

MOVIN' OUT:

Transition of HIV-Infected Young Adults from Pediatric/Adolescent Services to Adult Care



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RW All-Titles Meeting, August 2008



Objectives

- Basic adolescent maturation
- Overview of health care transition for chronically ill youth
- Pediatric/Adolescent HIV care information
- Planning and implementing transitional services

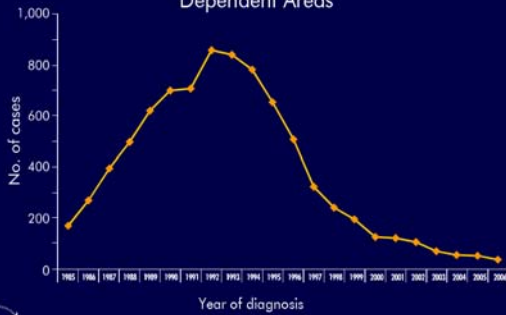
Funding Sources

- HRSA/Ryan White Part D (formerly Title IV) *Miami Family Care Program* H12HA00028 and *Youth Education Services in Tampa* H12HA23043
 - HRSA/Ryan White Part F *Florida/Caribbean AETC*
 - NIH(NICHD) *Adolescent Trials Network's* Miami U01-HD40494 and Tampa U01-HD40497 sites
 - Florida Department of Health and Miami-Dade County Health Department
 - Florida Developmental Disabilities Council, Inc.
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- Neither Ms. Garcia nor Drs. Straub or Friedman have conflicts of interest to report.

LEADING CAUSES OF DEATH IN U.S. FOR AGES 15 - 24

- Accidents
- Homicides
- Suicides
- Malignant Neoplasms
- Cardiovascular Diseases
- **HIV Spectrum of Diseases**

Estimated Number of Perinatally Acquired AIDS Cases by Year of Diagnosis, 1985–2006—United States and Dependent Areas

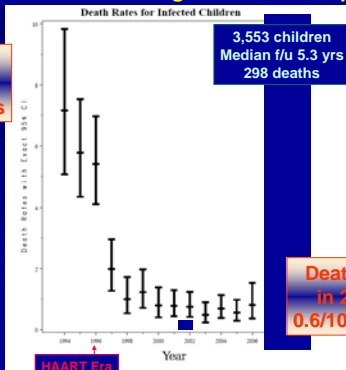


Note: Data have been adjusted for reporting delays and cases without risk factor information were proportionally redistributed.



Yearly Mortality (1994-2006) in HIV-Infected Children Enrolled in PACTG 219 Long-Term Follow-Up Study

Death rate in 1994:
7.2/100 pt-yrs

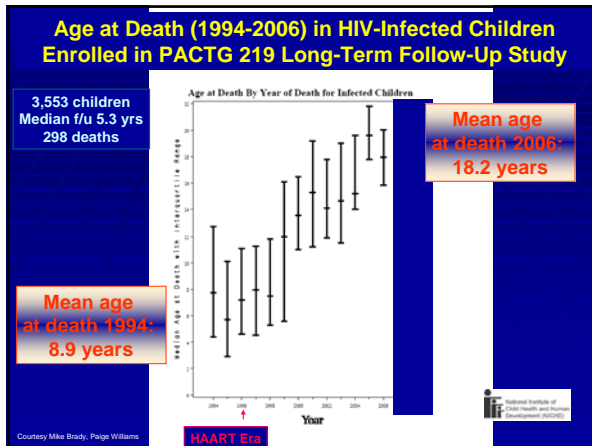


3,553 children
Median f/u 5.3 yrs
298 deaths

Death rate in 2006:
0.6/100 pt-yrs



Courtesy Mike Brady, Paige Williams



Reported Cases of HIV Infection (not AIDS), by Age Group at Diagnosis, Cumulative through 2006—45 States and 5 U.S. Dependent Areas

HIV Infection (not AIDS)

Age (years)	No.	%
<13	5,314	2
13-14	473	<1
15-24	45,514	16
25-34	98,844	34
35-44	88,270	31
45-54	36,916	13
55-64	9,839	3
≥65	2,784	<1
Total	287,954	

Note. Data from 45 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting as of December 2006.

