



**18th Annual Health Care Transition Research
Consortium Research Symposium
October 21, 2026
Agenda**

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8:00 AM	Opening Remarks <i>Cecily L. Betz, PhD, RN, FAAN; Megumi J. Okumura, MD, MAS</i> <i>HCTRC Research Symposium Co-Chairs</i>
	<i>Albert C. Hergenroeder, MD</i> <i>Baylor College of Medicine, Texas Children's Hospital</i>
8:15 AM	Keynote Presentation: Transitional care: What do we already know and what do we still need to know? <i>Philip Moons, PhD, RN, FAHA, FAAN</i>
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<i>Moons, RN, MSN, PhD; Megumi Okumura, MD; Michelle Gurvitz, MD, MS; Anushree Agarwal, MBBS, MD</i>	
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4:45 PM	Wrap-Up
<i>Cecily L. Betz, PhD, RN, FAAN; Megumi J. Okumura, MD, MAS</i> <i>HCTRC Research Symposium Co-Chairs</i>	

	Presentation Titles
	Platform Session 1: Continuous Quality Improvement/Program Development/Models of Care
Platform #1	Metrics That Matter: Using Patient and Program Data to Build, Sustain, and Scale a Healthcare Transition Program <i>Betsy Hopson, PhD, MSHA; Carlie Somerville, MD</i> Background: Healthcare transition (HCT) programs serving adolescents and young adults with medical complexity face persistent challenges demonstrating value and securing resources. Only 20 to 25% of youth with special health care needs receive structured transition, and programs struggle to translate clinical activity into metrics that drive institutional decisions. We describe how the Staging Transition for Every Patient (STEP) Program at the University of Alabama at Birmingham uses transition-specific metrics to guide care, demonstrate impact, and secure investment. Methods: Since 2020, STEP has embedded standardized transition assessments into workflow: the TRAQ, PHQ-9, GAD-7, Zarit Burden Interview (ZBI), Individualized Transition Plans, and emergency care plans. Programmatic metrics include cohort growth, behavioral health prevalence, caregiver burden, transition readiness, transfer to adult primary care, and post-transition utilization. Family focus groups complement quantitative data. Metrics are used iteratively to identify gaps, guide team expansion, and build the case for funding. Results: The STEP cohort has grown to 941 patients (801 active; mean age 24.9; 50% Medicaid; 32% non-verbal); 125 have transitioned out after meeting criteria including TRAQ greater than 4.5, connection with an adult primary care provider, and a documented emergency care plan. Patient-level metrics revealed unmet need: 22% screened positive for depression, 25% for anxiety, and 25% of caregivers screened moderate-to-severe on the ZBI. Program-level metrics demonstrated post-transition impact: among adults with cerebral palsy followed by STEP, hospital length of stay was 1.67 days versus 6.05 days for non-STEP peers. These findings supported a successful 2025 institutional proposal funding additional clinical and behavioral health staff, and enabled launch of an inpatient consult service in October 2025 (67 consults in three months, reflecting strong demand). Conclusions: A disciplined approach to transition-specific metrics, embedded in workflow rather than added on top, enables HCT programs to identify patient needs, demonstrate value, and secure the staffing required for sustainable, equitable lifespan care. Contact: Carlie Somerville, MD; chstein@uabmc.edu
Platform #2	The Evolution of the BRIDGES Program: Creating Systems for Safe, High-Quality, Equitable Care for Adults in a Freestanding Children's Hospital <i>Ahmet Uluer, DO MPH; Kristin Taylor, BS, BSN RN; Lisa Volpigno, MSW LICSW; Julia Roboff, FNP; Nadia Abdulrazak, ANP; Cassandra Fleurentin, FNP; Leah Ratner, MD; Frances O'Hare, MD; Niraj Sharma, MD MPH; Susan Shanske, LICSW</i> Background: Adults with complex chronic conditions receiving care at freestanding children's hospitals create clinical, ethical, and operational challenges. A Department of Public Health mandate requiring oversight of elective procedures for patients aged 21+ provided the impetus to further formalize adult care oversight at our institution. The BRIDGES Program, developed to address transitional care needs through ambulatory, inpatient, and quality improvement

