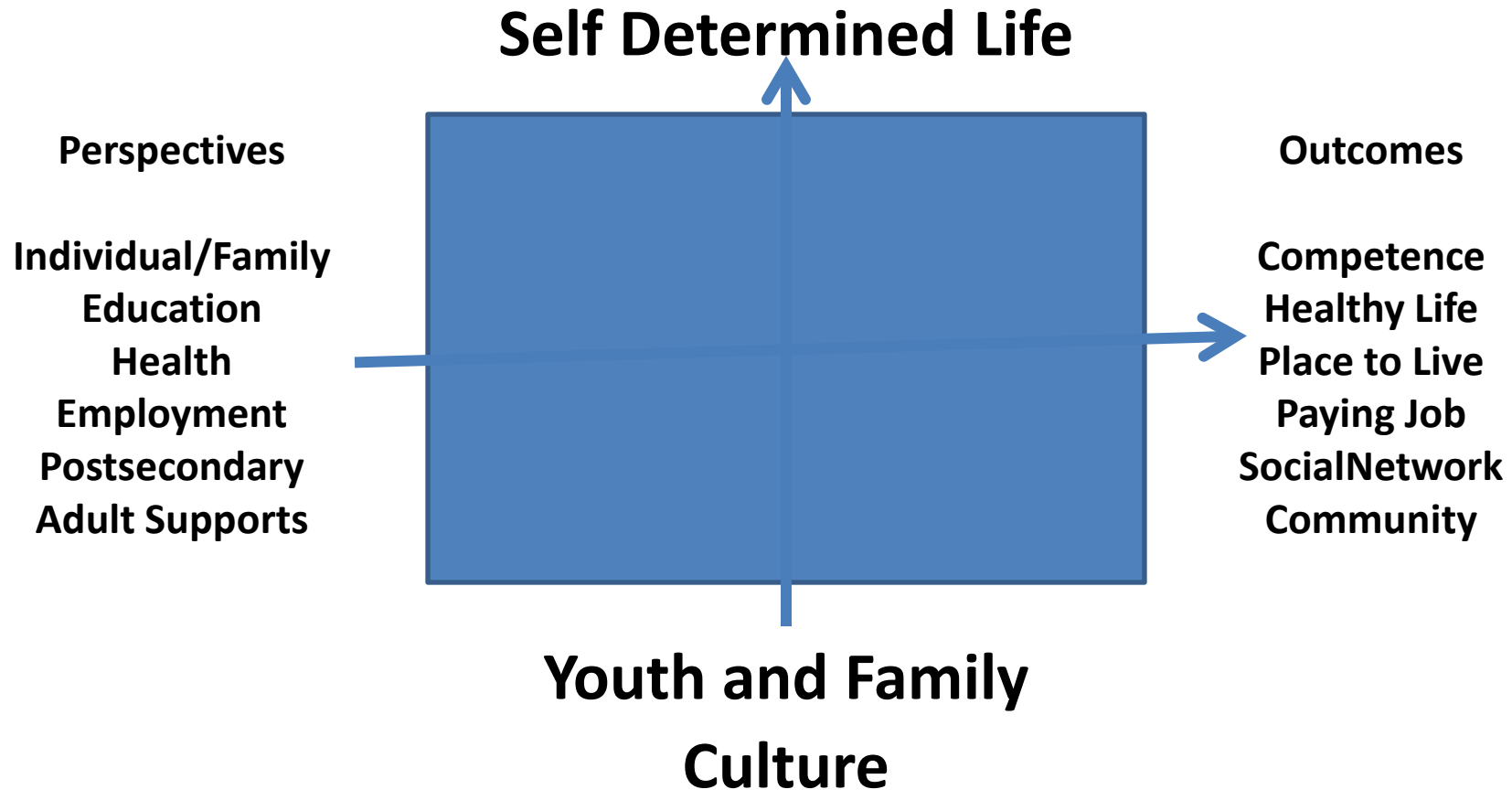
Insufficient understanding of the role of culture in an individual or family's concept or approach to transition

Why

The tendency for professionals within each realm of transition (education, health, community living, employment, and others) to function in silos and to use language that is not easily understood by other professionals, youth with IDD, families, or other community partners

Why

Neglect to specifically explore how transition in the different realms could/should be linked to maximizing success


Self Determined Life
Perspectives
Individual/Family
Education
Health
Employment
Postsecondary
Adult Supports
Outcomes
Competence
Healthy Life
Place to Live
Paying Job
SocialNetwork
Community
Youth and Family
Culture

Core Ideas

- Self-Determination as the foundation and ultimate outcome
- Integrate multiple perspectives
- Understand the role of culture in transition
- Promote an interdisciplinary, interagency approach to transition and develop strategies for linking disciplines and agencies
- Increased awareness of AUCD network resources

Self Determination

Self Determination

Being the Causal Agent

in all aspects of your own life.

Self Determination is linked to:

- **employment and independent living** (Martorell, Gutierrez-Rechacha, Pereda, & Ayuso-Mateos, 2008; Wehmeyer & Palmer, 2003; Wehmeyer & Schwartz, 1997);
- **recreation and leisure outcomes** (McGuire & McDonnell, 2008);
- **positive quality of life and life satisfaction** (Wehmeyer & Schwartz, 1998; Lachapelle et al., 2005; Nota, Ferrari, Soresi, & Wehmeyer, 2007; Shogren, Lopez, Wehmeyer, Little, & Pressgrove, 2006).
- self-determination status at the end of high school predicted significantly more positive employment, career goal, and community access outcomes, with students who were self-determined scoring significantly higher in all of these areas **one and two years after school** (Shogren, Wehmeyer, Palmer, Rifenbark, & Little; 2012) .

Self Determination can be taught

- There are numerous curricular and instructional models identified to enable teachers to provide an instructional focus on self-determination (Wehmeyer & Field, 2007).
- There is evidence of the efficacy of instruction to promote component elements of self-determined behavior, including interventions to promote self-advocacy, goal setting and attainment, self-awareness, problem-solving skills, and decision-making skills (Algozzine, Browder, Karvonen, Test, and Wood; 2001).

Impact of Intellectual Capacity

(Wehmeyer & Garner, 2003)

This study examined the self-determination and autonomous functioning of 301 adults with intellectual or developmental disabilities and found that intellectual capacity was **not** a significant contributor to either self-determination or autonomous functioning for this group. Opportunities to make choices, however, contributed significantly and positively to greater self-determination and autonomy.

Conclusion

- Promoting self-determination of adolescents with disabilities is **best practice** in secondary education and transition services (Wehmeyer, Agran, Hughes, Martin, Mithaug, & Palmer, 2007)
- Self-determination is about providing increasingly complex opportunities for goal-setting, problem-solving and decision-making across **ALL** the dimensions of transition.

NGSD: NGSD Home - Windows Internet Explorer

http://www.aucd.org/ngsd/template/index.cfm

Google

Web Search | Upgrade Your Toolbar Now | Bookmarks | Settings | HP Games | Snapfish | Mail

Favorites | Suggested Sites | Web Slice Gallery | AUCD - Home (2) | AUCD - Home (3) | AUCD - Home (4) | AUCD - Home

NGSD: NGSD Home

Page | Safety | Tools

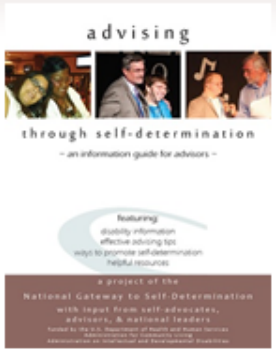
A National Gateway to Self-Determination

SEARCH Google™ Custom Search go

Home | Join Our Listserve | SharePoint Portal | Text A+ A- A

- NGSD Partners
- SD Videos
- Resource Guide
- Scaling-Up SD
- News and Events
- Publications
- SD Links

Self-advocates talk about self-determination.



Click to download

Welcome to the National Gateway to Self-Determination Web Portal, a clearinghouse on resources, training, and information on Self-Determination.

Gateway to SD
GatewaytoSD

http://www.aucd.org/ngsd

Internet | Protected Mode: On

95%

Association of University Centers on Disabilities

Perspectives on Transition

Youth and Family Perspective

Expectations

Youth with IDD have many of the same expectations for the future as do other adolescents.

(The National Longitudinal Transition Study)

"I would like to live with my aunt who has provided me with the care that no one else has been able to do. I plan to find a part-time paying job. I would like to spend the rest of my days going to the gym to keep up my health, doing recreational activities in the community and being part of my social community. I can only do these things if I have wheelchair transportation, a job coach and a nurse to meet my medical needs."