CDC

Who is an Adolescent?

- AAP: 12-21 years old
- SAM: 10-24 years old
- APA: 10-18 years old
- AMA: 11-21 years old
- WHO: 10-19 years old

In general: second decade of life, time between “childhood” and “adulthood.”

Adolescents are:



- Not children
- Not adults
- Childlike in thought and behavior maybe
- Adult physically perhaps
- Have ongoing brain changes and cognitive maturation

MILESTONES OF ADOLESCENT DEVELOPMENT

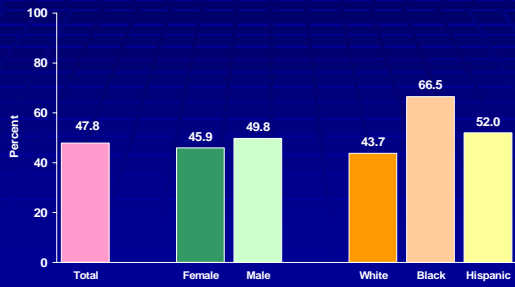
- **Body image concerns/puberty:** early adolescence mostly, cognitive changes begin
- **Independence/emancipation:** ongoing throughout, risk-taking behaviors during middle adolescence
- **Identity formation (including *sexual identity*):** ongoing throughout
- **Future orientation/delineation of functional role:** late adolescence mostly, mortality issues

PROCESSES ARE UNIVERSAL AND CONSISTENT

HIV/AIDS AND YOUTH

- Approximately 56,000 new HIV infections occur each year in the United States (**CDC-2008**).
- CDC estimates that half of new HIV infections in the US occur in people < 25 y/o.
- **CDC estimates that one young person per hour of every day is infected with HIV.**
- YRBS-2007 indicates nearly half of high school students are sexually active by 12th grade.
- Of reportable STDs, 2/3 occur in 15-24 y/o's.

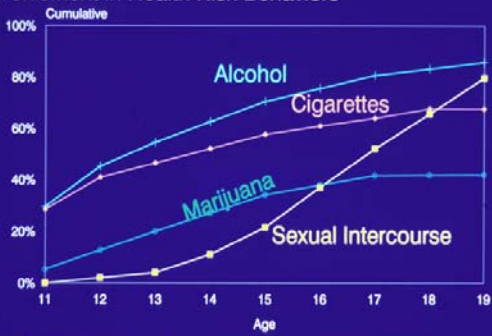
Percentage of High School Students Who Ever Had Sexual Intercourse, by Sex* and Race/Ethnicity, 2007**



* M > F
** B > H > W

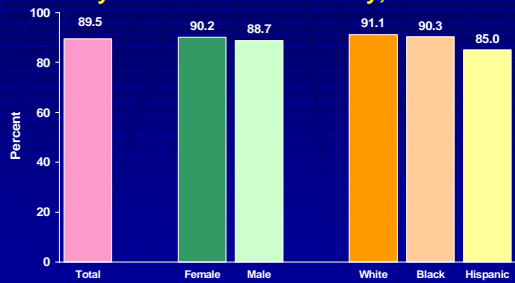
National Youth Risk Behavior Survey, 2007

Involvement in Health Risk Behaviors



Sources: See LIT Module 1 reference list

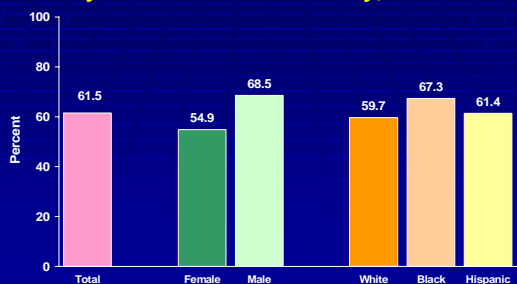
Percentage of High School Students Who Were Ever Taught in School about AIDS or HIV Infection, by Sex* and Race/Ethnicity, 2007**



