# Empowering Students to be Ready to Take Charge of their Health Care as Adults

Wisconsin Association of School Nurses April 27, 2023

#### Presenters



Julie Hajewski, MSN, ANP-BC, APNP Wisconsin Youth Health Transition, Provider Education NP - Internal Medicine at UW Health, Beaver Dam since 2010



Tim Markle Father and Curriculum Developer for Wisconsin Youth Health Transition Initiative

#### Disclosures

•None

#### Learner Objectives



- 1. Define Health Care Transition (HCT)
- 2. Describe the current status of HCT efforts
- 3. Summarize three barriers to HCT
- 4. Identify the possible roles of the school nurse in HCT
- 5. Describe the role of HCT in the IEP, IHP, Emergency Care Plan

#### Primary Network in Wisconsin



#### Statewide Initiative

# HEALTH TRANSITION WISCONSIN

SUPPORTING YOUTH TO ADULT HEALTHCARE

#### Purpose

Ensure that "high-quality, developmentally appropriate, health care services are available in an uninterrupted manner as the person moves from adolescence to adulthood"

-Pediatrics, 2018





#### Southern Regional Center

Location: Waisman Center, Madison Phone: 608-265-8610 Toll Free: 800-532-3321 Director: Tim Markle

<u>cyshcn@waisman.wisc.edu</u> <u>waisman.wisc.edu/cshcn</u>



#### Northeast Regional Center

Location: Neenah Phone: 920-969-5325 Toll Free: 877-568-5205

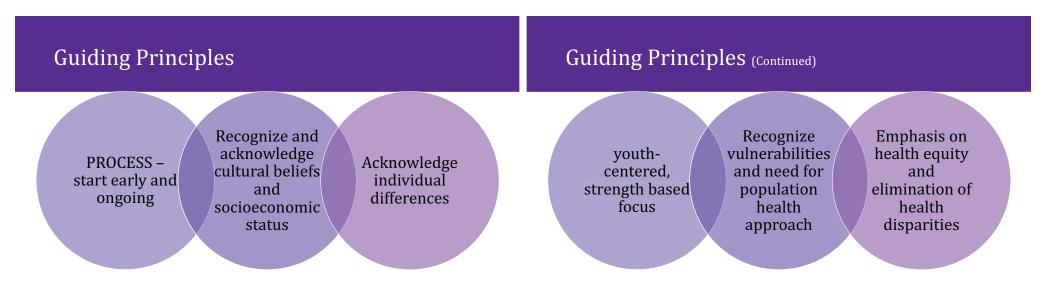
infonerc@chw.org northeastregionalcenter.org



#### Definition

• Heath Care Transition is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician





#### 2023 WASN Annual Conference 1A - Empowering Students to be Ready to Take Charge of their Health Care as Adults

#### **Measuring Transition Success** Guiding Principles (Continued) Youth had time alone with provider during their last Allow youth preventative care visit to build **Emphasis** on Emphasis on knowledge selffamily and and decision determination The provider worked with youth to gain self-care skills or making skills caregiver and selfunderstand the changes in health care that happen at age 18 regarding engagement management their own health The provider talked with the youth about eventually seeing providers who treat adults

# How are we doing? 2019-20 Data





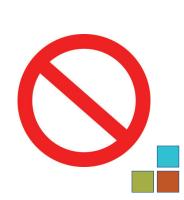
-2019-2020 National Survey of Children's Health, Wisconsin

Roughly 80% of CYSHCN in the US and >65% in WI don't receive transition Services...And numbers are even more dismal for our "typical" kids without complex healthcare needs



# What are the Transition Barriers?

- Patient Barriers
- Inadequate Planning Barriers
- System Barriers



#### **Patient Barriers: Fear** New health care system, hospital, provider...



#### **Inadequate Planning Barriers** Not having Inadequate seen support and provider preparation alone Socioeconomic



#### **Systems Barriers**



### System Barriers

- Lack of communication and/or coordination between providers and/or systems
  - Lack of time
  - Lack of tools
  - Lack of resources to implement transition process



#### System Barriers

- Limited availability of adult primary and specialty care providers
  - Lack of time/assistance
  - Lack of matching systems