Quote from a letter from a youth with IDD to an agency administrator

"I expected assistance in planning ways that my daughter could function with support in various adult roles….I expected that the various entities that were involved with her support…would collaborate together to design supports that would help her reach her unique adult goals. I expected to have good, complete and understandable information….I expected that supports would be available in her own community in places of her choosing…. What I needed most was a guide."

Quote from a mother

"Families want information and planning processes that are clear, simple and individualized. Families and individuals want choice and control – their own voices primary in design of services – rather than decisions made arbitrarily by others….. want what any family wants for their young adult…. looking for the ways and means…."

Quote from a community supports navigator

The Need for Information

- More than **90%** of families reported needing information on **adult service systems** (including housing, employment, post-secondary education, and health)
- More than **70%** reporting needing information on **plannin**g for effective transition, **guardianship**, and creating a **positive vision** for their family member's future.
- **47%** of respondents in a survey of families/guardians of individuals with intellectual and developmental disabilities reported **receiving sufficient information** to plan services
- **53%** reported that the information they received was **easy to understand**.

Effective Youth and Family Practices

- Accurate, complete, understandable **information**
- **Person-centered** transition planning
- Family/Community Support **Navigators**
- **Self-Determination** Curriculum

Health Care Transition Perspective

Definition

- Health Care Transition is “the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health care systems.”

Blum et al.,1993

Purpose

- Maximize lifelong functioning and potential of the adolescent/young adult (AYA) by providing high quality, developmentally appropriate and uninterrupted health care services

AAP, AAFP, ACP, 2002

Health Care Transition Needs To Be

- Flexible
- Responsive to the needs of AYA and family
- Continuous
- Comprehensive
- Coordinated

AAP, AAFP, ACP, 2002

Health Care Transition Data

- 40.0 % of all youth 12-17 years with special health care needs receive the services necessary to make appropriate transition to health care, work, independence

National Survey of Children with
Special Health Care Needs, 2009/2010 Data

Guidelines & Best Practices

- American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and American College of Physicians (ACP) 2002 Consensus Statement
  - Six First Steps to Successful Transition
- AAP, AAFP and ACP 2011 Clinical Report
  - Health Care Transition Planning Algorithm
- Center for Medical Home Improvement
  - Six Core Elements of Health Care Transition

Potential Health Care Transition Team Members

- AYA
- Family Member(s)/Caregiver(s)
- Pediatric Primary Care Provider & Staff
- Adult Primary Care Provider & Staff
- Pediatric Specialist(s) & Staff
- Adult Specialist(s) & Staff
- Others

Shared Management Model

Shift in responsibilities from family to young adult to the proper developmental limit.

Time and age increase

Provider	Parent/Family	Young Person
Major Responsibility	**Provides Care**	**Receives Care**
Support to parent/family & child/youth	**Manages**	**Participates**
Consultant	**Supervises**	**Manager**
Resource	**Consultant**	**Supervisor**

Gall C, Kingsnorth S, Healy H. Growing Up Ready. Shared Management Approach. *Physical and Occupational Therapy in Pediatrics*; 2006; 26; 47

Barriers to a Successful Health Care Transition Process

Barriers for AYA

- Little involvement/empowerment in transition process
- Little knowledge about condition, health status, health issues, health management
- Late start to transition planning

Barriers for Pediatric Providers

- Little time for transition care/coordination
- Lack of reimbursement for transition support
- Difficulty identifying adult primary care providers and specialists
- Little knowledge about available community resources

McManus, Fox, O'Connor, Chapman & MacKinnon, 2008

Barriers for Adult Providers

- Lack of training in congenital and childhood onset medical conditions
- Lack of training in working with patients who have disabilities
- Lack of communication from pediatric primary care providers and specialists
- Low/no reimbursement for comprehensive care/care coordination

Okumura et al., 2008
Peter, Forke, Ginsburg & Schwarz, 2009

Other System(s) Barriers

- Educational
  - No/little connection to educational system/information
- Vocational
  - No/little connection/understanding of vocational system

Strategies To Improve The Health Care Transition Process

Strategies for AYA

- Active participation in health care process/health management and transition preparation
- Utilizing transition resources and tools specific to AYA
- Early and active participation in finding adult primary care provider and specialists

Strategies for Family Member(s)/Caregiver(s)

- Early and active transition planning
- Encouraging/empowering AYA to participate
- Utilizing transition resources, tools and information specific to families
- Initiating identification of adult provides
- Asking for portable and accessible medical summary

Strategies for Pediatric Providers

- Establishing transition policies and processes
- Developing transition plan at age 12-14 years and annual updates
- Providing transition resources to families
- Initiating contact with adult providers
- Communicating with adult providers
- Providing medical summary
- Utilizing EMR

AAP, AAFP and ACP 2011

Strategies for Adult Providers

- Engaging in transition process as receiver of patient
- Learning from AYA and family member(s)/caregiver(s)
- Learning about congenital and childhood onset medical conditions
- Communicating with pediatric providers
- Utilizing EMR

How to Get to an Interagency, Interdisciplinary Approach to Transition?

Strategies for Systems

- Improved transition training/disability training through medical school curricula/residency programs
- Linkages between pediatric and adult health care systems
- Linkages between medical and educational/vocational systems
- Linkages between medical and DD service systems

Resources

- Got Transition Website
  - www.gottransition.org
- FloridaHATS
  - www.floridahats.org
- Illinois Transition Care Project
  - http://illinoisaap.org/projects/medical-home/transition/trainings-and-events/
- University of Florida Education Health Care Transition Certificate Program (online; tuition)
  - http://education.ufl.edu/education-healthcare-transition/

Relevant Publications

- Bhagat, S. & Richards, C. (2012). Transition's missing link: health care transition. *Policy Brief No 5*. National Collaborative on Workforce and Disability for Youth, Washington, D.C. From www.ncwd-youth.info

- White, P., McManus, M., McAllister, J. & Cooley, W. (2012). A primary care quality improvement approach to health care transition. *Pediatric Annals, 41*, 1-7.

Employment and Post Secondary Education Perspective

Reports, National Activities & Court Decisions Influencing Transition

- A Better Bottom Line (National Governor's Association)
- Office of Special Education Guidance Letter on Least Restrictive Environment (June 22, 2012)
- DOJ lawsuits (Oregon, Rhode Island) for segregation of services and subminimum wage
- Projects for National Significance Employment Systems Change Grants (Partnerships in Employment)
- Employment First
- Transition and Postsecondary Programs for Students with ID (TPSID), 27 model demonstration programs funded by the Office of Postsecondary Education, U.S. Department of Education. 2 & 4 year colleges and universities
- Promise Grants

Transition Requirements of IEP

- When child turns 16 (or younger) IEP must include:
  - **Appropriate measurable IEP goals**
  - **Transition Services**, including courses of study to reach goals
  - With consent of parents or child, **invite public representative of public agency**/agencies

Definition of Transition Services: A Coordinated Set of Activities

- **Results Oriented Process**

- **Facilitate movement school to post-school activities**, including postsecondary education, vocational education, integrated employment (including supported employment); continuing and adult education, adult services, independent living, or community participation;

- **Based on the individual child's needs**, taking into account the child's strengths, preferences, and interests; and

- Includes instruction, related services, community experiences, the **development of employment and other post-school adult living objectives**, and, if appropriate, acquisition of daily living skills and functional vocational evaluation.

[34 CFR 300.43 (a)] [20 U.S.C. 1401(34)]

