TransitionInAction Clinic Proposal
Submitted by Sonoran UCEDD
October 28, 2019

Introduction

For all young adults, the transition from adolescence to adulthood is a time of uncertainty when youth and families are navigating multiple systems to prepare for and plan the trajectory towards a quality, productive adult life. In particular, health care transitions from pediatric to adult medicine for young adults with special health needs are both extremely challenging and poorly managed. Their transitions are often not successful and routinely result in increased health disparities and poorer outcomes for this population (Lotstein 2010). This is a persistent and systemic problem of access and care coordination (AAP/AAFP/ACP 2011).

Within this time frame – characterized as *emerging adulthood* – it is critical that individuals "acquire the physical, cognitive, emotional and economic resources that are the foundation for later life health and wellbeing" [*2016 Lancet Commission* - Patton, et al, 2016]. It is at this point that these emerging adults are "biologically, emotionally, and developmentally primed for engagement *beyond their families*" [emphasis added, *ibid*]. Further, precisely *because* adolescents are primed for participation in life beyond their families, we must create broad reaching but coordinated opportunities to *directly* engage and empower *them* in all aspects of their lives.

Medical professionals all across the healthcare system are recognizing that without additional supports, this group of emerging adults will often experience worse health care outcomes compared with other young adults. Importantly, it is now recognized that a lack of protocols, tools, and inconsistent training for care coordination exists at all levels (Sharma 2013).

The proposed development/replication of a "Transition Clinic" and related activities outlined below address these transition issues explicitly. Succinctly, the clinic provides much needed protocols and tools to facilitate care coordination across systems. Equally important, the proposed clinic empowers emerging adults with disabilities and/or chronic health care needs by helping them understand their needs and to provide them a plan to practice decision-making, to explore, and to grow from real-world opportunities and connections.

Emphatically stated by the Lancet Commission, investing in adolescent health and wellbeing at the point of emerging adulthood yields the "triple benefit" of impacting 1] the immediate life of the young person, 2] the future adult life of that young person, and 3] the life of their own families in the future – in positive ways.

Background

The TransitionInAction Clinic, developed at the University of South Dakota Center for Disabilities (https://www.usd.edu/medicine/center-for-disabilities/transitions-clinic) is a

comprehensive, day long, multi-disciplinary team experience designed to assess a young adult's current status and future goals in the major life areas of health, education, employment, and independent living as they plan their transition to adulthood. Participants served by the clinic ranged in age from 16 to 21 and presented with a disability label of Autism, Intellectual Disability, Down Syndrome, Traumatic Brain Injury, Deaf Blindness, Fetal Alcohol Syndrome Disorder, and many with co-occurring mental health, behavioral, and health conditions.

The Clinic includes interviews, assessments, discussions, meetings with a family member and self-advocate peer mentor, a guided health care transition simulation, situational assessment mini work experiences, and one-on-one meetings with representatives from adult services (e.g., vocational rehabilitation, independent living, supported employment provider, family advocacy, mental health, benefits planning, and developmental disability resource coordinator). The *Transition Engagement Guide* (Parent-Johnson, Parent-Johnson, & Meier, 2017), a tool developed with a diverse group of stakeholders and pilot-tested with promising results, is used to guide youth with disabilities, families and health professionals in the development of an action plan that promotes assets, opportunities, and connections in preparation for transition from pediatric to adult healthcare.

Both the young adult and family participate in separate and together activities focused on allowing the team to get to know the young adult's strengths, interests and vision for the future. Together with the young adult and family member, the multidisciplinary Clinic team generates a comprehensive plan for transitions that is focused, coordinated and action oriented with specific recommendations for "next steps" as they relate to successful transitions. Resources and a clinic report highlighting recommendations are provided to enable sharing this information with other key people involved in the young person's transitions such as school, health care, and adult services. Clinic follow-up is conducted at regular intervals. Annual revisits as needed can be completed to update and address transition issues.