* F > M
** W, B > H

National Youth Risk Behavior Survey, 2007

Percentage of High School Students Who Used a Condom During Last Sexual Intercourse,* by Sex** and Race/Ethnicity,*** 2007



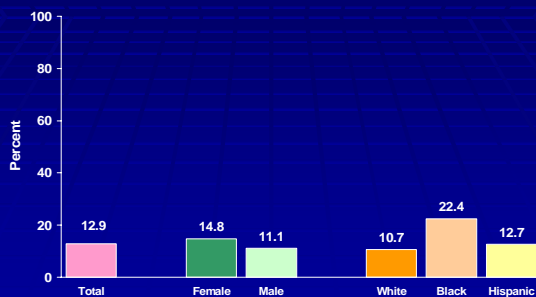
* Among the 35.0% of students nationwide who had sexual intercourse with at least one person during the 3 months before the survey.
 ** M > F
 *** B > W
 National Youth Risk Behavior Survey, 2007

Percentage of High School Students Who Used a Condom During Last Sexual Intercourse,* 1991 – 2007



* Among students who had sexual intercourse with at least one person during the 3 months before the survey.
¹ Increased 1991-2003, no change 2003-2007, p < .05
 National Youth Risk Behavior Surveys, 1991 – 2007

Percentage of High School Students Who Were Tested for HIV*, by Sex** and Race/Ethnicity,*** 2007



* Does not include tests conducted when donating blood.
 ** F > M
 *** B > W, H
 National Youth Risk Behavior Survey, 2007

Overview of Health Care Transition

Background and Significance

- Approximately 13% of children have special health care needs
- > 90% reach adulthood
- Less likely to:
 - finish high school
 - pursue postsecondary education
 - find a job
 - live independently

USDHHS, 2001

Definition

- Health care transition is a purposeful, planned process that supports adolescents and young adults with chronic health conditions and disabilities to move from child-centered (pediatric) to adult-oriented health-care practices, providers, programs, and facilities.

Blum et al., 1993

Why Now?

- **Medical Advances**
 - Increase in survival rates and disability risk
- **Societal Expectations**
 - Independence, self-sufficiency
- **Legal Requirements**
 - Age of majority
- **Professional Guidelines**
 - Pediatrics, Adolescent Medicine, Family Practice, Internal Medicine

Importance of Planning

- HCT doesn't happen automatically
- Young adults with disabilities and special health care needs often require ongoing medical care
- Expertise of care needed
- Anticipation of need for health insurance
- Social and legal aspects of independence; integration of medical and social/environmental factors
- Requires time, practice, and teamwork

Study Results: All Stakeholders

▪ Perceptions

Health care transition = changes that occur in service provision

(e.g., identifying and moving from pediatric provider to an adult provider)

All Stakeholders (cont)

Experiences/ Practices

Minimal attention to preparing youth:

- Learning about health insurance
- Improving communication skills
- Knowing their legal rights
- Taking medication independently
- Describing own medical condition or special needs
- Accessing community resources

All Stakeholders (cont)

Barriers

- **Lack of availability and quality of adult providers who are:**
 - Trained in pediatric onset conditions
 - Willing to take primary responsibility for care
- **Lack of communication among providers**
- **Lack of information about community resources and services for adults**

Pediatricians: Other Barriers

Parents who are:

- Overly emotional
- Overprotective
- Unrealistic expectations

Systemic barriers

- Adequate health insurance after age 18
- Adult systems fragmented and complex
- Lack of transportation
- Minimal case management in adult practices
- Limited public assistance for adults with disabilities

Limitations of Pediatricians

- **Pediatrician Perspective:**
Role = Referral to adult health provider
- **Family Perspective:**
Pediatric providers do not address psychosocial aspects of transition
- **Pediatricians look to families and other support systems to prepare youth for *non-clinical* aspects of transition**

Adult Providers: Other Barriers

- **Small % of patients with disabilities referred by pediatric providers**
- **Pediatricians do not:**
 - Initiate contact
 - Arrange for systematic transfer of records
 - Co-manage care during transition