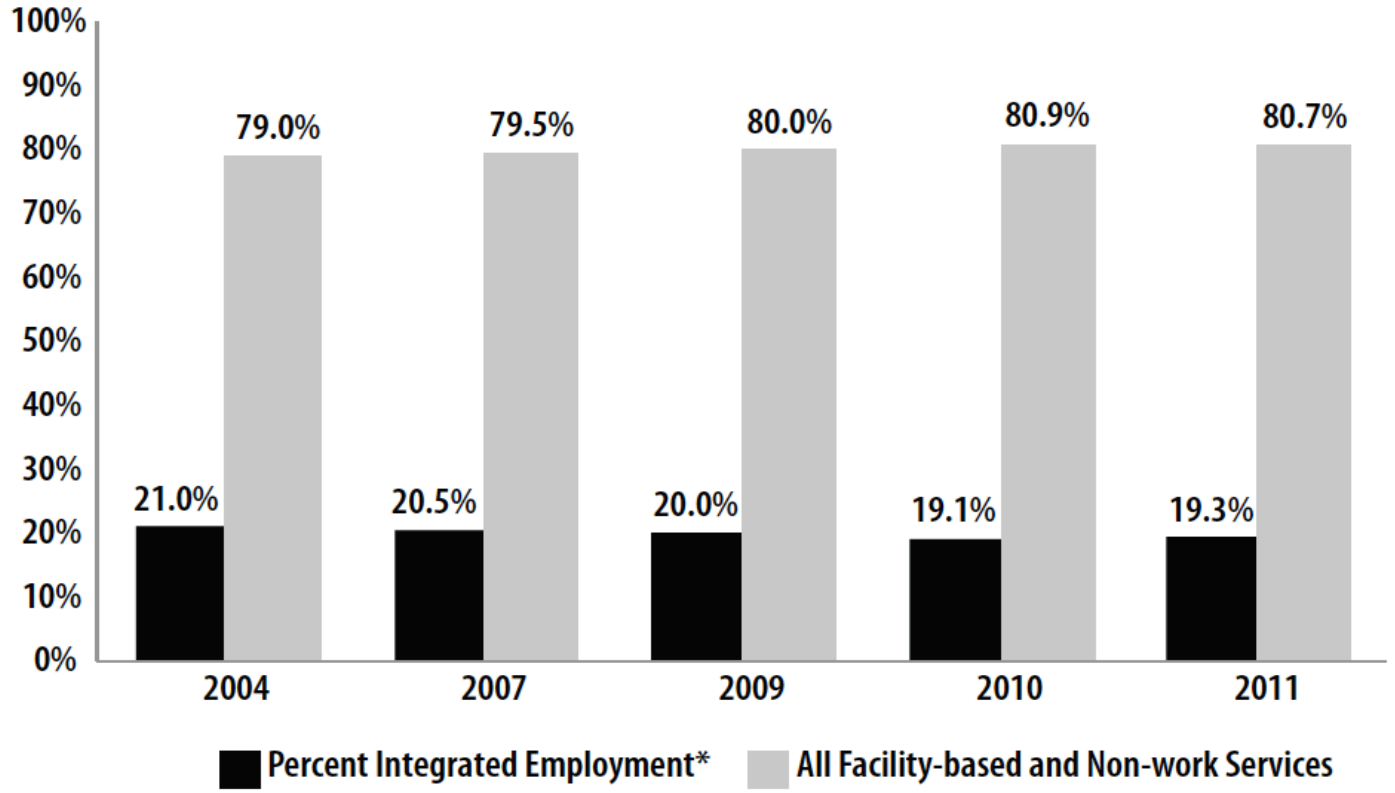
Employment and Postsecondary Education Participation for Youth with IDD

Findings from the National Longitudinal Transition Study-2

- At 1 year post high school
  - 17% of youth with IDD & 12% of youth with multiple disabilities were employed (Wagner et al., 2005)
- At 8 years post high school:
  - 38.8% of youth with IDD and 39.2% with multiple disabilities were employed. 28.7% of youth with IDD and 32.8% had enrolled in any type of PSE (Newman et al., 2011)

State Data: National Report on Employment Services and Outcomes

Figure 4. Estimated IDD Agency Service Distribution by Year



** Percents displayed represent estimates for the number of people served in integrated employment nationally (in all 50 states and Washington, DC).*

(Butterworth, J., Hall, A.C., Smith, F. A., Migliore, A., Winsor, J., Domin, D., & Sulewski, J., 2012)

Employment Barriers and Outcomes for Youth

- Poor system linkages between Education and Adult Services
- Transition specific services for youth within IDD agencies vary greatly from state to state (Butterworth et al., 2012)
- Increasing number of youths receiving Social Security Income Benefits and continuing on the benefits rolls

Employment Barriers and Outcomes for Youth

- Wide variation in employment outcomes amongst states from 5% (Alabama) to 65% (Washington & Oklahoma) are employed
- Overall low participation rate in employment
- 34 % live in poverty (ages 16-64)
- $195 mean weekly earnings with VR closure
- 23.7 hours mean weekly hours worked

(Butterworth, J., Hall, A.C., Smith, F. A., Migliore, A., Winsor, J., Domin, D., & Sulewski, J., 2012)

Occupations of Young Adults with IDD & Multiple Disabilities

- Food preparation and serving
- Building Grounds and Cleaning
- Production
- Office and Administrative Support

(Newman, L. et al., 2011)

What Practices Contribute to Successful Transition to Postsecondary Education & Employment?

Interdisciplinary Strategies to Improve Employment

Self Determination/Self Advocacy Training

High Expectations by Families, Educators, Providers

Interdisciplinary Approaches

Interdisciplinary Strategies to Improve Employment Outcomes (Cont.)

When Employment is a Core Element of the IEP

Work Experience/Paid Employment

Participation in Postsecondary Education

References

- Butterworth, J., Hall, A.C., Smith, F. A., Migliore, A., Winsor, J., Domin, D., & Sulewski, J. (2012). StateData: The national report on employment services and outcomes. Boston, MA: University of Massachusetts Boston, Institute for Community Inclusion.
- Hall, Allison Cohen; Butterworth, John; Gilmore, Dana Scott; and Metzel, Deborah, "Research to Practice: High-Performing States in Integrated Employment" (2003). *Research to Practice Series, Institute for Community Inclusion.* Paper 21.
- Wagner, M. Newman, L. Cameto, R. Garza, N., & Levine, P. (2005) *After high school: A first look at the post school experiences of youth with disabilities.* A report from the National Longitudinal Transition Study -2 (NLTS@). Menlo Park, CA: SRI International.
- Newman, L., Wagner, M., Knokey, A.-M., Marder, C., Nagle, K., Shaver, D., Wei, X., with Cameto, R., Contreras, E., Ferguson, K., Greene, S., and Schwarting, M. (2011). The Post-High School Outcomes of Young Adults With Disabilities up to 8 Years After High School. A Report From the National Longitudinal Transition Study-2 (NLTS2) (NCSER 2011-3005). Menlo Park, CA: SRI International.