Of particular significance is the active role young adults with disabilities are reported to be taking in their health care and other transition planning and services. A component of the clinic focuses on self-efficacy and self-determination with emphasis on practicing goal setting and how to take steps to accomplish those goals. The youth themselves decide on something they would like to achieve in their life and receive help with identifying the steps they need to take. The parent agrees to support the youth in working on their goal and follow-up contacts check on the status and progress. For many youth, this is the first time they have actively participated in decision-making and self-direction in their lives. For many families, they never thought this was possible and began understanding how they might actually be restricting their son or daughter with taking part in these kinds of activities. For example, Lucas and his family participated in the clinic. Lucas was 18, had a diagnosis of deaf blindness, intellectual disability, and other health conditions. Lucas and mom decided he would become independent in taking his medications and obtaining his prescriptions. Mom contacted the pharmacist to let them know Lucas would be contacting him. Lucas called, requested his refill, and rode his bike to pick it up. Mom said "I never realized how much he could do on his own and how I was holding him back until I attended this clinic".

TransitionInAction Clini data suggest positive gains in important indicators for transition as well as increases in social networks, increases in opportunities to be independent, and increases in perceptions of what's possible. Perhaps most compelling is anecdotal evidence from the families and youth who participated.

Family Feedback:

"Now we have more resources than we ever could have imagined."
"I feel more confident in the transition process."
"The whole thing was very eye-opening."
"I had no idea this stuff was out there. Oh my gosh, this is what I needed!"
"….has become a different person since the Transition Clinic. He's doing more on his own, just more independent – he seems older."
"I hope…that other families will have this wonderful experience and to provide another young person the opportunity to use this great resource to assist them as they transition to the adult world. I highly recommend it! A++"

Young Adult Feedback:

"There were no low points to the day."
"I'm actually really glad I went here. I learned a lot about myself today. I have great ideas and resources now."
"….I learned a lot of new things; now the fun part will be applying it."

Adult agency personnel indicated how helpful spending time with the family and youth was, how they wish they could do this with all of their clients, and stated "this is what we should be doing." Teachers conveyed an appreciation for all of the information shared and the usefulness of the recommendations in shaping the Individualized Education Plan (IEP) goals.

Case Study Example

Sophie is 17 years old and attends a local public high school where she is learning how to grocery shop and cook, use a cell phone, call in prescription refills and take medications on her own, ask a friend to go to the movies, and navigate her community. She is participating in work experiences in a variety of restaurants and related businesses throughout the school year to help her explore the environment, work culture, and job duties she is most interested in. Sophie's schedule includes classes in the general curriculum with her peers while many of her academic requirements are integrated throughout the individualized functional activities. Sophie is planning the move to a supported living situation to occur while she is in her senior year at school since an opening came up with the local community support provider. Her transition Individualized Education Plan (IEP) is driven by the needs Sophie has to fully participate in these settings, become competitively employed, and gain independent living skills to achieve the post-school outcomes that she and her parents would like.

A year ago, when Sophie was 16, her education program looked quite different. She was described as friendly, social, active, and impulsive; someone who exaggerates the truth, displays behavioral outbursts, requires prompting to complete a task, recognizes numbers only, and reads at a kindergarten level. Her IEP objectives reflected segregated, in class workbook and computer activities focused on preparing her for the long-term goal of moving to community-

based vocational and independent living skills training. School personnel were unsure if Sophie could become employed and felt her aggressive behaviors, chronic health issues, and extensive support needs were prohibitive of her gaining any level of independence. Sophie expressed an interest in working at a restaurant and her parents said they would like to see her have a job, apartment, community involvement, and friends. Questions were raised by the transition IEP team about what the possibilities might be and what resources were available to assist with achieving them, creating the impetus for change.

What was the change creating the impetus for Sophie's "new life" at age 17? Sophie's physician believed she could do more and referred her to the TransitionInAction Clinic when she was 16. The experience opened the family's eyes as to the possibilities and the clinic report offered new information and recommendations for school, adult service, and other transition-related personnel. As a result, the goals for Sophie's remaining year's in school are focused on preparing her for a quality, productive life after she graduates.

1st Year Implementation Plan

Replication of the TransitionInAction Clinic in Arizona would be designed to meet the needs of families, youth with disabilities, educators and other professionals in the state. This project is proposed to support the development, implementation, evaluation, and dissemination of a sustainable innovative transition clinic designed to improve post-school outcomes related to employment, health, and independent living. The goals of the project are as follows:

1. Develop a TransitionInAction Clinic model in Arizona together with stakeholder and ADDPC involvement to make any modifications and additions to best meet the needs of this community.

2. Expand and replicate the Clinic at a second location to enhance its availability to interested persons in Arizona and identify essential elements for scaling up implementation to locations.

