Health Care Transition & Title V Care Coordination Initiatives: Webinar Series

Webinar #2 | March 28, 2018

TRANSITION PREPARATION

Michelle Jiggetts, MD, MS, MBA
Program Administrator
Complex Care Program and Parent Navigator Program
Children’s National Health System’s Goldberg Center

Patience White, MD, MA
Co-Director, Got Transition
The National Alliance to Advance Adolescent Health
Disclosures and Funding Source

Michelle Jiggetts and Patience White have no financial disclosures or conflicts of interest.

Got Transition, a program of The National Alliance to Advance Adolescent Health, is funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, DHHS.
Got Transition’s Webinar Series Goals

• Support state Title V implementation and measurement of health care transition (HCT) in care coordination programs
• Guide care coordination improvements by sequentially building on the evidence-informed Six Core Elements
• Share promising practices from state Title V-supported care coordination programs (CC)
• 5-session webinar series on HCT and care coordination
• The webinars and handouts will be available following each session at www.gottransition.org
Webinar #2
Objectives

At the conclusion of Webinar 2, attendees will be able to...

• Identify key components of HCT policy for CC programs that families/youth want to know

• Customize transition readiness assessment (RA) for CC programs

• Pilot and disseminate HCT policy and RA

• Incorporate RA skill needs into plan of care and educate youth and families on needed skills

• Prepare medical summary and emergency care plan with youth and families and their providers
Webinar #2 Handouts

1. Webinar #2 Slideshow
2. iPhone and Android Info sheets
3. Got Transition RA
4. Youth with ID/DD and parent readiness assessments
5. Medical Summary for youth with ID/DD
Webinar #1 REVIEW

- HCT Clinical Foundations
- HCT Performance Measurement
- Title V Baseline Assessment
- Starting a HCT Pilot using Quality Improvement and the Core Element Processes
Six Core Elements of HCT: Transitioning Youth to an Adult Clinician

1. Transition Policy
2. Transition Tracking and Monitoring
3. Transition Readiness
4. Transition Planning
5. Transfer/Integration into Adult-Centered Care
6. Transition Completion/Ongoing Care
Sample Forms and Templates

- Discuss transition policy
- Track progress
- Assess skills
- Develop transition plan
- Transfer documents
- Confirm completion

AGE 12-14
AGES 14-15-16-17-18
AGE 18-21
3-6 months after transfer
TRANSITION POLICY
Purpose: Formalize CC program’s approach, reduce care coordinators’ variability and offer a transparent approach to youth and families

Content:
- Define program approach and recommended ages for transition preparation for adult-focused care, transfer, and integration into adult care
- Clarify adult approach to care and legal changes at age 18
- Reading level should be appropriate

Post: Communicate it to all involved early in the process
Transition Policy Challenges

- How to establish a written HCT policy?
- What topics should be included in a policy?
- How best to get youth and family/caregiver involvement and feedback?
- How and with whom should the policy be shared?
Core Element #2: TRANSITION TRACKING & MONITORING

**Purpose:** Facilitate systematic data collection to improve quality at individual and population levels

**Content:**
- Demographic and diagnostic/complexity data
- Date of receipt of each core element (e.g., policy shared, readiness assessment administered, etc.)

**Format:** paper checklist, excel spreadsheet, EHR
Transition Tracking & Monitoring Challenges

- What information should be tracked – e.g., name, date of birth, case mix complexity, diagnosis, date of receipt of each core element?

- What options are available to track and trigger use of core elements within CC programs?
TRANSITION READINESS
"First they make you button your own shirt, then they make you tie your own shoes...you gotta ask yourself — where's this all heading?"
Core Element #3: TRANSITION READINESS

Purpose: Assess the youth’s skills to manage their health/health care in the adult approach to care.

Content:
- Ranks importance of changing to adult provider before age 22
- Ranks confidence about ability of changing to adult provider
- Assesses self-care skills related to own health and using health care services

Use:
- Completed several times during the transition process
- Used as a discussion tool to plan skill-building education
- Does not predict transition success
- Customized to meet the needs of the practice’s population
Transition Readiness or Self-Care Assessment

Assessment indicators of importance and confidence added to the readiness assessment tool (post testing)

- Drawn from decision making & motivational interviewing content
- Includes questions with rating scale:

1. **Importance**: *How do you feel at this moment about Moving to a doctor who cares for adults? How important is it to you personally to manage your own health care?* (If 0 was not important and 10 was very important, what number would you give yourself?)

2. **Confidence**: *If you decided right now to transfer to an adult provider, how confident do you feel about succeeding with this?* (If 0 is not confident and 10 is very confident, what number would you give yourself?)