#### System Barriers



- Difficulty locating adult providers with specialized knowledge regarding pediatric onset conditions and community resources
  - Lack of transition training in residency, esp. internal medicine
  - Increased training opportunities (CME and MOC) needed for practicing clinicians

#### System Barriers

- Loss of insurance of young adults and costs of care
  - Service/therapy coverages may be age dependent
  - Eligibility changes
  - Coverage differences Medicaid to Medicare



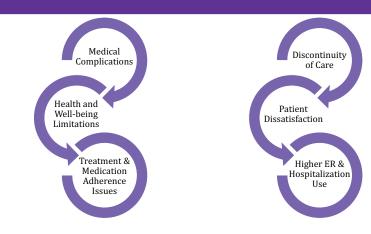
#### Consequences



"Special populations may not represent the majority of youth transitioning to adulthood, but in the aggregate, they include those must vulnerable to poor outcomes and higher health care costs."

-Pediatrics, 2018

#### Consequences





### Individualized Education Plan (IEP)

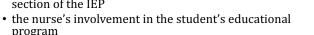
• An individualized education program (or IEP) is a written statement for a student with a disability that is developed, reviewed, and revised by a team of people, including the student's family, that outlines an educational plan for the student.



-https://dpi.wi.gov/familiesstudents/student-success/ccr-iep

#### Documenting nursing services in the IEP

- Need for nursing services should be documented in the "present level of performance" and the "related services" section of the IEP
- Documentation in the IEP should include:
  - nursing services necessary to benefit from an education
  - consultation between the nurse (if 3<sup>rd</sup> party nursing services are utilized), school nurse, and teachers – document in the program modifications and support section of the IEP





https://dpi.wi.gov/sites/default/files/imce/sspw /pdf/snnursingservices.pdf

#### Individualized Health Plan (IHP)

- Document based on the healthcare needs of a student. that impact or has the potential to impact
  - Learning or academic performance
  - Safe and optimal school attendance
- Based on the Nursing process!
- Should include student goals and expected outcomes with the goal of promoting health, preventing disease or injury, and enhancing academic achievement

https://dpi.wi.gov/sites/default/files/imce/sspw/pdf /wilvschoolnursesandplans.pdf https://www.nasn.org/nasn-resources/professionalpractice-documents/position-statements/ps-ihps

#### IHP's – Why Are They Important?

- Quality assurance documentation
- Foundation of health information needed to develop other school plans
- Enables essential, coordinated care and evaluation
- Promotes communication

program

- Provides quantifiable data about the outcomes that school nurses contribute to student success
- Documents evidence of our practice in accordance with professional standards

https://dpi.wi.gov/sites/default/files/imce/sspw/pdf /wilyschoolnursesandplans.pdf https://www.nasn.org/nasn-resources/professionalpractice-documents/position-statements/ps-ihps



### IHP's – Who Needs One?

- Students whose health care needs affect or have the potential to affect safe & optimal school attendance & academic performance
- Students with whom the nurse has multiple interactions (usually complex)
- Students with multiple health related absences

https://dpi.wi.gov/sites/default/files/imce/sspw/pdf /wilyschoolnursesandplans.pdf https://www.nasn.org/nasn-resources/professionalpractice-documents/position-statements/ps-ihps

#### Development of the IHP – It is just a care plan!

- Document baseline assessment necessary to measure outcomes (evaluation)
- Incorporate cultural and social perspectives
- Utilize the nursing process
  - Assessment
  - Nursing Diagnosis
  - Goals
  - Interventions
  - Expected outcomes



https://dpi.wi.gov/sites/default/files/imce/sspw/pdf /wilvschoolnursesandplans.pdf