Resources

Guideposts for Success http://www.ncwd-youth.info/guideposts

Think College www.thinkcollege.net

National Secondary Transition Center http://nsttac.org

What Works http://ies.ed.gov/ncee/wwc/

Community Living Perspective

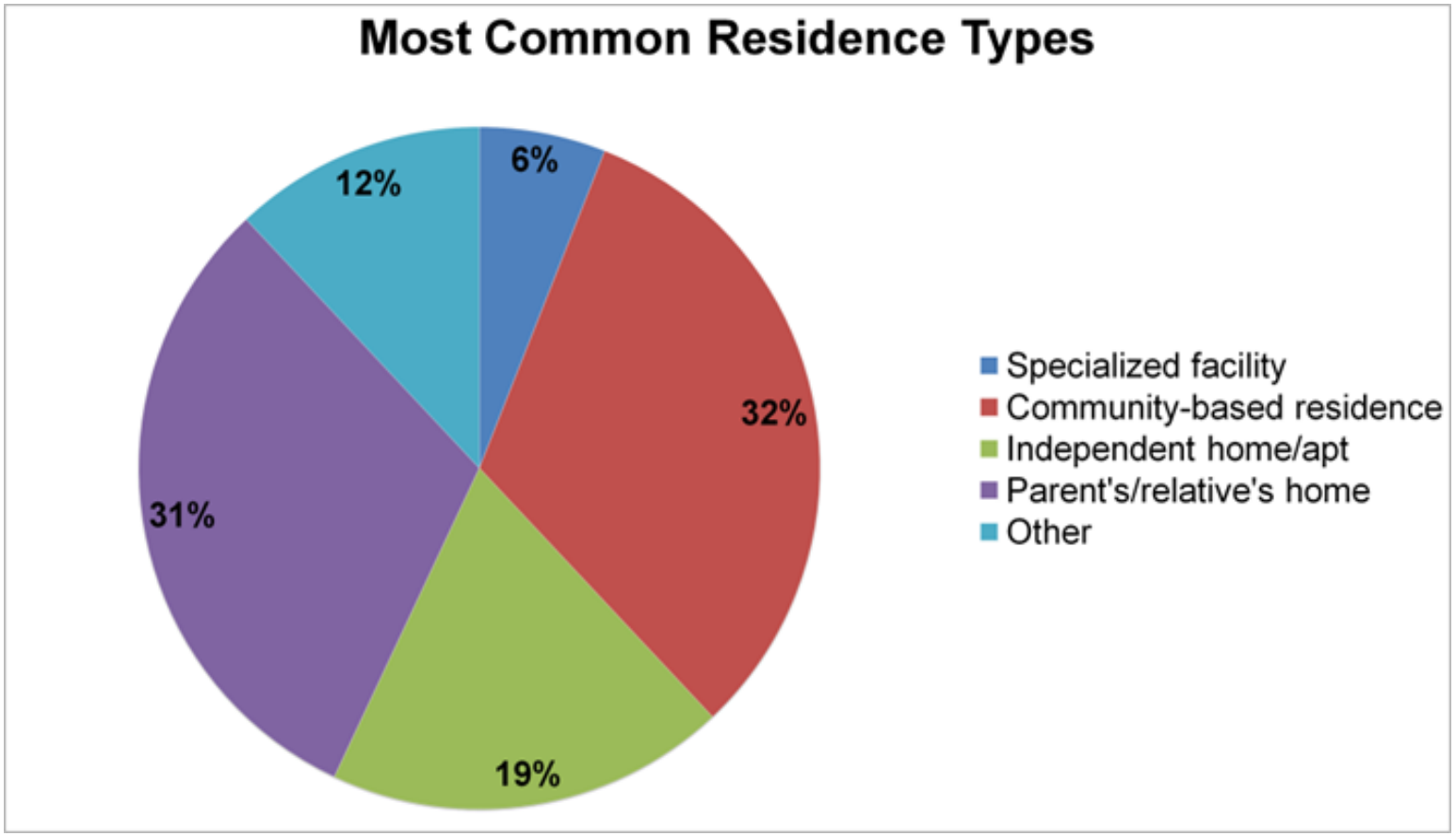
A Place to Live

- 599,152 (58%) people with ID/DD received publicly funded supports while living in the home of a family member
- 122,088 (12%) while living in homes of their own
- 40,967 (4%) while living in host family or foster care setting
- 276,460 (26%) people with ID/DD lived in congregate care settings
- 57% of those lived with six or fewer people.

Most of the growth in services in the last half century has been to support people living in their own or a family home.

Family and Individual Needs for Disability Supports

A Place to Live



A Place to Live

More than half of the family caregivers thought the ideal residential setting was somewhere other than these family homes

Family and Individual Needs for Disability Supports

Time in the Community

- 80-90% have participated in community activities in the past month
- 50% have exercised
- 50% participated in a religious service,
- 40% usually feel lonely
- 30% have ever gone to a self-advocacy meeting

NCI Consumer Report

Time with Others

How Time Was Spent During Three Days

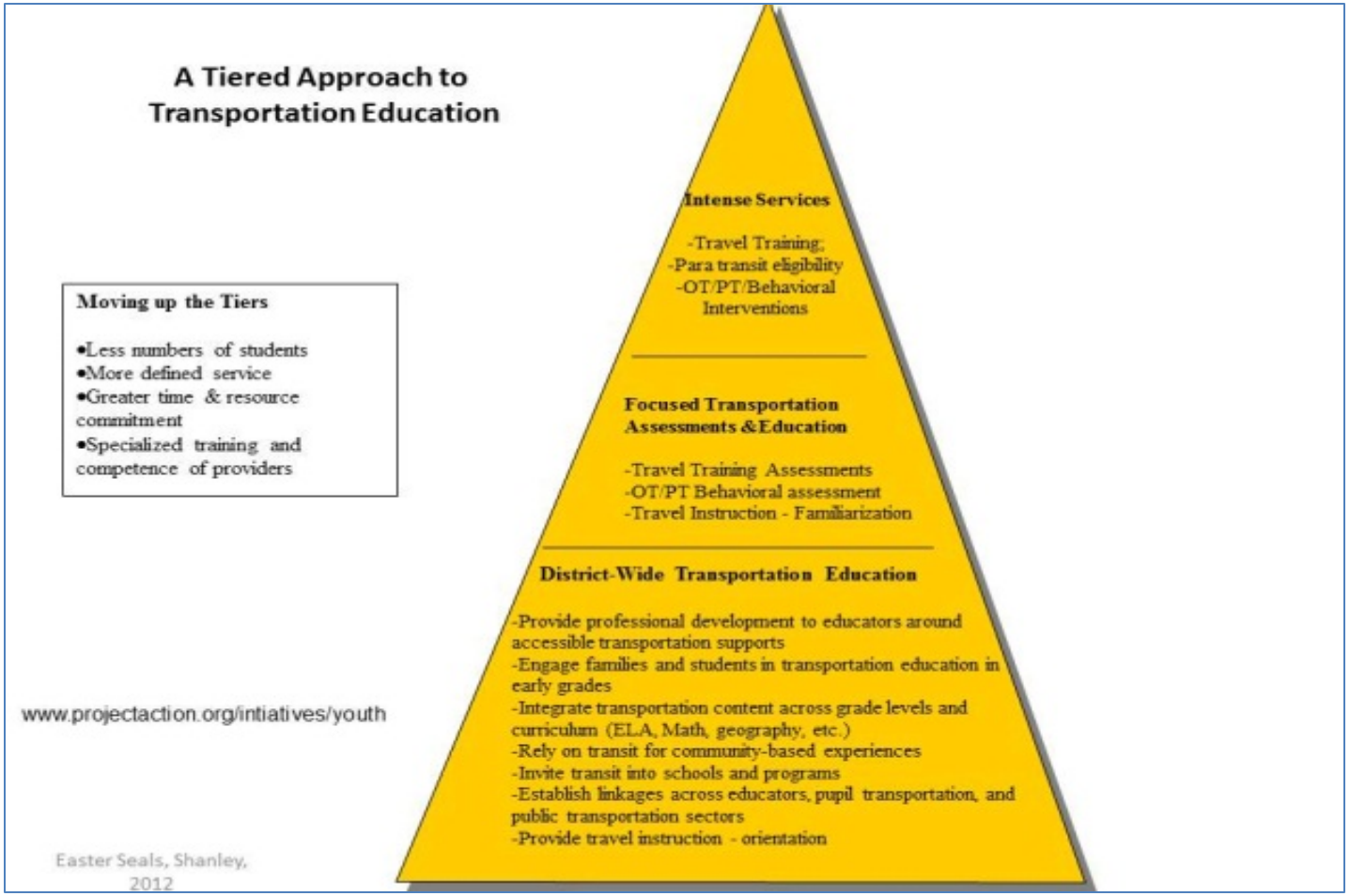
• Individual Only	**56.0%**
• Housemate	**21.2%**
• Agency Staff	**19.5%**
• Day/Workmate	**2.4%**
• Family Community Friend	**0.8%**
• Someone else	**0.1%**
• Community Acquaintance	**0.1%**

Initiating Activities

Who Initiated Activities During Three Days

• Individual	**71.6%**
• Agency Staff	**27.4%**
• Family Community Friend	**0.4%**
• Housemate	**0.4%**
• Someone else	**0.1%**
• Day/Workmate	**0.1%**