**Clinician action**: If importance rating is low, focus on this first; If ratings are roughly equal, start with importance
Strategies for Youth Uptake of Key Health Information Knowledge

Smart Phone

- Majority of youth/young adults have a cell phone
- Add health information to their phone e.g. diagnosis, allergies, medications, who to contact in an emergency
- Accessible without a passcode for access (EMS, others)
- Facilitates their ability to communicate/keep track of key health information
- Example: Health Apps for iPhones
ACP Council on Subspecialties Transition Initiative

• Partnership with Got Transition in 2016
• Customized Six Core Elements’ transition readiness assessment, self-care assessment, and medical summary for selected conditions (teams included representatives from pediatric and adult professional and patient groups):
  o General Medicine (SGIM, SAHM, HCTN, ACP, AAP, AAFP, AOA, Med-Ped Program Directors)
  o ID/DD
  o Physical disabilities
  o Hematology (Hemophilia, Sickle Cell Disease), Cardiology (CHD), Endocrine Society (Diabetes), Gastroenterology (IBD), Neurology (Epilepsy), Nephrology (ESRD), Rheumatology (JIA, SLE)
• Available at www.gottransition.org under News and Announcements or ACP website www.acponline.org
Pediatric to Adult Care Transitions Tools

Transition Readiness Assessment for Youth with Intellectual/Developmental Disabilities

This document should be completed by youth with intellectual or developmental disabilities who are under the age of 18 years old in order to assess their readiness to transition to an adult health care provider. If a youth's intellectual or developmental disabilities prevent him or her from independently filling out this document, the youth's caregiver should fill out the caregiver version of this Transition Readiness assessment form instead.

Please fill out this form to help us see what you already know about your health and using health care and areas that you need to learn more about. If you need help completing this form, please let us know.

Date:

Name: ___________________________ Date of Birth: ________________

Legal Choices for Making Health Care Decisions

☐ I can make my own health care choices.
☐ I need some help with making health care choices (Name: ____________ Consent: ____________).  
☐ I have a legal guardian (Name: _______________).  
☐ I need a referral to community services for legal help with health care decisions and guardianship.

Personal Care

☐ I care for my all my needs.
☐ I care for my own needs with help.
☐ I am unable to provide self-care, but can direct others.
☐ I require total personal care assistance.

Transition and Self-Care Importance and Confidence

On a scale of 0 to 10, please circle the number that best describes how you feel right now.

How important is it to you to take care of your own health care and change to an adult doctor before age 22?

<table>
<thead>
<tr>
<th>0 (not)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 (very)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How confident do you feel about your ability to take care of your own health care and change to an adult doctor before age 22?

<table>
<thead>
<tr>
<th>0 (not)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 (very)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

My Health

Please check the box that applies to you right now.

Yes, I know this. I need to learn. Someone needs to do this. Who?

I know my medical needs.


Transition Readiness Challenges

• What skills about health and health care are important for CC clients to know?
• How can youth and family/caregiver involvement and feedback on the RA be obtained?
• When should transition readiness be assessed?
• Will youth and parents complete the RA on their own or will the CC administer the RA?
Core Element #4: TRANSITION PLANNING

**Purpose:** Establish agreement between youth and CC and/or clinician about set of actions to address priorities and access current medical information

**Content:**
- Identify what matters most to youth in becoming adult beyond health goals
- Define how learning about health and health care supports youth's overall goals (add readiness assessment skill needs to the plan)
- ACP project developed POC templates for ID, physical disabilities along with some subspecialty diseases (see www.gottransition.org)

Also complete portable medical summary and emergency care plan with “special information” non medical for adult provider
### Pediatric to Adult Care Transitions Tools

#### Medical Summary & Emergency Care Plan for Young Adults with Intellectual/Developmental Disabilities

This document should be completed by medical providers, in collaboration with youth and their caregivers. A copy of this completed document should be shared with and carried by youth and caregivers to facilitate comprehensive information transfer and chart review when establishing care with new medical providers.