Adult Providers: Other Barriers (cont)

- **Pediatricians and families do not create expectations to become independent**
- **Youth not involved early enough in decision-making**
- **Families rely on external rather than internal support systems**

Limitations of Adult Providers: Contributing Factors

1. Managed care guidelines
2. Low reimbursement rates
3. Time required
4. Communication barriers
5. Lack of resources/supports
6. Lack of information about existing community agencies/services

Limitations of Adult Providers (cont)

7. Limited training and experience
8. "Word of mouth" could result in an overwhelming number of medically complex patients
9. Design of medical facilities:
 - Lack of ADA-compliant equipment
 - Non-accessible spaces
 - Waiting rooms problematic

Provider Recommendations

- Explore new models of health care
 - Specialties in "transition" and "disability" medicine
 - Network of primary care physicians
 - Clinics specializing in this population
 - Medical certification
 - More RNs and ARNPs
 - Utilizing AHECs to provide training

Provider Recommendations (cont)

- **Training and Information for Providers**
 - Local clearinghouses for information-sharing
 - Disability toolkit for adult practitioners
- **Training youth and families to become independent in own care**
- **Change in Medicaid reimbursement**
- **Private sector funding to pilot innovative approaches to care**

Youth and Families: Barriers

- 1. Not well-informed or prepared about adult service systems:**
 - Fewer available programs
 - Stricter eligibility criteria
 - Increased financial burden
 - Termination of childhood support systems
- 2. Pediatricians not proactive in planning for transition**

Youth and Families: Barriers (cont)

- 3. Confusion about available resources**
- 4. Do not teach youth to take responsibility for managing own care**
- 5. Unaware of legal implications when youth reach age of majority**
- 6. Communication is a significant barrier**
- 7. Worry about finding a knowledgeable, caring adult provider**

Youth and Families: Severe Disabilities

- Fear and uncertainty about their child's future as both parent and child grow older
- Social stigma and lack of support network should something happen to parent(s) or caregiver(s)
- Emotional and physical interdependence

Educators and Community-Based Service Agencies

- Receptive to integrating health care management skills into school- and community-based programs
- Families need to understand the relevance of teaching health care self-management
- Importance of cross-training health care professionals and social service providers

Conclusions

- We found multiple gaps in the transition process which need to be addressed in order to help this special population have a more successful transition to adult health care
- Research data were used to develop a multi-level health care transition education and training program
 - HCT Information & Resource Guide
 - School-based curriculum for high school students in special education
 - Research data helped facilitate a disability curriculum for the USF College of Medicine

Highlights

- Staff Training
- Curriculum
 - Development: multidisciplinary expert team, physical and mental health issues
 - Highlights: 7th grade reading level, 40+ hours of instruction over 8 weeks, multiple components (including personal health journal and medical summary)
 - Evaluation: high level of interest, perceived relevance, and satisfaction; statistically significant gains in knowledge

Curriculum: Topics

- Importance of self-determination
- Rights and responsibilities at age 18
- Managing medication needs, reading prescription labels
- Communicating with health care providers
- Finding adult physicians
- Health insurance, filling out medical forms
- Sexual health, keeping safe

All USF program materials can be downloaded at <http://usfpeds.hsc.usf.edu/adolescent>

- Student Curriculum, Teacher's Guide
- Information & Resource Guide
- Comprehensive Project Evaluation
- USF Medical Student Disability Curriculum



For more information, contact:

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Diane Straub: dstraub@health.usf.edu, (813) 259-8713

Additional (excellent!) resources can be found at:
<http://hctransitions.ichp.edu/ddcouncil>

