



Transition to Adulthood

The goal of planned health care transition is to maximize lifelong functioning and well-being for all youth, including those who have special health care needs and those who do not.³

- American Academy of Pediatrics (AAP)

- A joint plan is initiated and updated with the youth and family. The final step is implementing an adult care model at 18 years of age (or older).³
- Due to the broad range of complexity of youth with special health care needs (YSHCN), the AAP recommends transition with youth and their family start at age 12 years, but not older than 14.³
- In 2002, AAP, the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP)-American Society of Internal Medicine created a joint paper on the importance of transition to adult health care in YSHCN.¹
- Transitioning YSHCN to an adult health care setting may be challenging, especially for youth with more severe conditions or limitations.^{1,2}

Examining Youth with Special Health Care Needs

- Ohio performed similarly to the United States in transitioning YSHCN, both overall and by individual components of successful transition (Figure 1).
- Ohio's performance on meeting transitioning YSHCN to adult health care decreased from 2005/2006 to 2009/2010 while performance in the United States overall remained steady (data not shown).
- At the national level, meeting all criteria for transition to adult health care varied by condition experienced by youth (Figure 2).

Figure 1: Percent of Youth[§] with Special Health Care Needs Meeting Various Components of Transition to Adult Health Care, Ohio and the United States, 2009-2010

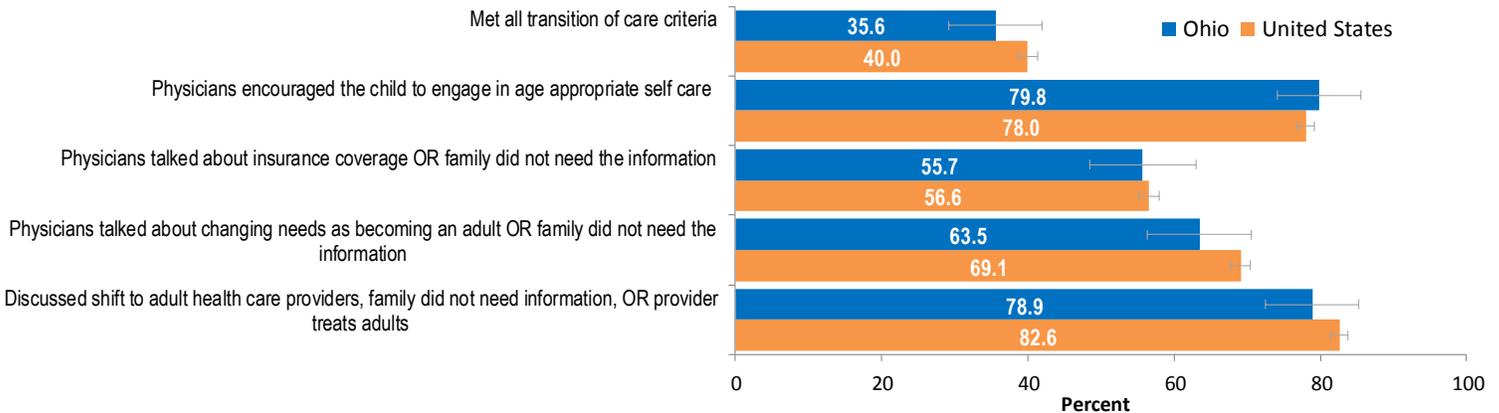
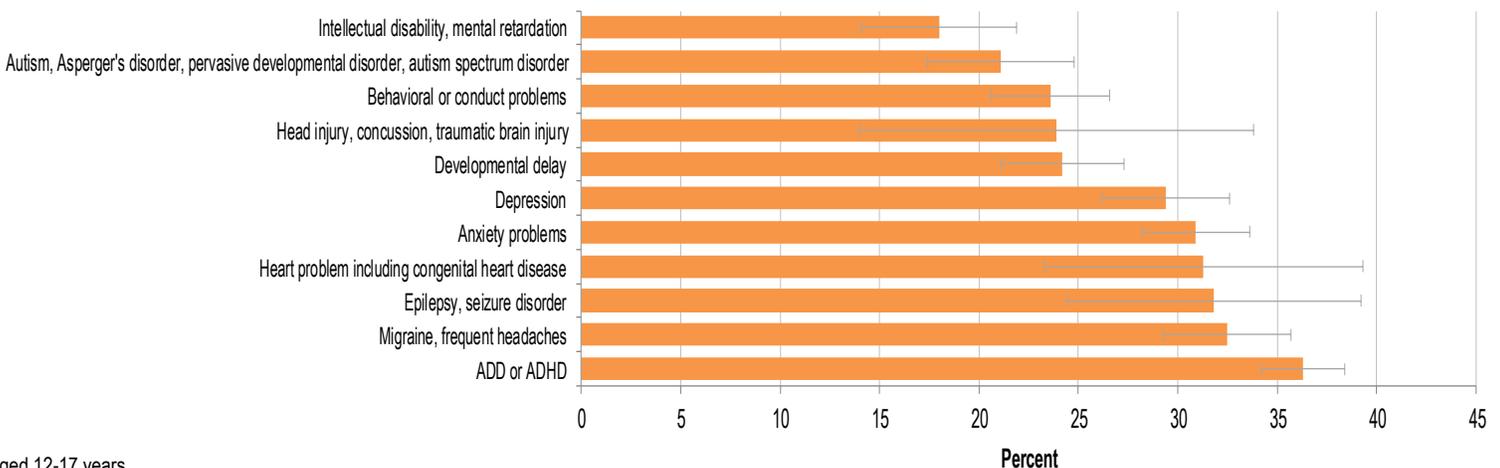