**Date Completed:**
**Date Revised:**

**Contact Information**

- **Name:** [Enter Name]
- **DOB:** [Enter Date of Birth]
- **Preferred Language:** [Enter Preferred Language]
- **Address:**
  - **Cell #:** [Enter Cell Number]
  - **Home #:** [Enter Home Number]
  - **E-Mail:** [Enter Email]
- **Parent/Caregiver:**
  - **Name:** [Enter Parent/Caregiver Name]
  - **Relationship:** [Enter Relationship]
  - **Address:**
  - **Cell #:** [Enter Cell Number]
  - **Home #:** [Enter Home Number]
  - **E-Mail:** [Enter Email]
  - **Health Insurance/Plan:** [Enter Health Insurance/Plan]

**Please add special information about strengths that the youth/caregiver wants their new health care team to know:**

<table>
<thead>
<tr>
<th>Developmental Disability</th>
<th>Sensory System</th>
<th>Verbal</th>
<th>Non-Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous System:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention deficit disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Down syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fragile X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prader-Willi Syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sipina bifida</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tourette Syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Degenerative:</th>
<th>Co-occurring Psychological Issues:</th>
<th>Metabolism:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscular dystrophy</td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relational</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-injurious Behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (Specify):</td>
<td></td>
</tr>
</tbody>
</table>

**Adolescent Functioning Domain**

- **Communication:**
- **Self-Distraction:**
- **Community Activities:**
- **Work:**
- **Functional Academics:**
  - **Functional Grade Level:** [Enter Grade Level]
  - **Date Tested:** [Enter Date Tested]
  - **IQ:** [Enter IQ]
  - **Date Tested:** [Enter Date Tested]
- **Home Living:**
- **Leisure:**
- **Sleep Issues:**
- **Nutritional Issues:**
- **Quality of Life Issues:**
- **Safety Issues**

**Emergency Care Plan**

- **Emergency Contact:**
  - **Relationship:** [Enter Relationship]
  - **Phone:** [Enter Phone]
- **Preferred Emergency Care Location:**
- **Common Emergent Presenting Problems**
- **Suggested Tests**
- **Treatment Considerations**

**Special Concerns for Disaster:**

- **Allergies and Procedures to be Avoided**
  - **Allergies:**
  - **Reactions:**

- **To be avoided:**
  - **Why:**
- **Medical Procedures:**
- **Medications:**

**Diagnoses and Current Problems:**

- **Problem**
  - **Details and Recommendations**
- **Primary Diagnosis**
- **Secondary Diagnosis**
- **Behavioral**
- **Communication**
- **Food & Swallowing**
- **Hearing/Vision**
- **Learning**
- **Orthopedic/Musculoskeletal**
- **Physical Anomalies**
- **Respiratory**
- **Sensory**
Transition Planning Challenges

• How to incorporate HCT into plan of care?
• How can youth and family/caregiver involvement and feedback on HCT plan of Care be obtained?
• How can CC programs enable HCP to complete medical summary and emergency care plan?
• Who will provide needed self care education?
What to do? Where to start?
Introductory Remarks

Djinge Lindsay, MD, MPH
Deputy Director for Policy and Programs
Community Health Administration (CHA)
Parent Navigators:
Making the Transition Connection in DC

Got Transition Webinar
Health Care Transition & Title V Care Coordination
“Transition Planning”

Michelle Jiggetts, MD, MS, MBA
March 28, 2018
Objectives

• Discuss History of Parent Navigator Program
• Discuss role of Parent Navigators
• Discuss Transition integration into the Medical Home setting using the Six Core Elements
• Next Steps
Parent Navigator Program: Our Story

- Program established in 2008
- Based in Goldberg Center for Community Pediatric Health
  - Children’s National COE
  - Support from DC DOH and Maryland DHMH
- Composed of parents of children with special health care needs (CSHCN) employed by the hospital to provide peer support to other families of CSHCN
  - Currently have 6 full time PN’s
  - Available to families of CYSHCN receiving primary care and complex care services at Children’s National
Parent Navigator: A Key Member of the Medical Healthcare Team

- Primary Care Medical Home
- School Nurse
- Specialty Physicians
- Community Therapists
- Private Duty Nurse
- Inpatient Care Team
- Insurance Case Manager
- Parent Navigator

[Image] Children's National
Roles and Responsibilities

Based on Pediatricians and Family Needs

- Provide Peer-to-Peer support
- Coach families how to advocate for their child
- Help families to communicate more effectively with health care professionals
- Coach families how to navigate services throughout the hospital and in the community
- Link families to community and educational resources
- Work with families to understand their educational rights and responsibilities (e.g. IFSP, IEP, 504)
- Provide follow-up with families to ensure needs are met
- Prepare families for transitioning to adult health services
Integrating Transition

• Formulated a Transition team
  – Program Administrator, Navigators, Physicians from both primary and adolescent departments
• Facilitate bi-weekly transition meetings
• Reviewed Six Core Element toolkit
• Performed a Self-Evaluation
• Designed Transition Integration according to the Six Core Elements
Self Evaluation

- Reviewed ‘Got Transition’ National Standards
Putting the Six Core Element Pieces Together
Transition Policy

Six Core Element National Standard

- Develop a transition policy/statement with input from youth and families that describe the practice’s approach to transition, including privacy and consent information.
- Educate all staff about the practice’s approach to transition, the policy/statement, the Six Core Elements, and distinct roles of the youth, family, and pediatric and adult health care team in the transition process, taking into account cultural preferences.
- Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care.