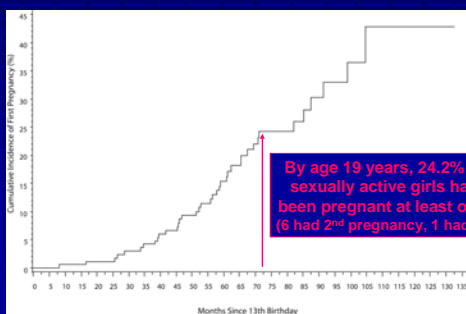


Pediatric HIV Infection in the United States

Courtesy Jim Oleska

- With effective prevention of most new perinatal HIV infection, it is estimated that <250 newly infected infants are born annually in the U.S. (**<2% MTCT rate with prophylaxis**)
- Effective therapies for HIV in children have **prolonged life** and quality of life (Lee GM et al. *Pediatrics* 2006;117:273-83).
- The median age of over 3,500 HIV-infected children followed at pediatric clinical trials sites is **14.8 years** (219 study summary, July 23 2007).

Cumulative Incidence of First Pregnancy in 174 Perinatally HIV-Infected Sexually Active Girls Age >13 Years, PACTG 219C
 Brogly SB et al. *Am J Public Health* 2007;97:1047-1052



By age 19 years, 24.2% of sexually active girls had been pregnant at least once (6 had 2nd pregnancy, 1 had 3rd)

Two Epidemiologic Subgroups of HIV-Infected Youth

- Perinatally-infected
- Behaviorally-infected
- These two groups have both distinct and shared clinical and psychosocial characteristics

Unique Clinical Issues

Perinatal:

- great growth in size of this cohort
- more likely to have depressed immune function and require HAART
- more likely to be at advanced stages of HIV disease
- more likely to have history of previous OI's with complications and deficits
- more likely to have heavy past ARV medication exposure and therefore more multi-drug resistance
- greater obstacles to achieving functional autonomy due to physical and developmental deficits
- higher mortality rates

Mental Health in HIV-Infected Children and Youth

Scharko AM. AIDS Care 2006;18:441-5

- Review of 8 studies including 328 HIV-infected children age 4-21 years; data were compared to prevalence in overall population.
- Prevalence of mental health disorders:
 - Attention deficit disorder: 24%
 - 6.0-fold increased risk ratio
 - Anxiety disorder: 29%
 - 3.8-fold increased risk ratio
 - Depression: 25%
 - 7.1-fold increased risk ratio

Unique Clinical Issues

Behavioral:

- more likely to be "healthy"
- more likely to be in earlier stages of HIV disease
- less likely to require HAART
- less likely to be resistant to ARV medications
- more likely to receive simpler HAART regimens when needed
- more likely to achieve functional autonomy
- have long-term chronic disease outlook

Differences in HIV Care Models: Pediatric vs. Adolescent vs. Adult

Pediatric:

- family-centered and multidisciplinary care with pediatric expertise in discreet and intimate family/child-friendly setting
- more longstanding relationship with care givers
- primary care integrated into HIV specialty care
- issues of HIV disclosure to patient
- youth's rights for confidentiality and consent
- "teen services" supplemental to existing services
- need for specialty consultants (i.e. gynecologist) and/or additional training for age-appropriate care

Differences in HIV Care Models: Pediatric vs. Adolescent vs. Adult

Adolescent:

- teen-centered and multidisciplinary in discreet, teen-friendly, and intimate setting
- maybe minimal to no relationship with parent/care giver
- primary care approach integrated into HIV care
- issues of confidentiality, consent, and disclosure
- care usually includes "core" teen health care services (sexuality, pelvic examinations/Pap smears, STD screening & tx, reproductive health, substance use, prevention education, adherence approaches)

Differences in HIV Care Models: Pediatric/Adolescent vs. Adult

Adult:

- adult-oriented care based on stricter medical model
- adult medical providers more often ID specialists (rather than pediatric/adolescent generalists)
- adult patients expected to behave as "adults"
- transitional issues usually not given any systematic specialized focus
- clinics tend to be very large, maybe intimidating, and easy for transitioning patients to "slip through the cracks" unless very motivated

ATN 060 Transitional Care for Adolescents with HIV

Preliminary Report

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Background and Significance

- Advancements in HAART have resulted in a significant increase in life expectancy of HIV-infected individuals, with more pediatric patients transitioning to adult care.
- The transition process from pediatric to adult care for adolescents with chronic diseases, such as HIV, is always a challenge.
- There is limited information in the literature as to best practices.