3. Determine metrics and evaluation measures and collect data to assess impact and youth/family outcomes over the course of the project summarizing, analyzing, reporting, and disseminating results.

4. Design training materials and learning opportunities for healthcare and other school and adult service professionals on implementing the Clinic and applying the recommendations in their programming.

5. Complete a study to gather evidence of the efficacy, utility, and validity of the *Transition Engagement Guide* (TEG) resulting in the TEG implementation protocol and metric. The TEG would be made available for widespread use with credit to ADDPC.

Year 1 Timeline and Action Plan

Develop a Transition Clinic for high school and middle school students in the Tucson area, replicate the Clinic in Phoenix, and establish the validity of the *Transition Engagement Guide* (TEG).

January, February, March, 2020 – Start Up

- Make personnel arrangements.
- Engage school, employment, independent living, and health stakeholders.
- Complete start up planning activities.
- Determine location and make logistical arrangements.
- Establish referral criteria, procedures, and materials.
- Obtain permissions and approvals.
- Contact and coordinate school, community, and medical clinic partners.
- Finalize workplace assessment sites.
- Design flyer and referral informational materials.
- Set up data collection and evaluation measures.
- Recruit clinic participants.
- Establish processes and procedures for implementation.

- Finalize TEG protocol and training webinar.
- Establish metrics to evaluate impact on patient-centered and healthcare provider indicators of successful transition.

April, May, June, 2020 - Pilot

- Pilot the clinic with 6 youth and families.
- Review data and stakeholder feedback and make any revisions.
- Create any additional informational materials, tools, and products.
- Finalize implementation protocols.
- Identify critical components for expansion to an additional site.
- Submit report to ADDPC and present at Council meeting.

- Recruit participants in Arizona including nurses, genetic counselors, community health providers, and other health care professionals.
- Provide TEG training for participants.

July, August, September, 2020 - Implementation

- Conduct the Clinic in Tucson twice a month for 6 youth and families.

- Collect impact and outcome evaluation data.
- Plan replication activities in Phoenix.
- Complete start-up activities for an additional clinic site.
- Make logistical arrangements.
- Identify clinic partners, workplace sites, and revise referral materials.
- Finalize implementation plans.
- Recruit participants.

- Have participants' pilot implement of TEG with youth/young adults.
- Provide assistance to participants and address questions.
- Begin completion of TEG with youth/young adult participants

October, November, December, 2020 - Replication

- Conduct the Clinic in Tucson twice a month for 6 youth and families.
- Pilot the Clinic in Phoenix with 6 youth and families.
- Review and analyze data and stakeholder feedback.
- Finalize protocol guidelines and replication process.
- Create training and Clinic implementation materials.
- Submit report to ADDPC and present at Council meeting.

- Complete implementation of TEG with youth/young adult participants.
- Utilize telehealth technologies to provide technical assistance and conduct observations.
- Collect qualitative and quantitative data at three month intervals.

Who is Being Targeted?

The Clinic will serve transition aged youth between 14 and 21 and their families. Criteria will include a disability and/or chronic health condition. Participants from around the state can be referred to the Clinic in Tucson and Phoenix.

The TEG validation study will target professionals including pediatric and family medicine nurses, genetics counselors, and community health providers who will implement the TEG and conduct transition planning serving youth with disabilities and/or chronic health conditions between the ages of 16 to 26.

How will they be Targeted and How Many?

Flyers and brochures will be developed and disseminated to schools, physicians' offices, parent organizations, and other potential referral sources describing the clinic and referral procedures. It

is estimated that 24 youth and their families will participate in the Clinic during year one with 18 at the Tucson Clinic and 6 at the Phoenix Clinic.

Outreach activities will focus on obtaining between 20 and 50 healthcare professionals to participate in the TEG validation study with each one of them serving between two and five youth for a minimum of 100 youth and their families during year one. A day-long training will be held to teach them how to implement the TEG with youth they serve.

Where will Activities Take Place?

The TransitionInAction Clinic will be developed in Tucson and replicated in Phoenix.

The TEG validation study will include professionals and youth around the state of Arizona.

When will Activities Begin and End?

Year one will occur during the calendar year from January to December, 2020.

*Note: A no-cost extension to collect 3 month post data for Clinic and TEG participants later in the year may be necessary.

What do You Plan to Achieve by Year One?