Getting There

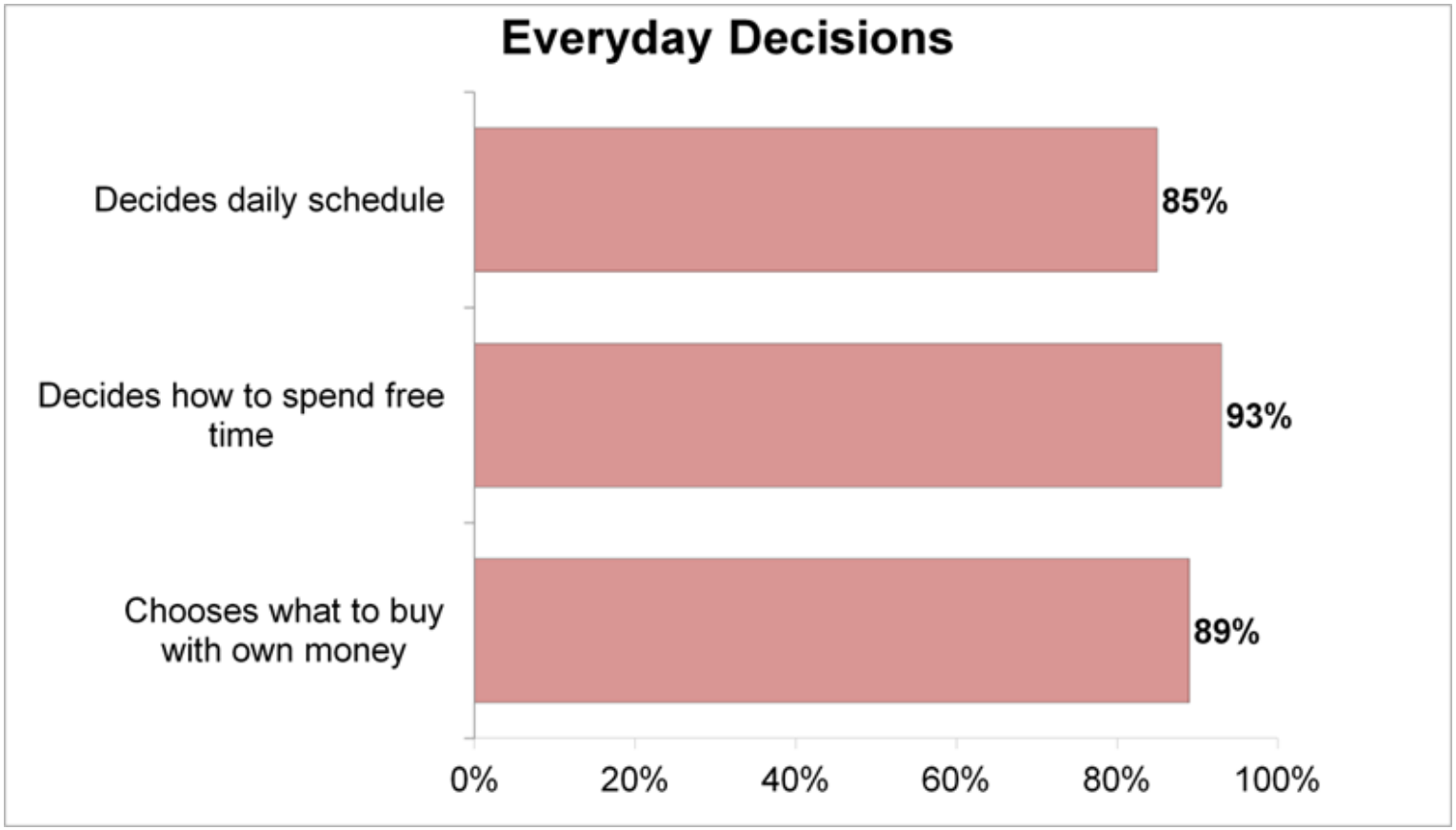


Transportation Resources

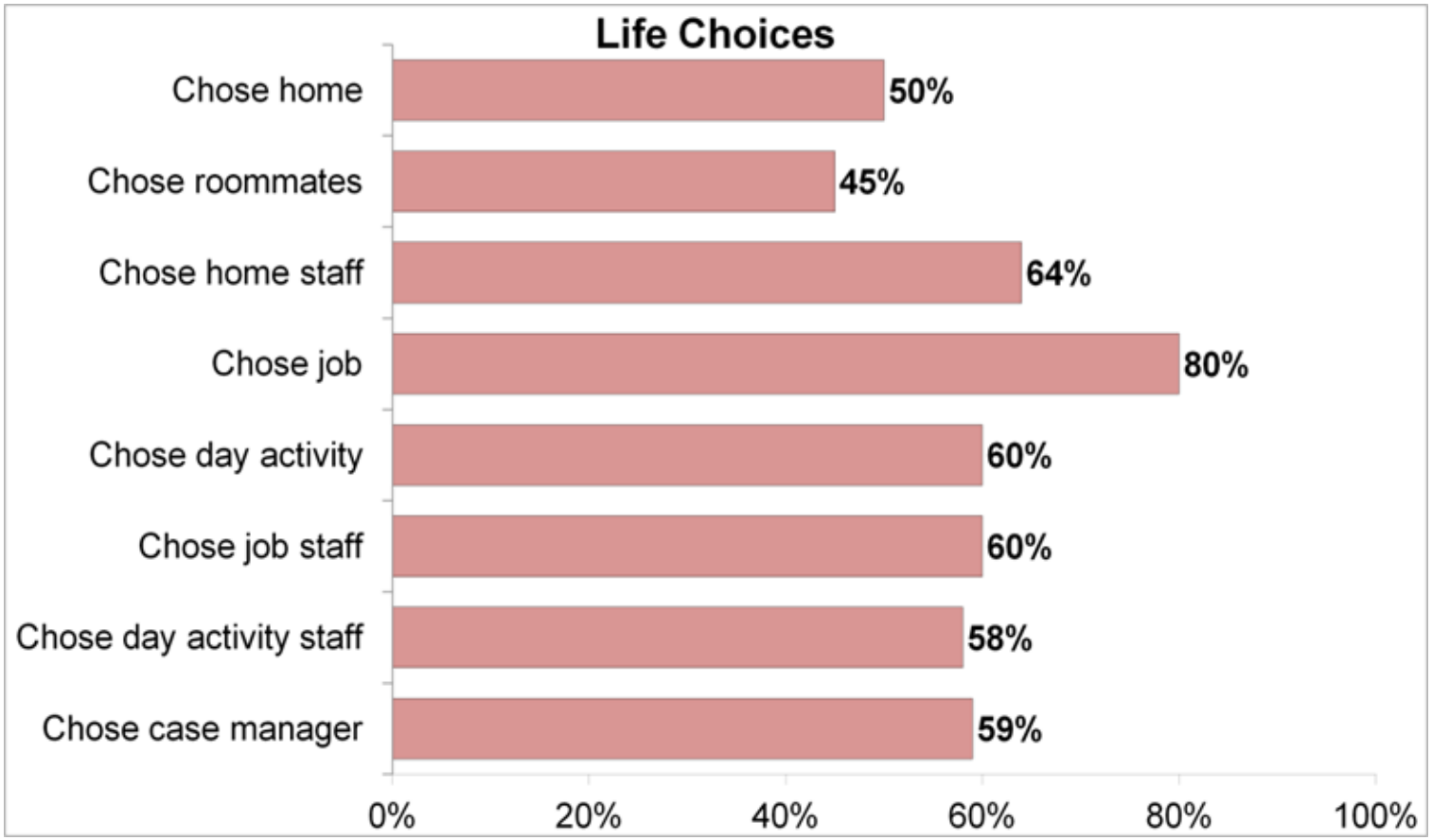
http://www.projectaction.org/Initiatives/YouthTransportation.aspx

- Mobility Options in Your Community. A resource mapping tool to help you analyze the accessible transportation resources in your community
- Building a Transportation Education Continuum. An activity to assist educators to build transportation education activities across multiple tiers.
- Building Awareness in Accessible Transportation: Transit Assessment Guide for Students, Families and Educators. A tool for students, families, and educators who would like to increase their understanding of transit systems and how people with disabilities use public transportation.

Making Decisions



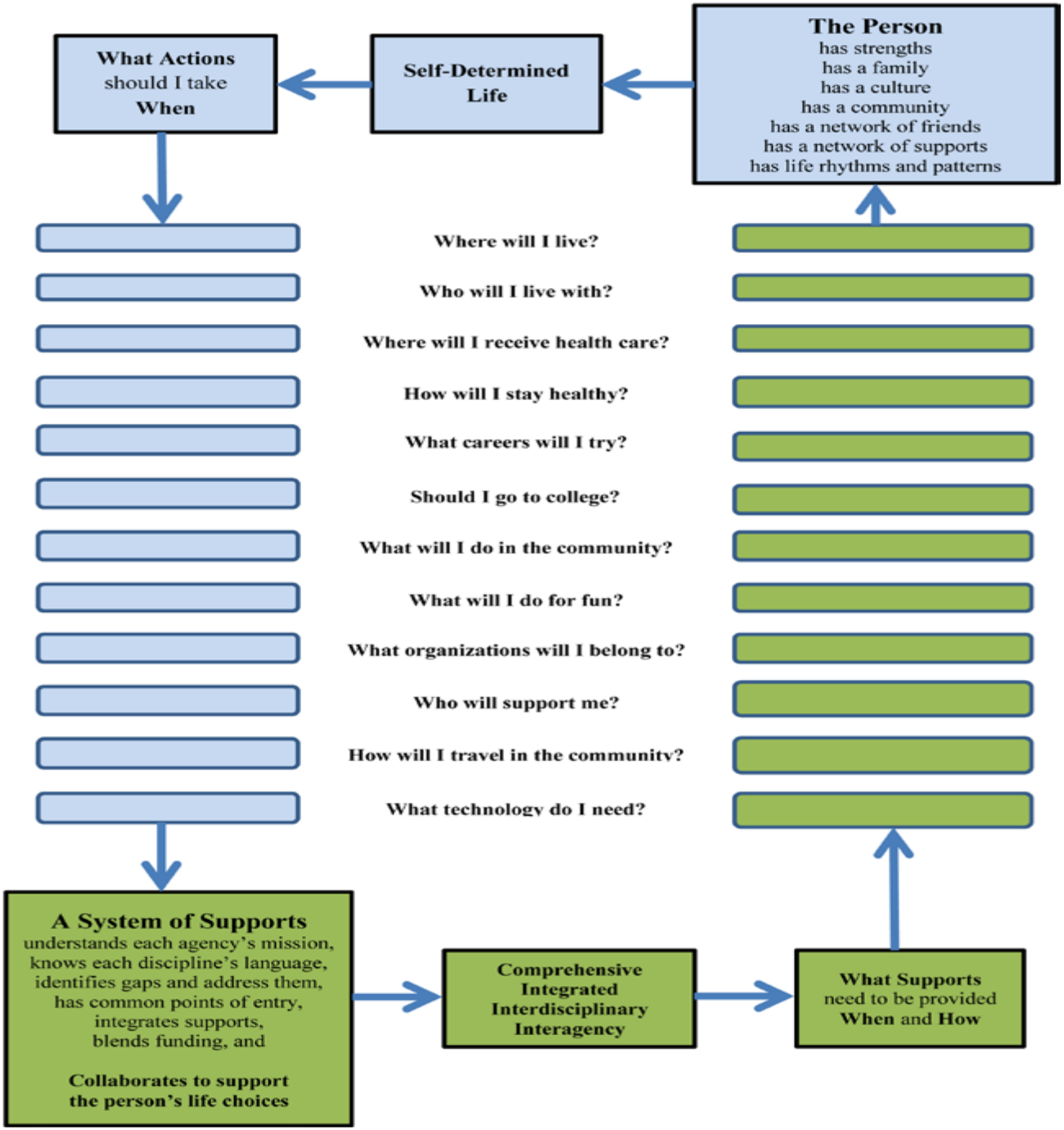
Making Decisions



Summary

Comprehensive Transition Planning should include:

- Where to Live
- Making Decisions
- Community Activity
- Leisure and Recreation
- Building a Social Network
- How to Get There


The Person
has strengths
has a family
has a culture
has a community
has a network of friends
has a network of supports
has life rhythms and patterns
Self-Determined Life
What Actions should I take When
Where will I live?
Who will I live with?
Where will I receive health care?
How will I stay healthy?
What careers will I try?
Should I go to college?
What will I do in the community?
What will I do for fun?
What organizations will I belong to?
Who will support me?
How will I travel in the community?
What technology do I need?
A System of Supports
understands each agency's mission,
knows each discipline's language,
identifies gaps and address them,
has common points of entry,
integrates supports,
blends funding, and
Collaborates to support the person's life choices
Comprehensive
Integrated
Interdisciplinary
Interagency
What Supports need to be provided When and How

Transition Through A Cultural Lense

TRANSITION THROUGH A CULTURAL LENS

Tawara D. Goode
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Associate Director, Georgetown University Center for Excellence in Developmental Disabilities

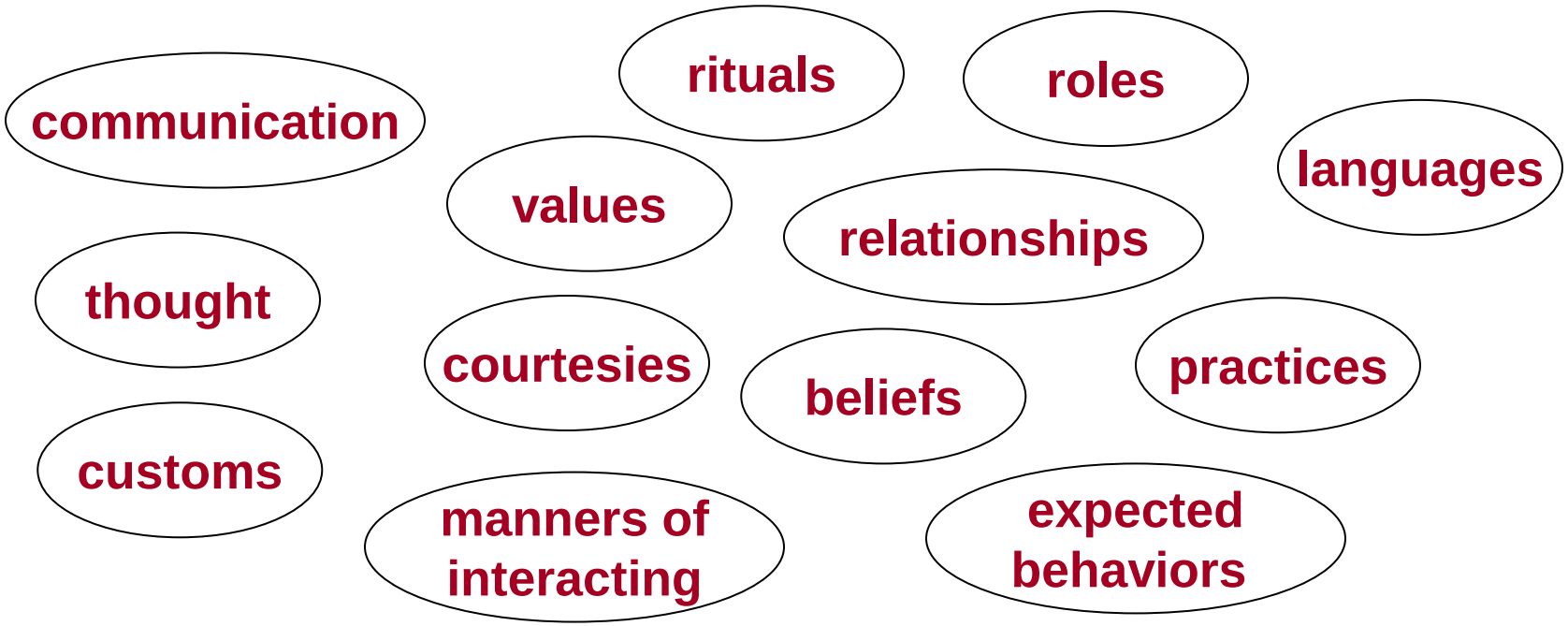
October 30, 2013

National Center for Cultural Competence

GEORGETOWN UNIVERSITY
Center for Child and Human Development

Georgetown University
Medical Center

Culture ***is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world*****. It includes but is not limited to:**



Culture applies to racial, ethnic, religious, political, professional, and other social groups. It is transmitted through social and institutional traditions and norms to succeeding generations. Culture is a paradox, while many aspects remain the same, it is also dynamic, constantly changing.

Data Source: Gilbert, J. Goode, T., & Dunne, C., 2007

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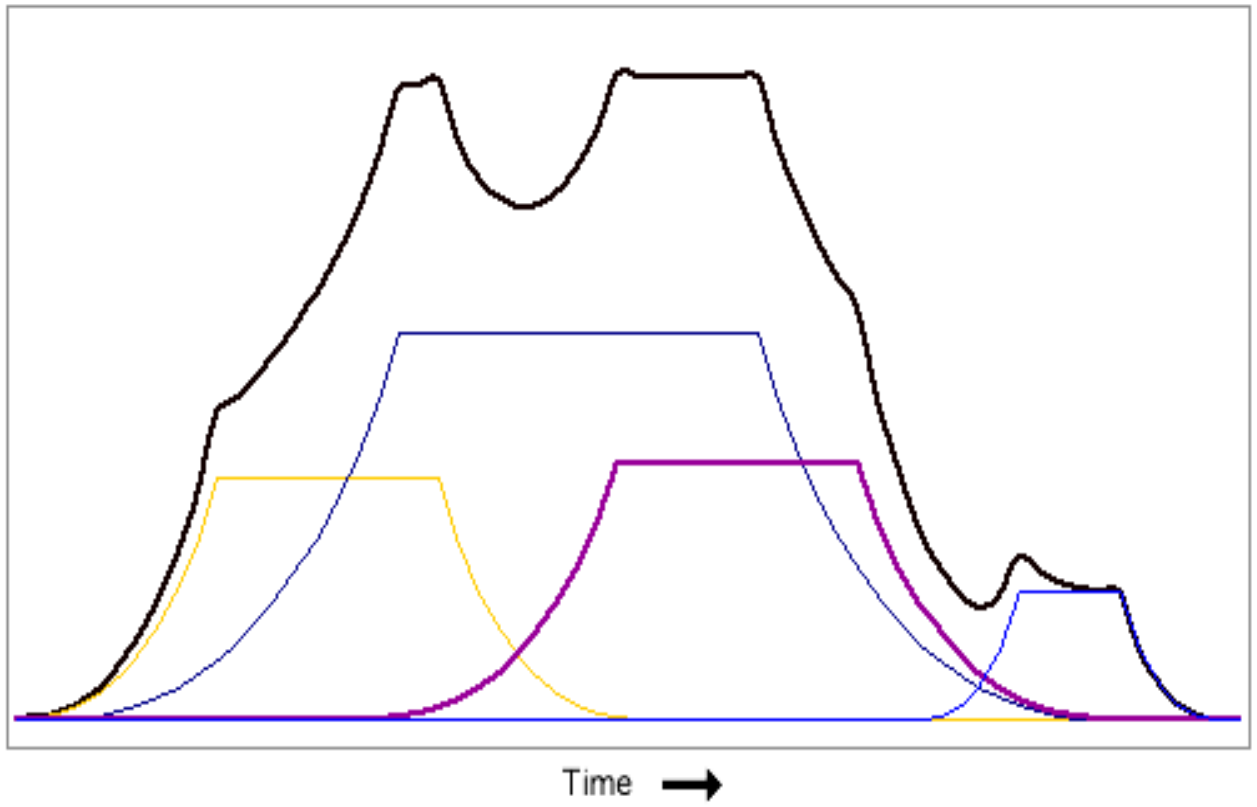
Multiple Cultural Identities