Background and Significance

“And with young people who can really fall into this whole denial thing real easy—Well, this is painful for me to think about, and the only time I really think about it—because I don’t feel it and see it every day. But the only time I do is when I go to the doctor. Well, guess what? I just won’t go to the doctor.”

The purpose of this study was to collect data about characteristics of clinical care systems that may most effectively transition adolescents with HIV into adult care.

Research Questions

- 1. What strategies have been developed to assist patients in making a successful transition to adult medical care?
- 2. What are the factors considered in planning the transition process?
- 3. How are the approaches to transition different among the different disciplines?

Research Questions

- 4. What are the differences in the transition process for various subpopulations of youth?
- 5. What are the barriers to a successful transition?
- 6. What are the facilitators to a successful transition?
- 7. What criteria are used when considering adult referral sites, if any?

Methods

- One to three representatives designated as most responsible for transition at their respective ATN site were approached for participation in the study:
 - Telephone interviews
 - Request for written policies and procedures, patient hand-outs, flowsheets, documentation tools, etc.

Analysis:

- Routine qualitative research analysis plan

Results: Interviews

- 19 staff members (8 MSW/LCSWs, 7NPs, 2 MDs, 1 RN, and 1 Health Educator)
- All 14 eligible sites

ATN Site Characteristics

- Number of patients in care at each site
 - Min=40, Max=260, Median=90
- Age of clinic population
 - Up to 25 yo
- Annual number of patients transitioned
 - 4-16 per year

ATN Transition Characteristics

- Annual number of patients *successfully* transitioned cannot be accurately determined.
 - Lack of tracking system in adolescent sites:
 - HIPAA issues
 - Lack of IT connection b/t youth and adult sites
 - Lack of funding to pursue
 - "Success" has not been defined (being in/staying in care, taking meds vs. showing up for initial appointments?)

ATN Transition Characteristics

"And after the first visit, first two visits, we're like, 'Okay, they're good. They're fine,' and we don't realize-- because we don't keep up with the transition sites, and many of them don't call us to say, 'Hey, that guy you transitioned to us last year? He stopped coming.' We don't realize it. And when they pop up in someone's emergency room, often times, we are the name that they give."

ATN Transition Characteristics

- Recommended age for transition to adult care
 - 22-24 years
- Age at which the *process* of transition begins and length of transition *process*
 - Large variation among the sites (16yo, 2-6 yrs vs. at transfer)
 - Partly due to differences in definition of transition as process vs. event

ATN Transition Characteristics

*"...people have different ideas of what transition even means and we probably spent let's say two years just talking trying to teach the difference between **transfer** and **transition**."*

*"[some providers] focus more on **transfer** than **transition** where the job was to simply get them an appointment at the clinic rather than teach them how to call the clinic and arrange that themselves.... I called, I got an appointment so it is done."*

ATN Transition Characteristics: Responsibility for Transition Process

- All sites mentioned a multi-disciplinary responsibility:
 - Lead (if mentioned) tended to be:
 - Social workers/case managers
 - Nurse practitioners
 - Variability among perceived roles
- Sites with most developed processes had developmental approach:
 - *"The other conflict that we found is that if you do not understand adolescence as a development process itself then your expectations of each individual are beyond their capability."*

Policies, Procedures & Processes

Majority of sites did not have formal policies, procedures, and processes

Sites with most developed processes describe revisions over time:

"A lot of the kids who transitioned really early on, they had a lot of anger at us because we were setting them up.... putting them out into this adult world without any tools and they were right. So we've really learned from our mistakes and they've taught us a lot about what we did wrong in the beginning. So learning from them and moving forward we continue to learn and... we have to be strong and we have to say no... that we are no longer your provider."