- Development of an Arizona transition clinic model to include middle school aged youth.
- Replication protocol pilot-tested.
- Established transition clinic in two locations around the state.
- Transition Clinic materials and resources produced and disseminated.
- A validated *Transition Engagement Guide* tool for use by healthcare professionals.
- Funding options for expansion and sustainability explored.
- Outcomes and impact summarized and shared through webinars, infographics, newsletter articles, stories, and presentations.
- An estimated 124 youth and their families will receive direct transition services and action planning.
- Quarterly progress reports and end of year reports provided to ADDPC.
- Updates provided at monthly Council meetings and presentations made to ADDPC as requested.

How will the TransitionInAction Clinic be Evaluated?

Pre and post qualitative and quantitative data will be collected for participants:

Youth: Self-determination measures, goal attainment scaling, and transition readiness

Families: Personal interviews and satisfaction surveys

Professionals and Stakeholders: Focus group feedback, satisfaction and impact surveys

TEG validation study:

Data on 65 patient indicators and 22 health care provider indicators will be collected at 3 month intervals to evaluate the status of patients with developmental disabilities and/or special health care needs ages 16 – 26 transitioning from pediatric to adult health care. Health care providers will provide data that validates the extent to which patients are transition ready to complete the transition from pediatric to adult health care. In addition, data will be gathered from patients, family members and support providers to evaluate the extent that they feel prepared to make the transition and are satisfied with the support they are receiving from health care providers to facilitate the transition from pediatric to adult health care. These data will establish the efficacy and use of the TEG.

Budget

Personnel Salary & Fringe: $91,980

Travel: $5,225

Printing & Copying: $1,164

Consultants X 3: $38,000

Subtotal: $136,369

Indirects @ 10%: $13,631

Total Requested: $150,000

25% Required Cost Share: $37,500 (unrecovered indirects)

Budget Justification

Personnel

Wendy Parent-Johnson, Principle Investigator & Project Director (10%) FTE will be responsible for administrative and fiscal oversight of the proposed project. She will lead hiring of new staff and provide supervision of all project staff. Dr. Parent-Johnson will function as the liaison with ADDPC staff, medical personnel, school administrators, and community partners. She will oversee development of the transition model and implementation procedures. Dr. Parent-Johnson will assist with site visits, design and implementation of replication clinic approaches, data collection and analyses, and development of products and resources. She will insure project activities are completed as proposed and submit progress and annual reports as requested. Dr. Parent-Johnson's responsibilities will be completed at no cost to the project. Total requested = $0.

TBH, Clinic Coordinator (100% FTE): This position is responsible for managing and overseeing implementation of the transition clinics, engaging local community partners, conducting recruitment activities and identifying participants, completing pre and post family interviews, and participating as train-the-trainer learning from consultants. He or she will be responsible for coordinating development of the Tucson Clinic and Phoenix replication clinic, communicating with on-site clinic partners, and responding to questions and requests for information. The person will assist with product development and dissemination of clinic results and resources. Total requested = $50,000.

TBH, Project Assistant (50% FTE): This position will be responsible for assisting clinic operations and overall project activities. He or she will be responsible for making clinic logistical arrangements, scheduling clinic days, insuring clinics flow smoothly, collecting pre-and post-clinic information, and compiling report sections from partners. The person will monitor and complete follow-up contacts and information gathering. He or she will be the point of contact for questions, requests for information, and sharing resources with interested persons around the state. Total requested = $20,000.

Fringe Benefits

Salaries are based on the University of Arizona salary structure, with fringe benefits that are based on the current DHHS rate agreement (31.4% for Full-Benefit Employees; 20% for Ancillary Staff; 11% for Graduate Assistants; and 2% for Student Employees). Total requested: $21,890.

Consultants

Richard Parent-Johnson, PhD, Clinic Director (20% FTE) will be responsible for developing the healthcare transition clinic, completing all procedural arrangements, designing protocols, training clinic staff, modeling clinic implementation, developing clinic reports and action plans, and gaining feedback to use an iterative approach to designing an AZ clinic. He will be

responsible for establishing process and criteria for replication, completing start up at additional site, and providing technical assistance. He will develop implementation materials, produce products and resources, and conduct qualitative data analyses. Dr. Parent-Johnson led development and implementation of the SD TransitionInAction Clinic and will oversee establishing a transition clinic model in Arizona. Total requested = $16,000.