Figure 2: Youth[§] with Special Health Care Needs Meeting Criteria for Transition to Adult Health Care, by Condition, United States, 2009-2010



[§] Aged 12-17 years

Source: National Survey of Children with Special Health Care Needs (NS-CSHCN) 2009/2010, Centers for Disease Control and Prevention

Transition within a Medical Home

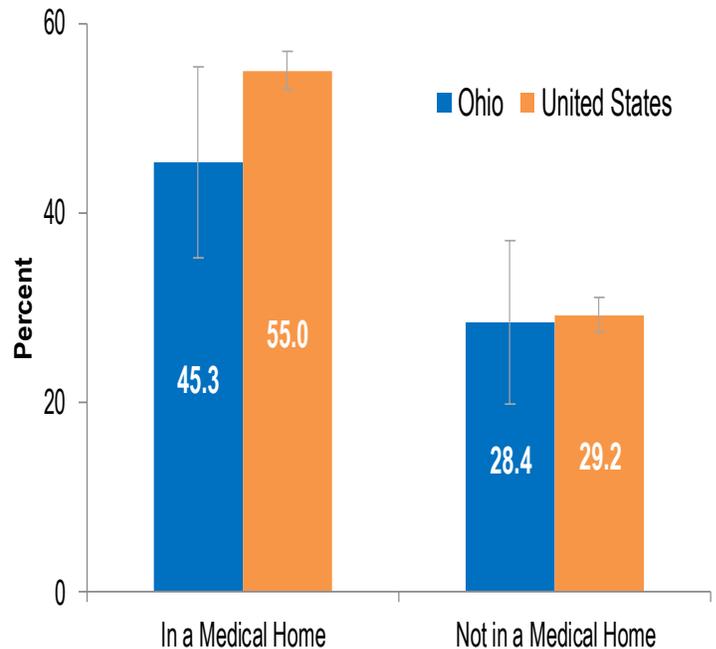
Medical home is a model of primary health care that focuses on efficiencies and decreased costs for providers and families, delivery of better patient health outcomes, and improved experiences for patients and families.

- In the 2011 publication “Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home” the AAP suggested that the transition from pediatric to adult care should begin within a medical home.³
- Figure 3 supports the AAP recommendation. In Ohio and at the national level, youth meeting all criteria for a medical home were more likely to also meet all criteria for transition to adult care.

*For more information see the “Medical Home” fact sheet

Each year, 21,000 Ohio youth with special health care needs are unprepared as they transition into adulthood.

Figure 3: Youth[§] with Special Health Care Needs Meeting Criteria for Transition to Adult Health Care, by Medical Home Status[‡], Ohio and United States, 2009-2010



[‡] Based on revised 2002 American Academy of Pediatrics definition of medical home
[§] Aged 12-17 years
 Source: National Survey of Children with Special Health Care Needs (NS-CSHCN) 2009/2010, Centers for Disease Control and Prevention.

Ohio

What Is Being Done to Improve the Transition of Youths in Ohio?

- Ohio’s investment in medical home will help support and strengthen the work that needs to be done to address health care transition for Ohio youth.
- The medical home model can serve as a solid starting point for practices working to implement strategies that help prepare adolescents and their families for a smooth transition into the adult health care system.
- ODH is supporting practice transformation to the patient-centered medical home model of care through work with family physician practices and a coalition of a broad range of stakeholders known as the Ohio Patient-Centered Primary Care Collaborative. Complementary work with a focus on pediatric medical home practice transformation is being proposed.
- The Ohio Department of Health (ODH), with leadership from Ohio’s Title V CYSHCN program and Ohio’s Adolescent Health program, is participating in a State Title V Transition Planning Group being convened by the Got Transition?/Center for Health Care Transition Improvement.

Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

A comment on CSHCN / CYSHCN / YSHCN: These terms are often used synonymously within the programs that provide services to children and youth with special healthcare needs. Use of one term over another is not mutually exclusive to a particular age cut-point, as service needs may differ over various conditions.

For access to further information on the NS-CSHCN, check out the Data Resource Center for Child & Adolescent Health: <http://childhealthdata.org/home>

References:

1. American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians-American Society of Internal Medicine. A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs. *Pediatrics*. 110 (2002) 1304-1306.
2. Bloom SR, Kuhlthau K, Van Cleave J, Knapp AA, Newacheck P, Perrin JM. Health Care Transition for Youth With Special Health Care Needs. *Journal of Adolescent Health*. 51 (2012) 213-219.
3. American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group. “Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home”. *Pediatrics*. 128 (2011) 182-202.

Data Contact: Richard Thomas, MPH
richard.thomas@odh.ohio.gov
Program Contact: Jessica Foster, MD, MPH
jessica.foster@odh.ohio.gov

www.odh.ohio.gov



Ohio
 Department of Health