| IHP <i>in</i> the IEP?                                                                                                                                       | Emergency Care Plan (ECP)                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <ul> <li>Including the IHP in the IEP is generally NOT</li> </ul>                                                                                            | Plan for others to implement in school setting                                        |
| recommended                                                                                                                                                  | • Written for lay person                                                              |
| <ul> <li>IHP's may change frequently</li> </ul>                                                                                                              | <ul> <li>Focus on life threating illness that requires immediate</li> </ul>           |
| <ul> <li>Would need to reconvene or follow DPI guidelines for IEP revision with every change</li> <li>Appropriate to reference the IHP in the IEP</li> </ul> | response<br>• Acute allergic reactions (Epi Pen)<br>• Seizure<br>• Hypoglycemia       |
| <ul> <li>Appropriate to reference the IHP in the IEP</li> </ul>                                                                                              | <ul> <li>May reference in IEP, but would not be included</li> </ul>                   |
| https://dpi.wi.gov/sites/default/files/imce/sspw/<br>pdf/wilyschoolnursesandplans.pdf                                                                        | https://dpi.wi.gov/sites/default/files/imce/sspw/pdf<br>/wilyschoolnursesandplans.pdf |

#### Implementing a Youth Health Transition Process and the Role of the School Nurse

# **Transition Implementation Timeline**

#### TRANSITION AND TRANSFER OF CARE



Transition timing should be individualized and consider the patient's cognitive development, physical abilities, and environment (e.g., socioeconomic characteristics and psychosocial support). The transition process should begin at age 12, with a written health care transition plan created by age 14, and to complete transfer between the ages of 18-26 years.

- Health transitions should not occur during a period of health crisis, especially when support systems are unstable.
- Families and caregivers should be encouraged to stay involved during the transition process, while also allowing patient autonomy and promoting self-care.

#### Transition related IHP Goal examples



2022: School nurse administering albuterol via inhaler Photo source: Teresa DuChateau https://www.wischoolnurses.org/a-day-in-the-life-home/pastand-present

- Assessment, education, and acquisition of health condition specific skills
  - Diabetes Measuring blood sugar, calculating insulin doses
  - Asthma Measuring peak flow, inhaler selection, administration of inhaler
  - Anaphylaxis allergies recognizing triggers, recognizing symptoms, administering self treatments
  - Self care and acquisition of ADL skills

#### **Got Transition**

Develop Goals based on the Assessment Got Transition has some sample goals to help you get started.

| HCT READINESS ASSESSMENT ITEM                                                                                                       | SAMPLE GOAL                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MY HEALTH                                                                                                                           |                                                                                                                                                                                      |
| I can name my learning differences, disability,<br>medical, or mental health diagnosis (e.g. diabetes,<br>depression).              | By the end of the IEP cycle, student will say aloud and/or spell out and/or enter into their cell phone the name(s) of their medical or mental health diagnosis(es), with% accuracy. |
| I can name 2-3 people who can help with my<br>learning differences, disability, medical, or mental<br>health needs in an emergency. | By the end of the IEP cycle, student will input their emergency contacts' information on their phone and name and identify the contacts in their phone when asked, with% accuracy.   |
| Before a doctor's visit, I prepare questions to ask.                                                                                | By the end of the IEP cycle, student will prepare and practice asking a few questions to their doctor before their next appointment, with% accuracy.                                 |
| I know to ask the doctor's office for<br>accommodations, if needed.                                                                 | By the end of the IEP cycle, student will identify which accommodations they need to request at a doctor's office, with _% accuracy.                                                 |
| I have a way to get to my doctor's office.                                                                                          | By the end of the IEP cycle, student will plan transportation to their doctor's office ahead of time, with% accuracy.                                                                |
| I know the name(s) of my doctor(s).                                                                                                 | By the end of the IEP cycle, student will input their doctor's contact information on their phone and name and identify their doctor in their phone when asked, with% accuracy.      |

Got Transition Radio Episode 6 Transition and School Health & the Individual Education Plan IEP)



https://www.youtube.com/watch?v=6e3jjDx7KbE

# How Can School Nurses be a Part of Transition Planning?

https://www.youtube.com/watch?v=Nd\_z0QAWx2w



March 22, 2023 <u>Recording Resource Sheet</u> Join Louise Wilson, Wisconsin Department of Public Instruction School Nurse Consultant, to talk about the overall role of school nurses and how they can be a critical part of successfully transition student from High School into adult life. Part of <u>Conversations on</u> <u>Showing Up for Kids!</u>