Emily Meier, MA, Training Specialist (20% FTE) will be responsible for assisting with developing the clinic content areas, training staff and community partners, utilizing a train-the-trainer approach to model clinic implementation, supporting peer advocates as mentors, and providing training on implementation of the TEG. She will assist with development of clinic materials, training webinars and materials, and technical assistance to professionals participating in TEG implementation. Ms. Meier will assist in development of a school-based clinic model and provide technical assistance to replication sites. Ms. Meier led a major component of the SD TransitionInAction Clinic; oversaw resident, genetic counselor, and nurse involvement and training; and disseminated information through multiple mediums. Total requested = $12,000.

John Johnson, PhD, Research & Evaluation Director (12% FTE): This position will be responsible for designing and managing data collection efforts focused on determining clinic outcomes and impact. He will be responsible for conducting the validation study of the TEG and evaluating the efficacy of implementation. Dr. Johnson will complete all IRB and site approvals, obtain any informed consents, and insure security of data storage. He or she will complete data analyses, provide on-going data reports to project staff to inform development and make data-based decisions, and gather reliability data to assess fidelity of implementation. Dr. Johnson was responsible for overseeing data collection and evaluation for the SD TransitionInAction Clinic. Total requested = $10,000.

Travel

Funds are requested to support travel of project staff to meet with community partners, attend meetings with ADDPC and agency personnel, visit participating clinic sites, provide training and technical assistance, and supporting the replication clinic. Costs are estimated at 2,000 miles at $ .445 per mile = $890 and travel for consultant from South Dakota estimated at three trips $907 each (airfare = $400, hotel = $300, per diem = $160, and ground transportation = $47) and travel for consultant from San Diego estimated at two trips $807 each (airfare = $300, hotel = $300, per diem = $160, and ground transportation = $47). Total requested = $5,225.

Printing

Funds are requested to support copying clinic materials and resources for families ($300), producing and disseminating products and informational materials ($200), and printing clinic brochures and DocTalk cards ($664). Total requested = $1,164.

Subtotal = $136,369

Indirects @ 10% = $13,631

Total Project Funds Requested Year 1 = $150,000

What else should I know about the *TransitionInAction* Clinic?

The Clinic runs from approximately 8:15 am until 4 p.m. and includes interviews, assessments, discussions and activities with a variety of personnel including medical, education, rehabilitation, and adult service providers. This Clinic also provides opportunities for graduate, doctoral, and medical students to gain knowledge of the transition process.

What's Next?

If you are interested in the *TransitionInAction* Clinic or have questions, please contact cd@usd.edu or 605-357-1439 to obtain a referral form. Your physician's referral is necessary to initiate the process.

Center for Disabilities

Health Science Center
1400 W. 22nd St., Sioux Falls, SD 57105
Phone: 605-357-1439 | Fax: 605-357-1438
1-800-658-3080 (Voice/TTY)
cd@usd.edu | usd.edu/cd
Twitter: @CD_SouthDakota
Facebook: The-Center-For-Disabilities-South-Dakota
YouTube: /Center4Disabilities
Pinterest: c4dsouthdakota

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This brochure is available inalternative format upon request.

*Development of the *TransitionInAction* Clinic is supported by funding from: 1) the Heartland Genetics and Newborn Screening Clinic, through a grant from the Genetic Services Branch of the Maternal and Child Health Bureau (MHCB) of the Health Resources and Services Administration (HRSA), Grant Number H46MC24089; and 2) the University Center on Excellence for Developmental Disabilities funded by the Administration on Intellectual and Developmental Disabilities, Administration for Community Living of the U.S. Department of Health and Human Services, Grant Number 90-DD-0704-02-00.