Navigator’s Role

- A Transition policy/statement has been developed, uploaded to our intranet.
- Educated management staff and Adolescent providers on the particulars of the policy.
- Policy is discussed with youth and families, beginning at age 14 when the Readiness Assessment is completed.
Transition Tracking & Monitoring

**Six Core Element National Standard**

- Establish criteria and process for identifying transitioning youth and enter their data into a registry.
- Utilize individual flow sheet or registry to track youth’s transition progress with the Six Core Elements.
- Incorporate the Six Core Elements into clinical care process, using HER if possible

**Navigator’s Role**

- Established criteria and process for identifying transitioning youth and enter their data into a registry.
  - All children between 14-21 years with complex medical needs, autism and developmental delay
  - Receive a list every week of eligible teens that have upcoming appointments
  - List is divided up among navigators according to alphabet
- Created a registry to track youth’s transition planning
## PN Transition Registry

### Excel Registry

<table>
<thead>
<tr>
<th>First Name</th>
<th>Age</th>
<th>Primary Service Location</th>
<th>Primary Insurance Name</th>
<th>Attempt Dates</th>
<th>First Attempt Date</th>
<th>Projected 2nd Attempt Date</th>
<th>Actual 2nd Attempt Date</th>
<th>RA Obtained?</th>
<th>RA Admin. Date</th>
<th>Goals Discussed</th>
<th>Adult Provider Identified</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD</td>
<td>14</td>
<td>Adolescent Health Center</td>
<td>HSCSN</td>
<td>10/13/2016</td>
<td>10/13/2016</td>
<td>10/16/2016</td>
<td>Yes</td>
<td>10/13/2016</td>
<td></td>
<td>know doctor's name and number, make appts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KM</td>
<td>19</td>
<td>CHC Anacostia</td>
<td>DC MEDICAID</td>
<td>9/26/2016</td>
<td>9/26/2016</td>
<td>9/29/2016</td>
<td>Yes</td>
<td>10/10/2016</td>
<td></td>
<td>patient to work on explaining medical needs to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LR</td>
<td>16</td>
<td>Good Hope Road Health Center</td>
<td>AMERHEALTH DC MEDICAID</td>
<td>9/28/2016, 10/21/2016</td>
<td>9/28/2016</td>
<td>10/1/2016</td>
<td>10/21/2016</td>
<td>Yes</td>
<td></td>
<td>put PCP and pharmacy numbers in cell phone</td>
<td></td>
<td>mother appreciates our preparing for adult transition</td>
</tr>
</tbody>
</table>

### Components of the Transition Registry

- Name
- Patient Residence
- Service location
- Insurance
- Attempts Made (1\textsuperscript{st}, 2\textsuperscript{nd}, 3\textsuperscript{rd})
- Date RA Obtained
- Goals Discussed
- Adult Provider Name
- Date of Appt.
- Feedback
Transition Readiness

Six Core Element National Standard

- Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care
- Jointly develop goals and prioritized actions with youth and parent/caregiver and document regularly in a plan of care

Navigator’s Role

- Conduct regular transition readiness assessments, beginning at age 14-21
  - Verification of cognitive level and age of patient to determine if the child or the parent should complete the Readiness Assessment (RA)
- Generate weekly calls to families
- Meet family at the visit
- Discuss goals and prioritize actions with youth and parent/caregiver.
- Utilize registry to track youth’s transition
  - RA documented in EMR
  - Telephone Encounter sent to provider seeing pt. to notify them of Administer the RA
Documentation of RA
<table>
<thead>
<tr>
<th>Actual Second Attempt Date</th>
<th>RA Obtained Yes/No</th>
<th>RA Admin. Date</th>
<th>Goals Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>2/3/2017</td>
<td>Mother obtaining Guardianship</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>5/14/2017</td>
<td>foster care - no goals</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>4/14/2017</td>
<td>Discussed Guardianship &amp; other decision making options</td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td>5/11/2016</td>
<td>Know where to get medical care when doctor's office is closed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/28/2016</td>
<td>Carry health info. (ins. card), make own doctor's appts.</td>
</tr>
<tr>
<td>12/15/2016</td>
<td>YES</td>
<td>12/15/2016</td>
<td>Mother obtaining Guardianship</td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Transition Planning

Six Core Element National Standard
- Including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and if needed, a condition fact sheet and legal documents.
- Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy and access to information.
- Determine level of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources.
- Plan with youth/parent/caregiver for optimal timing of transfer. If both primary and subspecialty care are involved, discuss optimal timing for each.
- Assist youth in identifying an adult provider and communicate with selected provided about pending transfer of care.
- Provide linkages to insurance resources, self-care management information and culturally appropriate community supports.