#### Transition Readiness Assessments - Tools for Assessing Student Related Health Transition Needs

#### **GotTransition**®

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| I can ex              | plain my t  | health need            | s to others.        |              |               |                       |              |                |              |         |
| I know h              | ow to ask   | k questions            | when I do n         | not underst  | and what r    | my doctor sa          | iys.         |                |              |         |
| I know r              | ny allergie | es to medici           | nes.                |              |               |                       |              |                |              |         |
| I know r              | ny family   | medical hist           | ory.                |              |               |                       |              |                |              |         |
| I talk to             | the docto   | r instead of           | my parent/          | caregiver to | alking for n  | ne.                   |              |                |              |         |
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|                       |             | how to get a           |                     |              |               |                       |              |                |              |         |
|                       |             | pet medical (          |                     |              |               |                       |              |                |              |         |
| I carry in<br>emerger | mportant I  | health information     | sation with<br>on). | me every o   | tay (e.g., in | nsurance ca           | rd.          |                | 0            |         |
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| I know t              | ow to find  | d my doctor            | s phone nu          | mber.        |               |                       |              |                |              |         |
|                       | ow to ma    | ke and can             | cel my own          | doctor app   | ointments     |                       |              |                |              |         |
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| I know h<br>I have a  | way to ge   | 41 to mily 000         |                     |              |               |                       |              |                |              |         |

#### Children's Wisconsin

| Children's<br>Wisconsin                                                                                                                                                                                                                                            |               | PAT      | TENT L  | ABEL             |             |   |
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| Managing Medical Condition                                                                                                                                                                                                                                         |               |          |         |                  |             | _ |
| Able to describe medical condition/disability,<br>Identifies changes/symptoms caused by condition.                                                                                                                                                                 |               | help     | now     |                  |             | _ |
| Able to describe medical condition/disability,<br>identifies changes/symptoms caused by condition,<br>Recognizes how liness impacts daily life.<br>Knows how to access information about medical                                                                   |               | help     | now     |                  |             |   |
| Able to describe medical condition/disability.<br>Identifies changes/symptoms caused by condition.<br>Recognizes how liness impacts daily life.                                                                                                                    |               | help     | now     |                  |             |   |
| Able to describe medical condition/disability,<br>identifies changes/symptoms caused by condition.<br>Recognizes how liness imports daily life.<br>Knows how to access information about medical<br>condition.<br>Takes care of medical condition independently at |               | help     |         |                  |             |   |

# Transition Readiness Assessment for Youth with I/DD

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• Word document of this assessment tool included with your handouts



#### Customizing Got Transition® resources

- PDF's are customizable and downloadable
  - non-commercial use
  - requires attribution to Got Transition
  - Requires simple registry and then immediately available

https://www.gottransition. org/six-core-elements/requestcustomizable-version.cfm



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| Thank you for your interest<br>health care transition                                                             | in             | First Name'          |                       | Last Name'                                               |             |       |     |   |   |
| improvement!<br>Got Transition is interested in<br>knowing how and where these is<br>care transition tools may be |                | Job Title"           | Organization*         |                                                          |             |       |     |   |   |
| Implemented.<br>Please provide the following<br>information to download the<br>customizable PowerPoint documents. |                |                      |                       | Apt/Suite #<br>ate/Province' Zip/Posta<br>Choose State * |             | l Cod | de' |   |   |
|                                                                                                                   |                | Email Address        |                       | Country'                                                 |             |       |     |   | X |

WHO WE ARE WHAT WE DO WHAT'S NEW PARTNERS

### Resources - GotTransition.org R



#### Resources – www.healthtransitionwi.org

UNIVERSITY of WISCONSIN-MADISON





WELCOME TO WISCONSIN'S YOUTH HEALTH TRANSITION INITIATIVE!

#### **Contact Information**

Jhajewski@wisc.edu <u>Tmarkle@wisc.edu</u> Wisconsin Youth Health Transition Initiative Waisman Center, UW Madison

Thank you!

# Did we meet your needs?



#### OR https://redcap.wisconsin.gov/surveys/?s=HH PPR93Y4A&sesson name=5

Please select the "Provider Education: Youth Health Transition" opt ion when submitting your session feedback. Please take the time to complete an evaluation on today's educational opportunity – that is how we maintain our funding to come to you today!



#### References

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