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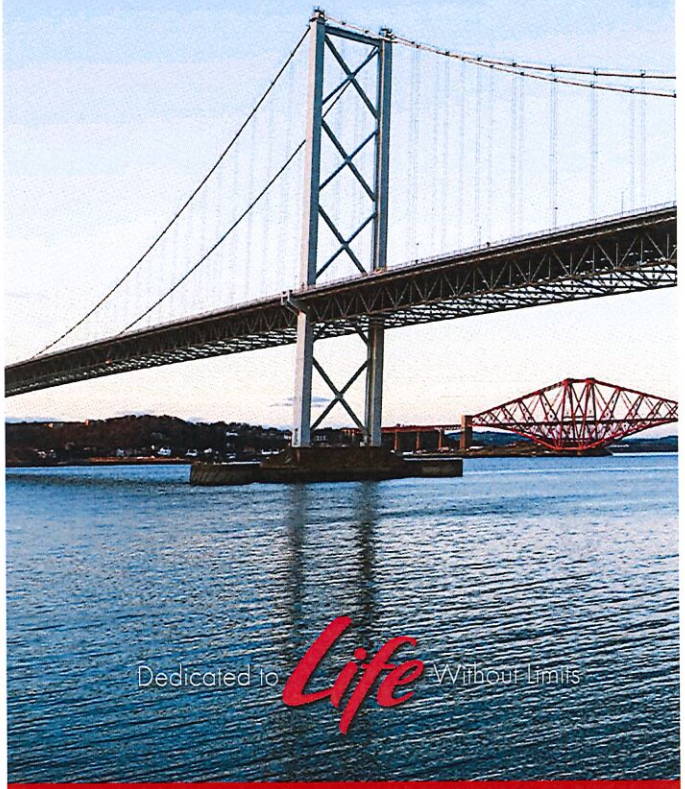
Center for Disabilities

TransitionInAction Clinic

Bridging Meaningful Connections for the Journey Ahead



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Do you have a young adult age 16-26 with a disability and/or chronic health conditions?

Are you overwhelmed with the transition to adulthood?

The Center for Disabilities offers a ***TransitionInAction*** Clinic that generates recommended "next steps" to successful transitions for young adults with a disability and/or significant, chronic health care needs. The Clinic is a comprehensive, day long, multi-disciplinary team experience designed to assess an young adult's current transition "status" and make recommendations in the following major life areas:

- Health care
- Employment
- Wellness
- Personal Supports
- Education
- Independent Living
- Self-Determination
- Future Planning

Pre-Clinic Activities

The pre-clinic process is designed to allow our clinic team to gather background information about your family. A packet will be sent to your home and a team member will contact you to learn more about your unique situation and concerns.

The Clinic

The ***TransitionInAction*** Clinic integrates interviews, assessments, and activities together with discussions that allow our team to get to know your young adult's strengths, interests and vision for the future. Together with your young adult and you, the multidisciplinary Clinic team generates a comprehensive plan for transitions that is focused, coordinated and action oriented.

Follow-up

The ***TransitionInAction*** Clinic focuses on health care, employment and education. Through Clinic activities an individual blueprint is created to guide future planning and steps for action in these areas.

After the Clinic is complete, an initial report with observations and action steps will be shared. Center staff will reach out again at six months and one year.

Health Care

In preparing for adulthood, young adults benefit from developing skills in active management of their own health care needs. A guided health care transition simulation will be conducted to assess the patient's current level of health care engagement and functioning. The clinic team will provide recommendations to foster independence and help the individual assume more responsibility in taking care of their health prior to transitioning from pediatric to adult care.

Employment

In order to assess an individual's current employability skills, members of the Clinic staff will conduct a variety of situational work experiences. Some of the areas assessed include: social skills in a work setting, on-task behavior, following directions, asking for help, most effective learning style, needed supports, interest level and attention to detail.

Education

Both the young adult and family will complete activities and have conversations regarding education transition goals. The individual's strengths and needs in this area are identified. The clinic team will help the family and transition team members by providing recommendations for creating and sustaining opportunities for the young adult to demonstrate their capacities for self-determination, goal setting and purposeful action.

Additional Supports

Transition is a multi-faceted process that involves all aspects of adult life. Young adults may experience barriers that stand in the way of a smooth and effective transition, which is why personal supports can be vital. The pre-Clinic information and conversations on topics such as self-advocacy, financial planning, supported decision-making and independent living provide insight to personal and/or family supports that may be beneficial.

Professionals in the adult service system are also integral in assisting with a smooth transition ensuring that services are uninterrupted and that planning continues in all areas. For this reason, outside community agencies are invited to participate in the Clinic to discuss services and resources available to the young adult. Education and personal support will be helpful in empowering young adults and their families to take an active role in the transition process.