Policies, Procedures & Processes

- 5 clinics have written policies
 - Age to initiate the transition process
 - Staff responsibilities with time-lines
 - Objectives for the process of transition
- 3 clinics have transition specific documentation
- Use of existing resources (i.e., AETC resources, "health literacy checklist")

Differences in the transition process for subpopulations of youth

- Age
 - Relatively consistent (22-24 y/o), but developmental level of young adults helps determine when transition process is initiated
- Perinatal vs behavioral infection
 - Little impact on transfer to adult care
 - Impact on transfer to adolescent clinic (develop “typical teenager behavior”)
- Medical complexity/acuity
 - “Sick” patients allowed to stay longer
 - More medical communication
 - More likely to refer to university practice

Differences in the transition process for subpopulations of youth

- Gender
 - Minimal impact, except as related to pregnancy and sexual orientation
- Pregnancy
 - Often referred out, return afterwards but sometimes transitioned earlier
- Sexual orientation
 - Emphasis on matching patient to adult clinic site (i.e., “gay-friendly” environment)

Perceived Facilitators of “Successful” Transition

- Patient maturity
- Patient independence
- Strong support system
- Matching patient to adult provider/clinic
 - Sexual orientation
 - Confidentiality
 - Access – location, transportation

Perceived Facilitators of “Successful” Transition

- A single contact person at the adult clinic
- Case management follow-up after transfer
 - *“Sometimes we are the only family that they have ever known in a long-term relationship. That is just part of the process and I’m not sure [it’s] all bad.”*
- Flexibility in process

Perceived Barriers to “Successful” Transition

- Mental Health
- Substance Abuse
- ‘AIDS’ clinic:
 - Lack of anonymity
 - Complexion of adult clinic vs. pediatric clinic
 - Very ill patients
 - *“One of the scariest things for the kids, is adult clinics sound scary....The people are afraid--the adult patients look so sick and that...you know, [that is] what they’re going to look [like] some day. And they’re afraid of that.”*
- Lack of knowledge regarding adult clinic models of care and procedures

Models of Transitioning

- Tour prospective clinical sites
- Visit to adult clinic prior to transfer of care
- Interaction between pediatric and adult settings:
 - Adult provider included in an adolescent clinic visit
 - Adolescent clinic member accompanies patient to first adult provider appointment
 - Provider splits time between adolescent and adult clinic

Models of Transitioning

- Peer partner or care advocate assistance
- Continued support after transition
 - Encourage feedback from young adult after transfer of care
 - Provide support (“counseling”), but not medical care (undermines process)

Models of Transitioning

- Education/support groups working on life skills
 - Classes/individual coaching on life skills that young adults would need to be successful in the adult world
 - Knowledge: meds, labs
 - Skills: how to get prescriptions filled, arrange transportation, schedule appointments
 - Self-advocacy

“It is so easy for people who don’t have a developmental background to write off the adolescent care that we give as coddling patients and things like that when it’s actually that we’re building life skills. I think you have to be focused, you have to have goals, clients have to partner and go along with these goals....I think it’s a very holistic approach to get a successful transition to adult care.”

Models of Transitioning

Preparation for adult care setting:

- Review expectations: different environment
 - Very ill, “scary” patients
- Role-playing:
 - *“We also did...like assertiveness training. When we talk to them about how to assert themselves with [the] doctor, when you go in to see the doctor at this new site...the doctor is ... going to probably have ten or fifteen minutes with you. So he’s going to have an agenda. He’s going to come in, he’s going to rush, and that, if you’re really not prepared for that, he might come across as somewhat intimidating. So we talked about preparing them for that visit, teaching them to ask...write down questions.”*

Models of Transitioning

Preparation for adult care setting:

- Graduation ceremony
 - *"The bulk of us think of it as it's almost like a graduation. Like, "Congratulations, you're an adult now. And you're going to do great," as we've hopefully prepared them for managing a chronic illness for the rest of their life, and navigating the health care system.... Our attitude towards it makes a big difference."*

