Small Group Discussion Notes

Topic: Reducing Health Disparities Across the Lifespan: Transition

Existing Resources	New Resources Needed from TA Centers
• Ohio VR – counselors in high school • (WI) Model programs – evidence for models: PROMISE Grant; Project Search; YIPPE – youth employment/self advocacy supported employment; Quality improvement – healthcare mini grants to healthcare practices; PATCH – Self advocates trainees and trainees in adolescent health care (expand to include disability) • Report on intersectionality/race/disability/healthcare – 4 years ago • Driving apps/buses/screening/skills/diagnostics – Rutgers! (Dr. Feeley Center for Advanced Infrastructure "Transportation" • AAP Transition Tools • Medical residency transition training	• Safety risks in the community/ law enforcement • ACL soft skills modules! Get info out to group! • Transition app?/ how technology can help us
Obstacles or Challenges Experienced	**Lessons Learned**
• National performance standards = transition for <u>all</u> students, model for all if address kids with disabilities • No connection between health care/ transition models -> not available to all yet • Misperception that transition to employment = good transition to adulthood, but they are not equal • Keeping kids in pediatrics too long with no specialist to transition them to (particularly if at in housing/employment etc.…other services) – pediatrics has team approach adult doesn't • IEPs are only about employment transition – not healthcare, housing, safety, social life, etc. • Once out of school system IEP lost/ not at postsecondary; adult MDs don't want to see them • Taking medical records and sharing them more broadly/ how do we control? • Transportation!! (need transportation training) • Lack of care coordination	• Medicaid managed care as an organization of case management/organization/"trying it"

Opportunities for Grantee Collaboration	Outside Collaborators
• (OH) Medical school training? • Ongoing conversation – follow up after? AUCD Webinars? Conference? Carry it forward? • ECHO Models • University health system transition • PROMISE	• AAP (transition tools) • Adult doctors • Adolescent healthcare providers • Autism treatment network talking to medical records system • School nurses • Experts in intersectionality • LEAH • OAR < researchautism.org>

Recommendations for future action by each grantee group

Research

1. Building support during transition and continuing those supports; how to track long term? Looking at outcomes 2-5 years after transition to adulthood
2. Adopt recommendations of the "Intersectionality of Disability" report (mentioned by Anne Harris)
3. Leverage existing ECHO resources
4. Encourage teams with innovative ideas to seek funding from the Organization for Autism Research (OAR). OAR awards $600k per year (maximum of $30k per grantee).
5. Develop a computer program/interface that will guide Primary Care Physicians (PCPs) through checklists for each visit/help them identify ALL of the treatment needs of their patients with Autism Spectrum Disorder.

State Systems Change

1. Billing structure – built into medical records system! (able to look up info online as needed)
2. Team approach in adult services
3. Health literacy for high school health
4. Medical home for adults with DD/Autism
5. Collect data from Medicaid and Managed Care Organizations on the number of hospital Emergency Room (ER) visits made by people with developmental disabilities (who often use the ER for primary care purposes) each year.
6. Utilize this data to make the case for increased funding to healthcare transition services and supports.
7. Look into/share the current activities of the IAAC Transition Workgroup around transition-aged individuals; create an agenda for assisting and training the adult provider system in adopting a lifecourse perspective.

Training

1. Develop strategies for LEAH and LEND to collaborate around healthcare transition.
2. Train DBPs and medical students, adult doctors and adolescent health providers on the needs of adolescent and adults with developmental disabilities. Offer mini-fellowship opportunities for adult PCPs. CME to get "training" for community practitioners (Offer ECHO model for PCPs on how to establish a medical home for individuals with DD.)
3. Encourage the CARES network grantees to adopt strategies from the MedPeds model (in which physicians are cross-trained on how to work with teens and adults).
4. Offer training opportunities for transition aged youth to receive training and learn the soft skills needed for navigating healthcare transition, specifically training for medical records/ what to share or not and what is relevant or not
5. Educate providers and the community about the concerns of diverse populations as they relate to seeking healthcare (i.e., reasons that a population may avoid seeking healthcare) Cultural competence/ intersectionality