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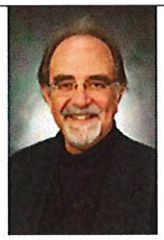
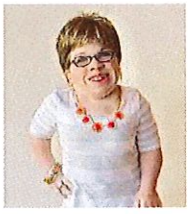
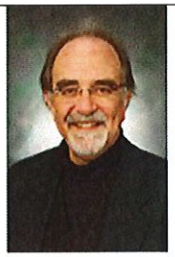
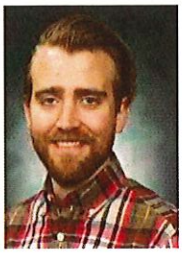
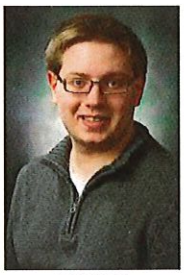
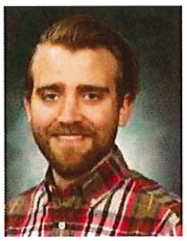
TransitionInAction Clinic

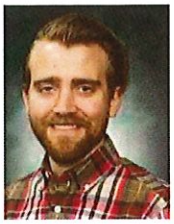
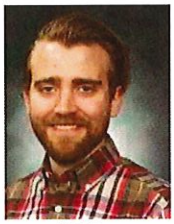
June 13, 2018

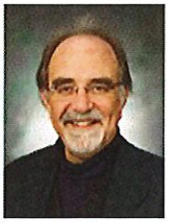
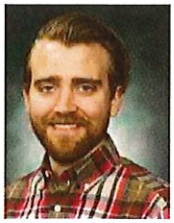
TIME	ACTIVITY	

	Good Morning! 		 STEVEN  ERIN
8:30 AM		Welcome and review of the day	 CAITLIN  RICHARD
8:45 AM Parry Center		**PARENT & YOUTH** Health Care Transition [Simulation]	Augustana University Genetic Counseling Students
9:45 to 10:45 AM Room L07		**YOUTH** Interests and Goals	 KENDRA

9:45 to 10:30 AM Room L07		**PARENT** Supported Decision Making	 RICHARD
10:30 to 11:15 AM Room L07		**PARENT** Wellness, Interests & Goals	 EMILY
10:45 to 11:15 AM HSC 2nd Floor		**YOUTH** Situational Assessment #1	 WENDY  JON
11:15 to 11:45 am Room L07		**YOUTH** Wellness Interview	 EMILY MASON
11:15 to 11:45 AM Room L07		**PARENT** Transition	South Dakota DHS JULIE JOHNSON DRESBACH, Resource Coordinator, Program Specialist, DHS
11:45 AM to 1:00 PM		**LUNCH**	ON YOUR OWN

1:00 to 1:30 Room L07		**YOUTH** Discussion with Self-Advocate	 RYAN
1:00 TO 1:30 Room L07	 Benefits & Issues	**PARENT** Benefits & ABLE Accounts Discussion	SDDS RHONDRA ERICKSON Benefits Specialist
1:30 PM Home2 Suites		**YOUTH** Situational Assessment #2	  WENDY JON
1:30 to 2:00 PM Room L07		**PARENT** Transition	ILC JENNY HALLAN, Peer Support Program Independent Living Specialist
2:00 to 2:30 Room L07		**PARENT** Employment Discussion	SDDS DEB BRINKMAN Vocational Rehabilitation Counselor

2:15 PM Dakota Food Court		**YOUTH** Situational Assessment #3 Dakota Food Court	  JON WENDY
2:30 to 3:00 Room L07		**PARENT** Parent Supports and Resources	SOUTH DAKOTA Parent Connection TERESA NOLD, Parent SD Parent Connection
3:00 to 3:30 HSC Wegner Library		**YOUTH** Situational Assessment #4 HSC Library	 JON
3:00 to 3:30 Room L07		**PARENT** Supported Employment Discussion	Supported Employment PAM BROWN, Lead Employment Specialist, LifeScape

3:30 PM Room TBD		**YOUTH & PARENT** Debriefing & Culmination Discussion	 RICHARD  JON  EMILY  CAITLIN

Talking with Your Doctor

Be relaxed.

Face the Person.

Make eye contact.

Ask your questions.

1. Does _____ change my ...?

Eating and drinking

School or work

Driving

Energy level

Social activities

Emotions

2. What changes could I actually experience?

_____

3. When and how long will this go on?

_____

4. What should I do next?

_____