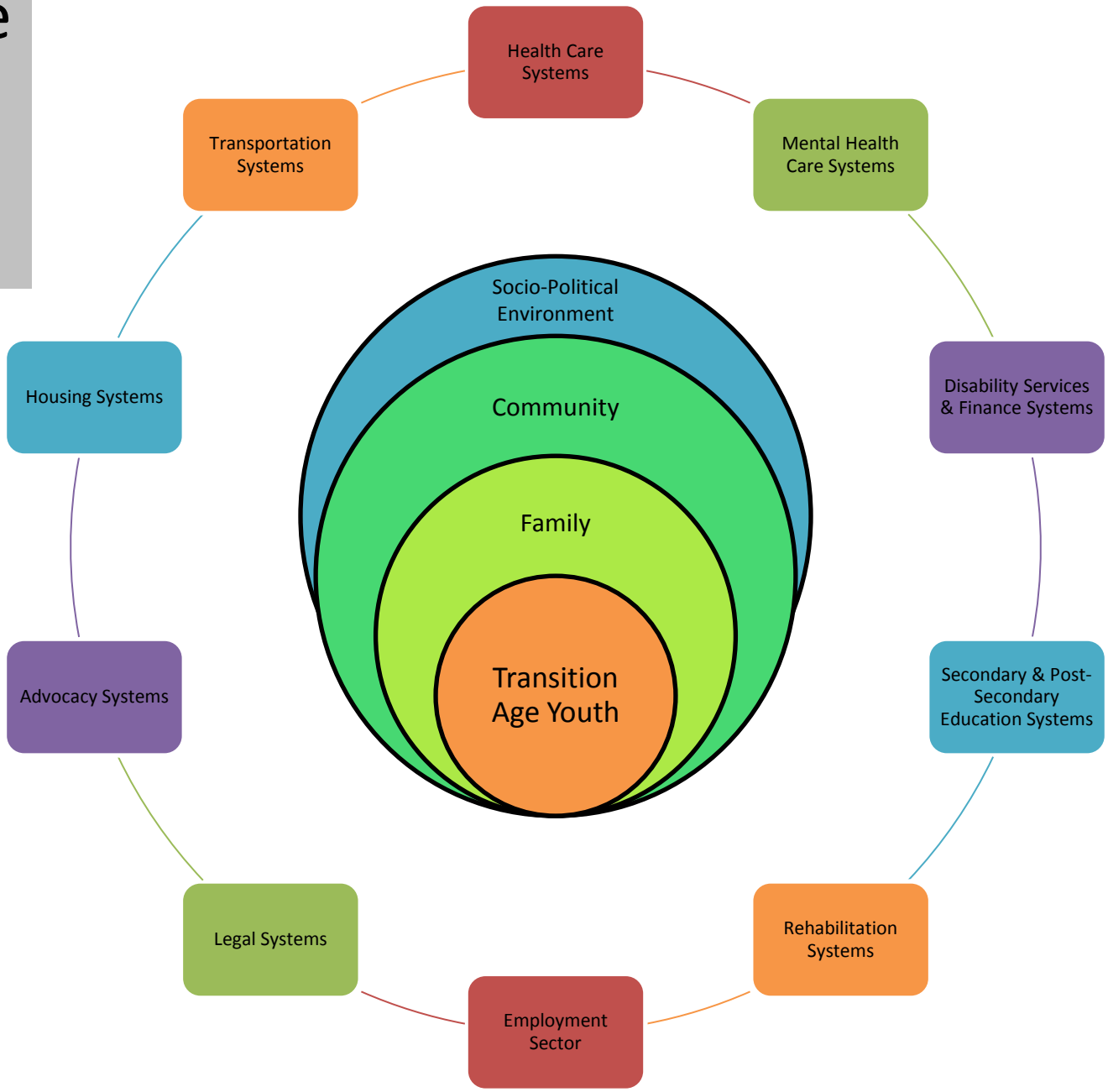


POINT IN TIME & CONTEXT

Slide Source: 2013 - National Center for Cultural Competence

Convergence of Cultural Contexts:

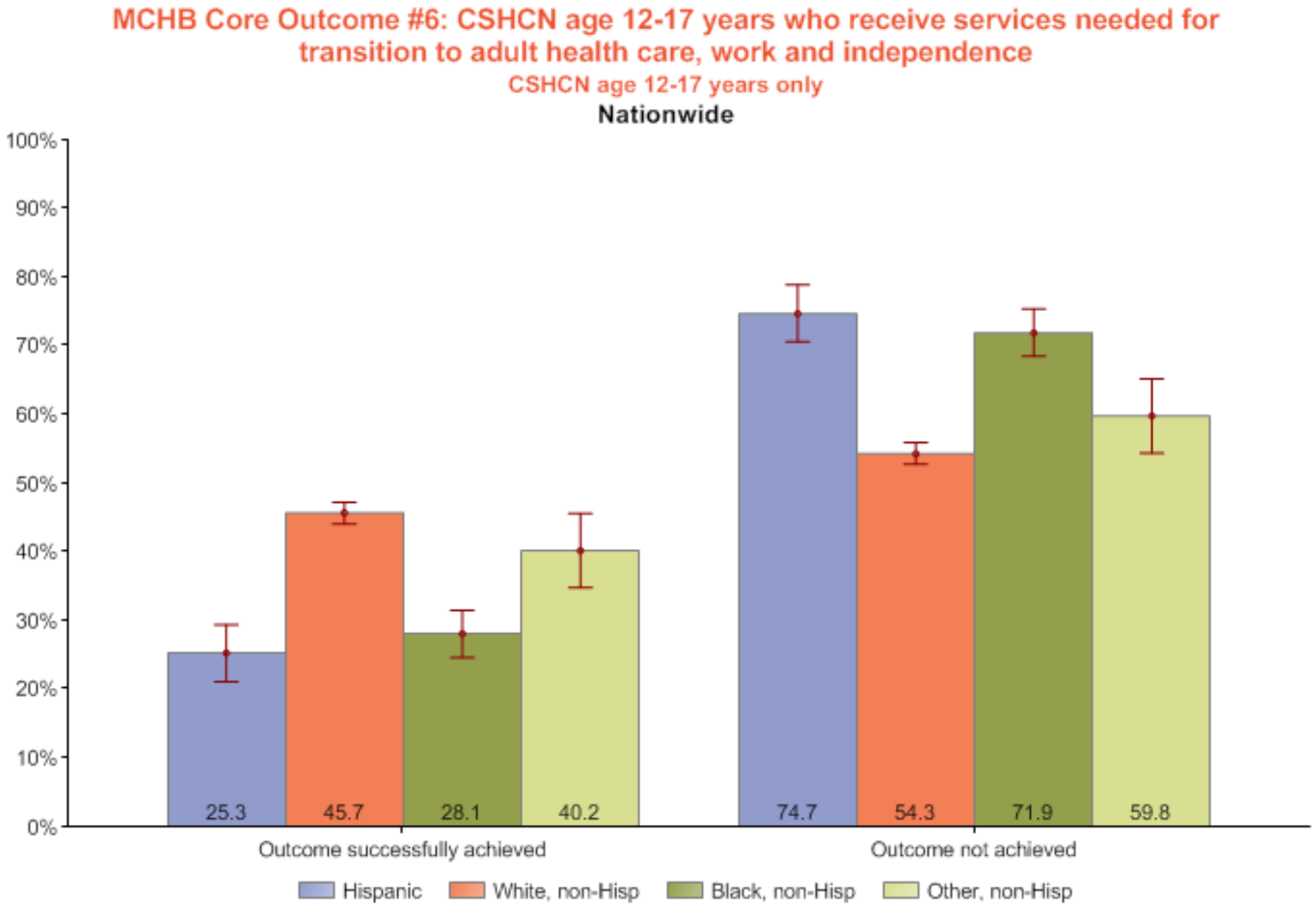
A Focus on Transition



There are significant racial and ethnic disparities in transition services and outcomes.

Goode, T. *Transition Through A Cultural Lens*. In Anthony Antosh (Ed.) A Collaborative Interagency, Interdisciplinary Approach to Transition from Adolescence to Adulthood. Association of University Centers on Disability. Silver Spring, MD: Association of University Centers on Disabilities.