	platforms, leveraged an institutional migration to EPIC to streamline a screening algorithm for elective procedures hospital-wide. Methods: An algorithm embedded within EPIC places all elective cases involving patients aged 21–34 into a queue for chart review, while those aged 35 and older receive mandatory in-person evaluation. Cases are classified as approved, approved with preoperative recommendations, approved with recovery at an affiliated adult institution, or not approved. As a result of the increased focus, BRIDGES receives more referrals and stratifies patients across a five-level transfer readiness framework through ambulatory clinic visits. Results: From EPIC integration through April 2026, 1,200 patients were screened via pre-procedure process, with 116 requiring in-person evaluation. Median chart review turnaround for patients aged 21–34 was approximately one day. Nearly 40% received new clinical recommendations, including anticoagulation guidance, mental health referrals, subspecialty needs identified pre-anesthesia, and transition appropriateness determinations. In the ambulatory clinic, 378 patients have been seen in the last 4 years. 25% transferred care and are no longer admitted to the children's hospital, with an additional third approaching readiness for transfer. Conclusions: The BRIDGES Program demonstrates that systematic, algorithm-driven adult oversight within a children's hospital is feasible, clinically impactful, and scalable while also raising institutional awareness to the over age 18 population and transitional care needs of youth. Transition support is a clinical and ethical imperative that improves safety and increases bed availability for pediatric patients while ensuring quality care for adult patients. Contact: Ahmet Uluer, DO MPH; ahmet.uluer@childrens.harvard.edu
Platform #3	Description of Clinics Providing Primary Care to Adults with Intellectual and Developmental Disabilities <i>John Berens, MD; Tamsen Bassford, MD; Kristen Ann Ehrenberger, MD, Ph; Ellen Fremion, MD; Carlie Stein Somerville, MD; Sarah Mixter, MD, MPH; Jordan Kemere, MD, MS; Brianna Marzolf, DO, MS; Laura Hart, MD, MPH</i> Background: There are significant unmet healthcare needs for the growing population of adults with intellectual/developmental disabilities (AIDD). Little is known about the characteristics of primary care clinics who care for this population. Methods: We conducted a cross-sectional, nationwide survey of clinics providing primary care services to AIDD. Survey invitations were sent via various professional listservs. Results: 51 clinics responded, with a median clinic size of 300 AIDD. Most clinics (N=38, 74.5%) reported extended visit times and most (N=39, 76%) received funding support outside traditional insurance reimbursement. Clinics with over half of their visits devoted to AIDD were significantly more likely to have longer visit times ($p<0.01$) and dedicated nursing ($p=0.03$) and care coordination support ($p=0.02$) compared to clinics who had less than half of their visits for AIDD. There was a mix of medical home and consultative care models, though only 3 (5.9%) clinics offered exclusively consultations. Conclusions: Clinics providing primary care for AIDD offer enhanced care supports but often require additional sources of funding. The results suggest differences in care delivery based on the proportion of clinic visits dedicated to AIDD. Continuing qualitative and quantitative research in this area can aim to create a better understanding of the different care models,

