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

October 30, 2013
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
A Collaborative Interagency, Interdisciplinary Approach to Transition from Adolescence to Adulthood
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
• 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.
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.
Failure to support **self-determination** as the central element of the person-centered process of transition
Insufficient understanding of the role of culture in an individual or family’s concept or approach to transition
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
Neglect to specifically explore how transition in the different realms could/should be linked to maximizing success
Self Determined Life

Youth and Family
Culture

Perspectives
Individual/Family
Education
Health
Employment
Postsecondary
Adult Supports

Outcomes
Competence
Healthy Life
Place to Live
Paying Job
Social Network
Community
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).
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.
A National Gateway to Self-Determination

Self-advocates talk about self-determination.

Welcome to the National Gateway to Self-Determination Web Portal, a clearinghouse on resources, training, and information on Self-Determination.
Perspectives on Transition
Youth and Family Perspective
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 planning 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
• 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
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.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Parent/Family</th>
<th>Young Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Responsibility</td>
<td>Provides Care</td>
<td>Receives Care</td>
</tr>
<tr>
<td>Support to parent/family &amp; child/youth</td>
<td>Manages</td>
<td>Participates</td>
</tr>
<tr>
<td>Consultant</td>
<td>Supervises</td>
<td>Manager</td>
</tr>
<tr>
<td>Resource</td>
<td>Consultant</td>
<td>Supervisor</td>
</tr>
</tbody>
</table>

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](http://www.gottransition.org)

- FloridaHATS
  - [www.floridahats.org](http://www.floridahats.org)

- Illinois Transition Care Project

- University of Florida Education Health Care Transition Certificate Program (online; tuition)
  - [http://education.ufl.edu/education-healthcare-transition/](http://education.ufl.edu/education-healthcare-transition/)
Relevant Publications


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)]

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**Definition of Transition Services**

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

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

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
When Employment is a Core Element of the IEP

Work Experience/Paid Employment

Participation in Postsecondary Education
References


• 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.


Resources
Guideposts for Success http://www.ncwd-youth.info/guideposts
Think College www.thinkcollege.net
National Secondary Transition Center http://nsttac.org
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*
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
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

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>71.6%</td>
</tr>
<tr>
<td>Agency Staff</td>
<td>27.4%</td>
</tr>
<tr>
<td>Family Community Friend</td>
<td>0.4%</td>
</tr>
<tr>
<td>Housemate</td>
<td>0.4%</td>
</tr>
<tr>
<td>Someone else</td>
<td>0.1%</td>
</tr>
<tr>
<td>Day/Workmate</td>
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</tr>
</tbody>
</table>
Getting There

A Tiered Approach to Transportation Education

Moving up the Tiers
- Less numbers of students
- More defined service
- Greater time & resource commitment
- Specialized training and competence of providers

Intense Services
- Travel Training
- Para transit eligibility
- OT/PT/Behavioral Interventions

Focused Transportation Assessments & Education
- Travel Training Assessments
- OT/PT Behavioral assessment
- Travel Instruction - Familiarization

District-Wide Transportation Education
- Provide professional development to educators around accessible transportation supports
- Engage families and students in transportation education in early grades
- Integrate transportation content across grade levels and curriculum (ELA, Math, geography, etc.)
- Rely on transit for community-based experiences
- Invite transit into schools and programs
- Establish linkages across educators, pupil transportation, and public transportation sectors
- Provide travel instruction - orientation

www.projectaction.org/initiatives/youth

Easter Seals, Shanley, 2012

AUCD
Association of University Centers on Disabilities
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

Everyday Decisions

- Decides daily schedule: 85%
- Decides how to spend free time: 93%
- Chooses what to buy with own money: 89%
Making Decisions

Life Choices

- Chose home: 50%
- Chose roommates: 45%
- Chose home staff: 64%
- Chose job: 80%
- Chose day activity: 60%
- Chose job staff: 60%
- Chose day activity staff: 58%
- Chose case manager: 59%
Summary

Comprehensive Transition Planning should include:

- Where to Live
- Making Decisions
- Community Activity
- Leisure and Recreation
- Building a Social Network
- How to Get There
What Actions should I take When

Self-Determined Life

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

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 addresses them,
- has common points of entry,
- integrates supports,
- blends funding,
- 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
Assistant Professor & Director, National Center for Cultural Competence
Associate Director, Georgetown University Center for Excellence in Developmental Disabilities

October 30, 2013
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:

- communication
- rituals
- roles
- languages
- thought
- values
- relationships
- practices
- customs
- courtesies
- beliefs
- expected behaviors
- manners of interacting

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
Multiple Cultural Identities

Race or Ethnicity
Disability
Gender or Gender Identity
Religious or Spiritual Affiliation

Point in Time & Context

Slide Source: 2013 - National Center for Cultural Competence
There are significant racial and ethnic disparities in transition services and outcomes.

Status of Core Outcome 6 by Race and Ethnicity

MCHB Core Outcome #6: CSHCN age 12-17 years who receive services needed for transition to adult health care, work and independence

CSHCN age 12-17 years only

Nationwide

Transition services and outcomes generally reflect the values of *individualism and independence* vs. *collectivism and interdependence*.

Self-determination is a cultural construct

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.

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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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 achieve 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 other’s 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


Resources
# 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](http://www.aucd.org/directory).

<table>
<thead>
<tr>
<th>State &amp; Center</th>
<th>Contact(s)</th>
<th>Programs/Projects</th>
</tr>
</thead>
</table>
| **California** | Cecily Betz, Co-Chair of Health Care Transition Research Consortium (cbetz@chla.usc.edu) | • Nurse-led self-sustaining transition program  
• Annual Research symposium |
| **USC UCEDD at the Children’s Hospital Los Angeles at the University of Southern California** | | |
| **California** | Olivia Raynor, Director (oraynor@ | • California Consortium on Postsecondary Education for People with |
User Friendly Version
for individuals and families
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