Navigator’s Role
- Prepare youth and parent/caregiver for adult approach to care at age 18. Start the discussion around Power of Attorney versus Guardianship.
- Determine level of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources.
- Dissemination of guardian decision making and guardianship brochure.
- Assist youth in identifying an adult provider and communicate with selected provided about pending transfer of care.
  - PN provides family an adult provider list.
- Provide linkages to insurance resources, self-care management information and culturally appropriate community resources.
Transfer of Care

Six Core Element National Standard

- Confirm date of first adult provider appointment.
- Transfer young adults when his/her condition is stable.
- Complete transfer package, including final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and all needed, legal documents, condition fact sheet, and additional provider records.
- Prepare letter with transfer package, send to adult practice and confirm adult practice’s receipt of transfer package.
- Confirm with adult provider the pediatric provider’s responsibility for care until young adult is seen in adult setting.

Navigator’s Role

- Navigator assists family with scheduling the initial adult primary care visit.
- Assists family with getting a copy of the medical visit summary and an immunization record.
Transfer Completion

**Six Core Element National Standard**
- Contact young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm transfer of responsibilities to adult practice and elicit feedback on experience with transition process.
- Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed.
- Build ongoing and collaborative partnerships with adult primary and specialty care providers.

**Navigator’s Role**
- Navigators contacts families approximately 2 wks. after the appt. to verify attendance.
Reasons for continuing to do this...

Parent Comments

• “I never really thought about guardianship, happy that you’re doing it.”

• “Don’t know what my child is able to do. I can start working on goals with my her.”

• “Wish I started this process earlier.”

• “Why are you starting at 14 years of age.”
Next Steps

- Develop Training workshops for families
- Develop Training workshops for providers
- Collaborate with hospital staff to strategize on making this a hospital-wide effort
Questions?

• About writing HCT Policy with staff, youth and family and sharing it with them?

• About customizing the RA?

• About creating a plan of care with HCT components such as with RA skill needs?

• About how DC’s Parent Navigator Program implements the 6 Core Element Process?
Upcoming Title V Care Coordination Webinars

Transfer to Adult Care
April 26, 3-4 pm ET

Integration into Adult Care
May 31, 3-4 pm ET

Youth, Young Adult, & Parent Engagement
June 28, 3-4 pm ET

To register, please visit Got Transition's website under Webinars (www.gottransition.org/webinars)
Thank You!

WEBSITE
www.gottransition.org
See link to new transition news and articles and download the Six Core Elements 2.0 packages to start making HCT quality improvements in your practice

EMAIL
mjiggett@childrensnational.org
pwhite@thenationalalliance.org

FACEBOOK PAGE
HealthCareTransition

TWITTER
@gottransition2
# Pediatric to Adult Care Transitions Tools

## Medical Summary & Emergency Care Plan for Young Adults with Intellectual/Developmental Disabilities

### Adaptive Functioning Domains

<table>
<thead>
<tr>
<th>Communication</th>
<th>Social</th>
<th>Self Direction</th>
<th>Community Activities</th>
<th>Work</th>
</tr>
</thead>
</table>

### Functional Academics

<table>
<thead>
<tr>
<th>Functional Grade Level</th>
<th>Date Tested</th>
<th>FSIQ</th>
<th>Date Tested</th>
</tr>
</thead>
</table>

### Home Living

<table>
<thead>
<tr>
<th>Leisure</th>
<th>Sleep Issues</th>
<th>Nutritional Issues</th>
<th>Quality of Life Issues</th>
<th>Safety Issues</th>
</tr>
</thead>
</table>

### Emergency Care Plan

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Common Emergent Presenting Problems</th>
<th>Suggested Tests</th>
<th>Treatment Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Special Concerns for Disaster

### Allergies and Procedures to be Avoided

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reactions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>To be avoided</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Procedures</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
</tbody>
</table>

### Diagnoses and Current Problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>Details and Recommendations</th>
</tr>
</thead>
</table>

*Primary Diagnosis*

*Secondary Diagnosis*

*Behavioral*

*Communication*

*Feeding & Swallowing*

*Hearing/Vision*

*Learning*

*Orthopedic/Musculoskeletal*

*Physical Anomalies*

*Respiratory*

*Sensory*

*Stamina/Fatigue*

*Other*