	demonstrate the clinical supports necessary to provide high-quality care, and improve clinic sustainability through novel reimbursement models. Contact: John Berens, MD; john.berens@bcm.edu
Platform #4	A Program Promoting Successful Transition to Adult Healthcare for Underinsured Adolescents and Young Adults with Special Health Care Needs <i>Albert C Hergenroeder, MD; Julie Harmon, BA; Jordyn Babla, MS; Blanca Sanchez-Fournier, BA; Sahar Siddiqui, MD; Titilope Fasipe MD, PhD; Constance M Wiemann, PhD</i> Background: Uninsured or publicly insured adolescents and young adults with special health care needs (AYASHCN) experience increased morbidity/mortality during transition from pediatric to adult-based care. We conducted a 3-year quality improvement (QI) initiative to improve access to adult primary and specialty care for AYASHCN transitioning from a children's hospital to a county hospital system. Methods: Barriers/facilitators to transition between pediatric and adult healthcare systems for AYASHCN with renal or sickle cell diseases (SCD) were identified through stakeholder interviews, baseline data, and QI tools. SMART aims: by May 2026, 1) 90% of AYASHCN will attend a PCP appointment within 30 days of county service approval, and 2) 90% of AYASHCN referred to a specialist will attend appointments within five months. New structures/processes included: stakeholder meetings; partnership with Health Department to expedite financial assistance approvals; refined referral criteria; written policies and procedures; patient navigators in both systems; and tracking appointment completion. Plan-Do-Study-Act cycles were implemented. Metrics: number of AYASHCN approved for county services; percentage of AYASHCN attending PCP and specialist appointments within target timeframes; and stakeholder satisfaction. Results: 163 AYASHCN (129 renal, 34 SCD) were eligible for county services; 148 were approved. One hundred eight PCP appointments were made; 95 were attended the first time (n=75) or after rescheduling (n=20). Sixty-seven specialist appointments were made; 56 were attended the first time (n=44) or after rescheduling (n=12). Sixty-three percent attended a PCP appointment within 30 days of being approved (range: 25-100%). Likewise, 76% of AYASHCN referred to a specialist attended appointments within five months (range: 0-100%). Stakeholders reported high satisfaction with improved processes/services. Conclusion(s): Successful transition to primary and subspecialty adult care for AYASHCN aging out of Medicaid is attainable through structured processes and collaborative systems. Strategies included monthly stakeholder meetings and weekly pediatric and adult staff coordination. Flexible communication methods were essential to engage AYASHCN. Contact: Albert Hergenroeder, MD; acherger@texaschildrens.org
	Poster Session 1
Poster #1	Mental Health Screening in Youth with Medical Complexity During Healthcare Transition: A Retrospective Study of the STEP Clinic Cohort <i>Kristin Olson, MD, PhD, MPH; Betsy Hopson, PhD, MSHA; Madeline Eckenrode, MD; Carlie Somerville, MD</i> Background: Adolescents and young adults (AYA) with medical complexity face elevated risks for anxiety and depression during the transition from pediatric to adult health care. Mental

	health screening in this population is often limited, and prevalence across diagnostic subgroups remains poorly described. The Staging Transition for Every Patient (STEP) Clinic at the University of Alabama at Birmingham provides interdisciplinary, transition-focused primary care to AYA with complex pediatric-onset conditions and routinely screens patients who are cognitively able to complete screenings with the PHQ-9 and GAD-7. Methods: We conducted a retrospective chart review of 941 patients seen in the STEP Clinic. Patients with documented PHQ-9 or GAD-7 scores were included; only first recorded scores were analyzed. Standard cutoffs defined positive screens (PHQ-9 ≥ 10; GAD-7 ≥ 10). Demographic, clinical, and insurance data were extracted from the electronic medical record, and prevalence was examined overall and across demographic and diagnostic subgroups. Results: Among patients with completed screening, 22.3% (80/358) screened positive for depression and 24.6% (87/353) screened positive for anxiety. Females screened positive at higher rates than males for both depression (27.6% vs. 17.6%) and anxiety (31.1% vs. 18.9%). Although Hispanic patients comprised a small proportion of the cohort, they showed elevated rates of positive screens (38.5% depression, 41.7% anxiety). Prevalence varied across diagnostic groups: depression was highest in autoimmune (43%), endocrine (34%), and heme/onc (25%) conditions, while anxiety was highest in heme/onc (36%), autoimmune (36%), genetic (33%), and renal (33%) groups. Patients with cerebral palsy and epilepsy showed the lowest rates for both outcomes. Insurance type and number of additional diagnoses were not associated with screening outcomes. Conclusions: Transition-age AYA with medical complexity demonstrate high rates of anxiety and depression that exceed national averages, with marked variation across diagnostic groups. Findings support routine, standardized mental health screening within transition-focused care models and integration of psychosocial services to address unmet needs. Contact: Betsy Hopson, PhD, MSHA; betsy.hopson@childrensal.org
Poster #2	YOU & I Health Club: A Virtual Healthcare Transition Education Platform <i>Chelsea Ghena, DNP, APRN, EBP (CH); Carolyn Reynolds, MS, APRN; Aileen Casas, MHA; Bethany Nelson, BS; Trish Donahoe, CN-BA, MHM</i> Background: Much of the current literature on teen to adult health care transition (HCT) focuses on a specific disease process or clinic – leaving a gap in understanding at the system level. Within our own system, education and resource connecting is also provided at the clinic level, leaving many clinicians overwhelmed with the gathering and maintenance of materials. A virtual health club was designed to centralize HCT related education, skill building, and resource-connecting at the system level. Methods: The Got Transition® Readiness Assessment (RA) was used as a template for building an educational program to cover general HCT topics – ensuring there are resources available for each question on the RA. Educational materials were delivered in different modalities (flashcards, interactive activities, virtual classes, and website content) to engage youth and families in the learning process and increase accessibility to information. Results: All HCT-related education and resources are housed in a single location for anyone on the care team to reference. This empowers youth and families to interact with the materials independent of clinic visits and work at their own pace, making the material more digestible and less overwhelming. Youth and young adults identified communication or self-advocacy as the most important lesson they learned when interacting with these materials – filling a gap in