Limitations

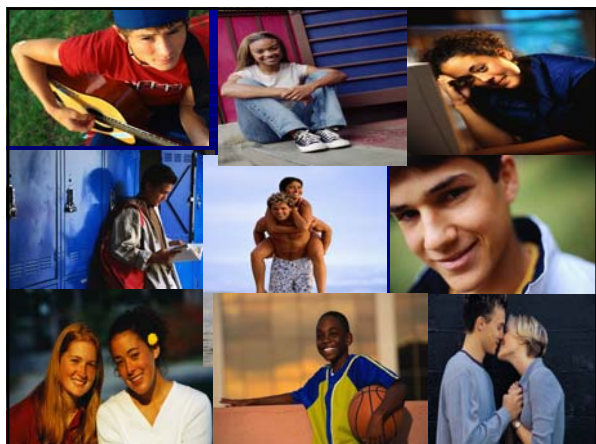
- Definition of "successful" transition
- Lack of tracking of transition at ATN sites

Next steps

- Determine best practices
- Develop, implement, and evaluate intervention(s)

Conclusions:

- Transition is HARD!
- Encouraging perspective:
 - *"We actually find it to be really exciting because, when you think about it, before, we were working really hard to engage people in care, but we were engaging them with the idea that they were going to die. That's the truth. So for us, transition is, like, such a hopeful thing because the idea behind it is that young people have a future. So we actually find it to be really exciting."*



TRANSITIONING YOUTH INTO ADULT CARE

Principles of Transitioning

- Process vs. event
- Begins at the day of diagnosis
- Provider reminders to ***let go***
- Adolescent must be involved in the decision-making
- Coordination across the SYSTEMS is essential

Where to Begin...

- Have a clinical infrastructure in place
- Develop a program transition protocol
- Identify appropriate adult care providers who are comfortable with the age group developmentally and familiar with chronic diseases of youth
- Consider patient-specific issues

...how to continue

- Establish client focus groups
- Include youth in transition policy development
- Formulate and implement screening tools
- Develop "Life Skills" curriculum
- "Graduate" class
- Understand that process is fluid and dynamic

Interdisciplinary Team

- Physicians
- ARNPs
- Nurses
- Social Workers
- Case Managers
- Psychologists
- Dietitian
- Peer Educator/Advocate
- CAB



Recommended Strategies

Models of Care

- Create a clinic specifically for teens/young adults (perhaps evenings or Saturday mornings)
- Have an "adult" doctor staff the teen clinics (once a month, weekly) for youth to establish a relationship with this provider before the transition
- Establish a Med-Peds care model
- Have co-located clinic setting

LIFESKILLS EDUCATION PROJECT TOPICS

- Anger Management
- Communication Skills
- Writing Skills Workshop
- Getting the Right Job
- Handling Stress
- Navigating Health Care System
- Keeping Healthy
- Building Job Interviewing Skills and Resumes
- Our Money: How Can We Make It Last
- Sexual Activity Factors
- Street Drugs: What They Do To Us
- I'm So Blue...What to Do

LESSONS LEARNED

- Need for ongoing evaluation!
- Esteem and confidence issues remain.
- Knowledge gap among adolescents regarding transition.
- Decrease in medical appointment adherence due to atmosphere and style of engagement found in adult clinic settings.
- Uncertainty about insurance eligibility, financial concerns, and service rules.

5 TAKE HOME TIPS

- Have a structured plan in place.
- Discuss transition early on.
- Offer options.
- Work with "appropriate" adult providers.
- BE FLEXIBLE!

•RESOURCES

- HRSA *Treating Adolescents with HIV*: www.hivcareforyouth.org
- CDC Website: www.cdc.gov
- National Institute of Allergy and Infectious Diseases Website: www.niaid.nih.gov/factsheets/hivadolescent
- HRSA HIV/AIDS Bureau: www.hab.hrsa.gov
- Friedman LB, Dyson JA, Rathore MH; "Adolescent Issues" in *HIV/AIDS Primary Care Guide*, Beal J, et. al. (eds.), Crown House Publishing Company LLC, Norwalk, CN; pp 485-493 (Chapter 35), 2006.

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