Status of Core Outcome 6 by Race and Ethnicity



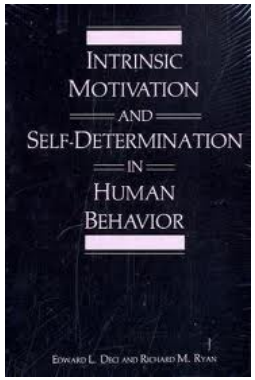
Data Source: Child and Adolescent Health Measurement Initiative. 2009/10 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Retrieved [10/19/2013 fromwww.cshcndata.org]

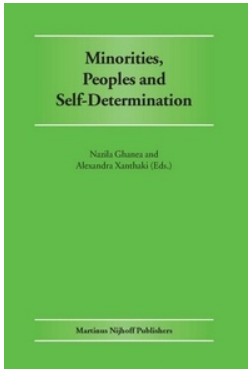
Transition services and outcomes generally reflect the values of

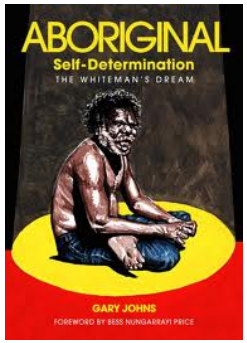
individualism and independence
vs.
collectivism and interdependence

Goode, T. *Transition Through A Cultural Lens*. In Anthony Antosh (Ed.) A Collaborative Interagency, Interdisciplinary Approach to Transition from Adolescence to Adulthood. Association of University Centers on Disability. Silver Spring, MD: Association of University Centers on Disabilities.

Self-determination is a cultural construct







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CULTURAL AND LINGUISTIC COMPETENCE IN TRANSITION SERVICES AND SUPPORTS

☑ Acquire knowledge about the beliefs and practices related to transition from youth to adulthood for the diverse cultural groups in the geographic area served by your organization or program.

☑ Recognize that self-determination is viewed and practiced differently across different cultural groups and must be taken into consideration in the provision of transition services.

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CULTURAL AND LINGUISTIC COMPETENCE IN TRANSITION SERVICES AND SUPPORTS

- ☑ Incorporate cultural values about independence vs. interdependence and collective vs. communal perspectives in planning and provision of transition services.
- ☑ Address family and youth needs and preferences for services in languages other than English.
- ☑ Engage in cultural and linguistic competence self-assessment (at both the organizational and individual level). Use results to strengthen cultural adaptations to transition services and supports.

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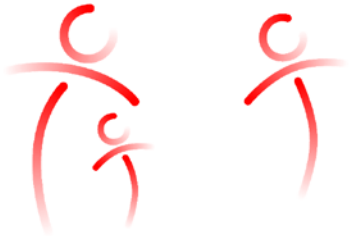
CONTACT US



National Center for Cultural Competence

http://nccc.georgetown.edu
cultural@georgetown.edu

Interagency Collaboration

Collaboration

The linking or sharing of information, resources, activities, and capabilities by two or more organizations to achieve jointly an outcome that could not be achieved in one organization separately.

(Bryson, Crosby, Stone, 2006)

Why Focus on Interagency Collaboration?

- Youth with disabilities in transition have complex support needs
- Critical need for the system(s) to work together
- States have failed to establish interagency required linkages under IDEA
- No agency has all that is needed to plan and provide comprehensive transition services (Morningstar, M. 2013)

Common Barriers to Collaboration for Students and Families

- Accessing needed services
- Navigating adult services
- No coordination amongst multiple agencies
- Lack of sufficient information/awareness
- Insufficient preparation of students for work

(US Government Accountability Office (2012), Better federal coordination could lessen challenges in the transition from high school)

Common Barriers to Collaboration Amongst Agencies

- Lack of shared vision or purpose
- Time, trust, & turf
- Unclear roles and responsibilities
- Actual policy and practice impedes partnership
- Resistance to change

Benefits of Interagency Collaboration

- Interagency collaboration is a critical element for improving adult outcomes –
  - in transition planning and in the sharing of resources (Morningstar et al.,1999)
- Positive outcomes associated with interagency collaboration
  - Higher rates of co-funded career assessments, concurrent enrollment in high school and community colleges, referral to and serviced by adult agencies, and increased rates of attendance in postsecondary education (Hasazi et al., 1999)

Three Levels of Interagency Collaboration

1. **Individual student transition team:** Work with individual students at IEP meeting or other interagency meetings
2. **Local transition team, council or committee:** Develop procedures and guidelines at district level or regional level
3. **State level interagency task force:** Develop cross-agency policies to facilitate transition

Individual Student Transition Teams

- In most cases, a single agency cannot provide all the necessary transition services. Therefore it is imperative for agencies to work together to increase student's ability to acieve post-school success
- Decisions such as:
  - Who will provide what?
  - When will it be provided?
  - How will it be provided?
  - Who will pay for services? (Blackmon, D. 2008)

Individual Student Transition Teams

- Requires that schools are familiar with the resources available in their local communities
- Requires that agencies are familiar with each others eligibility criteria, procedures and services of the agency
- Outcome: to establish, coordinate and plan for transition services and connect student's IEP with future plans and opportunities

Possible Representatives from Agencies for Student Transition Team

School district – general and special education
Employment Development Department One-Stops
Community College or University
Family and student
Social Security
Independent Living Center
DD Agency
Vocational Rehabilitation
Community Agencies
Mental health
Supported living/supported work providers
And more!

Local Transition Team, Council or Committee

- School and community professionals, family members and students and direct their attention to improving school and community transition services
- Capitalizes on the knowledge of those who are closest to the work
- Can reveal local assets and barriers
- Outcomes may include school and regional transition fairs, outreach to businesses, transition workshops for parents, help influence policy and procedures

State-Level Interagency Task Forces, Committees or Consortia

- Brings together statewide policy makers and administrators who may focus on evaluating current services and providing fiscal and legislative guidance to local communities
- Address policies across and within agencies that serve youth and young adults with disabilities
- Commonly the goal is strengthening coordination, training, funding, interagency agreements, information sharing and policies

Key Strategies for Successful Interagency Teaming

- Ability to build relationships
- Administrative support for transition and collaboration
- Using a variety of funding sources
- Skilled facilitator
- Shared stake among members in both process and outcomes
- Training students and families
- Dissemination of information

Summary

- Interagency collaboration is recognized as a critical element in successful transition planning
- Different levels of collaborative teams serve a number of purposes that may achieve needed sharing of resources, coordination, and capacity building needed for transition
- Building relationships and administrative issues of " time, turf and trust" are key elements towards developing effective collaborations

References

- Blackmon, D. (2008) *Transition to Adult Living: AnInformation and Resource Guide*. California Department of Education.
- Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature. *Public administration review*, *66*(s1), 44-55.
- US Government Accountability Office (2012), Better federal coordination could lessen challenges in the transition from high school.
- Morningstar, M. (2013) Effective Strategies for Interagency Collaboration: Ensuring Seamless Transitions to Adult Life, Developmental Disabilities Lecture Series, Elizabeth M. Boggs Center, New Jersey
- Morningstar, M. E., Kleinhammer-Tramill, P. J., & Lattin, D. L. (1999). Using Successful Models of Student-Centered Transition Planning and Services for Adolescents with Disabilities. *Focus on Exceptional Children*, *31*(9), 1-19.

Resources

AUCD Network

http://www.aucd.org/docs/publications/transition2013_full_sm2.p

Antosh, An... | AUCD - Ho... | AUCD - A C... | aucd.org

Suggested Sites | Web Slice Gallery | AUCD - Home (2) | AUCD - Home (3) | AUCD - Home (4) | AUCD - Home

UCEDD/LEND Interdisciplinary & Interagency Transition Activities, Programs, or Projects

Information by State

Center contact information and select program information can be found on the AUCD website and network directory at www.aucd.org/directory.

State & Center	Contact(s)	Programs/Projects
California *USC UCEDD at the Children's Hospital Los Angeles at the University of Southern California*	Cecily Betz, Co-Chair of Health Care Transition Research Consortium (cbetz@chla.usc.edu)	• Nurse-led self-sustaining transition program • Annual Research symposium
California	Olivia Raynor, Director (oraynor@	• California Consortium on Postsecondary Education for People with

User Friendly Version

for individuals and families

www.aucd.org

Questions and Discussion

Q & A

- How to Ask a Question
  - You can ask a question by pressing the * then # key to request the floor. Questions will be answered in the order they are received.
  - Type your questions into the ‘Chat’ box below the slides and the moderator will read the questions.

THANK YOU

Please take a few minutes to complete our survey!