	education provided at the clinic level. Conclusion: The health club has been piloted this year in 2 subspecialty clinics and 1 pediatric primary care clinic. The public nature of this website allows equitable access to HCT education and resources to families across our system and communities. This will also allow adult providers to continue supporting youth in this journey, by providing access to HCT resources to all providers, regardless of setting. Contact: Chelsea Ghena, DNP, APRN, EBP (CH); chelsea.ghena@imail.org
Poster #3	Creating a System-Wide, Consult-Based Transition Program <i>Chelsea Ghena, DNP, APRN, EBP (CH); Carolyn Reynolds, MS, APRN; Aileen Casas, MHA; Bethany Nelson, BS; Trish Donahoe, CN-BA, MHM</i> Background: Much of the current literature on teen to adult health care transition (HCT) focuses on a specific disease process or clinic – leaving a gap in understanding at the system level. Within our own system, transition support is siloed within each clinic, division, and service line. To provide wholistic HCT support, a centralized, system-wide transition consult program was created. Methods: Having the program be centralized at the system level allowed for standardized education and resources, the creation of a team of HCT content experts, and the ability to share information between clinics more easily. This team used a multi-pronged approach to support process improvement at the clinic level, preparation and patient education at the individual level, and transfer resources and support at the clinic level. Through a community, HCT needs assessment and multiple PDSA cycles, we have fine-tuned our support services. Results: Some of the lessons learned include: identifying a gap in skill development (how to schedule appointments, refill prescriptions, etc.) around HCT education, providing a family focused approach to HCT support, including all members of the interdisciplinary team to reinforce HCT discussions, and providing HCT education more broadly to facilitate community building and connection. Conclusion: Our HCT consult program continues to provide support as a centralized, system-level team. Our multi-pronged approach has been adjusted based on an ecological systems model to include direct support at the patient level, process improvement and transfer support at the clinic level, and education development and outreach at the community level. This allows us to support our entire system (pediatric, family medicine, and adult) and community partners in the HCT space. Contact: Chelsea Ghena, DNP, APRN, EBP (CH); chelsea.ghena@imail.org
Poster #4	Building the Bridge: A Nurse-Led Healthcare Transition Framework <i>Emily Rizzo BSN, RN, CPN</i> Background: Advances in medical care have increased survival among individuals with chronic health conditions originating in childhood, necessitating transition from pediatric to adult models of care. Although many pediatric professional organizations have issued best practice guidance for select populations, transition processes remain largely unstandardized. Evidence supports structured transition interventions for youth and young adults, demonstrating statistically significant improvements in individual and population health outcomes. This evidence-based practice project sought to develop a structured, standardized, nurse led framework to improve healthcare transitions within a large academic healthcare organization.

	Methods: This project utilized the John's Hopkins EBP model comprising of a literature review and semi structured interviews. Several peer reviewed articles were sourced from PubMed and through a focused review of the journal Transition from Pediatric to Adult Healthcare Services. Benchmarking was conducted through semi structured interviews with program directors and multidisciplinary clinicians at eleven pediatric hospitals across the United States to examine transition of care models, best practices, and key insights. Results: Based on literature and national practice experts, a successful healthcare transitions process involves a structured, multi-year engagement that provides individualized support, education and connection to resources. A nurse-led transition framework was developed and includes essential components such as transition readiness assessments, electronic health record integration, and robust system level organizational support. Conclusion(s): Nurses are uniquely positioned to serve as transitions coordinators and lead this process effectively. A nurse-led, evidence-based framework, that incorporates technology and nursing expertise, offers a scalable, patient centered care delivery model adaptable to diverse populations while maintaining standardization. This approach enables the translation of evidence into sustainable, system wide practice change. The framework should be piloted and, if successful, expanded across the system. Contact: Emily Rizzo BSN, RN, CPN; erizzo@uwhealth.org
Poster #5	Interactive Epilepsy Health Care Transition Learning Module for Physicians, Nurses, and Patient/Caregivers <i>Megan Gallagher, MPH; Rhonda G. Cady, PhD, RN; Becky Parker.</i> Background: Nealy 37% of Minnesota (MN) youth, ages 12-17, who have a special health care need (YSHCN), including those with Epilepsy, receive health care transition (HCT) preparation support from their health care providers. This lack in HCT preparation can be for a variety of reasons, but one reason is that YSHCN live longer, and there is an educational gap on how to transition to adult healthcare. Our team developed an interactive health care transition learning module for providers, social workers, nurses, etc. Methods: Material for the training was developed following a literature review from peer-reviewed publications, Got Transition, and Moving to Adult Health Care websites. Utilizing the RISE 360 education training tool, project staff developed the training with the following objectives: • Demonstrate understanding of successful HCT • Describe the process of HCT using the Six Core Elements of Health Care Transition™ • Understand the Health Insurance Portability & Accountability Act (HIPAA) and impact on communication with health care clinicians • Guide youth/family to understand what successful HCT is and how to work with their primary and specialty care providers to achieve successful HCT Results: A robust and interactive training module was developed to understand aspects of HCT. These include: • What is HCT? • Why is HCT Important? • Six Core Elements from Got Transition • Supported decision making • What do you need to know about HIPAA?

	• Are you ready for HCT? • How can you support youth/families to achieve successful HCT? • Resources and extra learning Conclusion: This training module is needed in the medical complex community and the pediatric to adult health care community at large, as this type of module does not exist. While this module fills an education gap, implementation of this module is essential. This training will be piloted with transition navigators working in a local school district and the Epilepsy Foundation of Minnesota. Contact: Megan Gallagher, MPH; meganmgallagher@gillettechildrens.com
Poster #6	From Acute Care Admission to Action: The PATCH Learning Collaborative <i>Rachel J. Peterson, MD; Susan Shanske, MSW, LICSW; Ashley Jenkins, MD</i> Background: The Got Transition guidelines recommend all adults, with and without a COCC transition, from pediatric to adult healthcare. Uncertainty grows about how to best care for adults with COCCs during acute illness requiring hospitalization. To enable collaborative learning and evidence generation for equitably addressing acute care needs for adults with COCCs, we developed the Pediatric to Adult Transitional Care in the Hospital (PATCH) learning collaborative in 2024. Methods: We used convenience and snowball recruitment methods through past professional connections, known publishers in the field, and existing listservs with professional organizations to develop the grassroots PATCH learning collaborative. We had monthly meetings over the first year with agenda items. We then conducted a mixed methods evaluation of PATCH collaborative evaluating. Quantitative measures were calculated using frequencies and included meeting frequency, meeting participants, and unique institutions on the listserv. and qualitative (e.g.,) data. Qualitative measures were examined using a descriptive qualitative study approach with thematic analysis of PATCH collaborative documents including meeting agendas, meeting minutes, and email discussion. Results: From June 2024 to June 2025, the PATCH learning collaborative had ten 60-minute meetings. Meeting attendance ranged from 11 to 23 participants. Listserv participants increased from 20 to 55. Six major themes emerged including: Consultation/Transition Service Development and Models, Care Quality and Value, Special Populations and Complex Needs, Coordination and System Gaps, Policy and Oversight, Scholarship and Education. Areas of Opportunity included: Advanced Practice Provider Integration. Conclusion: The PATCH Collaborative group is a grassroots initiative aimed at uniting providers and teams who care for adults with COCCs in the inpatient setting. Next steps include better defining the role of Inpatient Transition Care in the greater context of Transition work already underway. Contact: Rachel J. Peterson, MD; rachel.peterson@cchmc.org
Poster #7	The Six Core Element Approach to Health Care Transition: A Scoping Review of Challenges and Recommendations <i>Samhita M. Ilango, MSPH; Annie Schmidt, MPH; Margaret M. McManus, MHS; Patience H. White, MD, MA, FAAP, MACP</i> Background: The Six Core Elements (6CE) is a structured, customizable health care transition (HCT) approach that is recommended by professional organizations and outlines basic

	components of HCT preparation, transfer of care, and integration into adult-centered care. As part of a larger scoping review, we sought to understand common 6CE intervention implementation challenges and recommendations. Methods: We searched PubMed and Google Scholar to identify HCT interventions incorporating the 6CE between 2014-2025. We abstracted and synthesized the implementation challenges described by authors and any recommendations offered for future clinicians or systems considering implementing HCT interventions. Results: Among 77 articles implementing the 6CE, the most common intervention challenges were time constraints (25%), HCT process and clinician issues (23%), Covid-19 (17%), electronic medical record (EMR) issues (17%), staffing issues (14%), and appointment scheduling difficulties/care gaps (12%). Challenges reported less frequently included insurance issues, readiness assessment issues, lack of payment for clinicians, competing priorities for youth, lack of adult clinicians, patient/family reluctance to leave pediatric clinicians, difficulty gaining leadership support, family logistics, issues with specialty care, and lack of non-English tools. Authors shared recommendations for implementing the 6CE that included suggestions related to general HCT process strategies, youth/family engagement, structured process timing, clinician/health care team roles, education and topics to discuss with youth/family and clinicians, coverage/payment/financial support, EMR/infrastructure strategies, and future research. Conclusion: The volume of articles published on the 6CE reveals their widespread use, and this scoping review's findings highlight common challenges along with recommendations based on study authors' experiences to help other clinicians effectively implement the 6CE. Most recommendations are offered at a practice level, and this scoping review suggests it is important to consider how to scale up the 6CE interventions to a systems and policy level. Contact: Samhita M. Ilango, MSPH; silango@thenationalalliance.org
Poster #8	Improved Transition Readiness in ACCORD (The Adult Center for Childhood Onset Rheumatic Disease) – a Rheumatology Clinic Dedicated to Health Care Transition <i>Clare Peckenpaugh, BSN; Tressie Rollins: Sarah Wallgren; Suzy Richins; Aileen Casas, MHA; Rebecca Overbury MD, MS</i> Background: The transfer from Pediatric to Adult Rheumatology clinic is a vulnerable time. In response to this challenge, we created ACCORD in 2018 to focus on Health Care Transition and transition readiness. Methods: ACCORD incorporates a research registry that includes longitudinal Transition Readiness Assessment (TRA) from GotTransition® at two timepoints: at clinic entry (T1), and at last visit (T2). The TRA includes 23 questions specific to transition readiness (“yes” correlates with transition readiness); and a visual analog scale (VAS) 0-10 self-reporting confidence in ability to move to an adult doctor (10 is “very confident”). We analyzed the change in total “yeses” and VAS over time. Descriptive statistics and paired t-test analysis were used. Results: Of the 221 patients completing TRA at T1, 80 completed TRA at T2 and were included for paired longitudinal analysis. Total “yes” responses at T2 (n=1530, 83.2%) were more than at T1 (n=1300, 70.7%) with a statistically significant increase in individual “yes” responses (T1 (M=16.25), T2 (M=19.13), $p<0.001$, CI [-3.743, -2.016], (Cohen’s $d=3.859$)).

	VAS scores at T2 (M = 77.39) were statistically higher than at T1 (M = 65.13) ($p = .03$), 95% CI [-20.26, -4.27], (Cohen's $d = -0.34$). Conclusions: These results show statistically significant longitudinal improvement in transition readiness in a Rheumatology clinic dedicated to HCT. While attrition is a risk of bias in this study, 112 of the original cohort (221) had transitioned to an adult provider before T2 TRA could be completed or had completed T1 TRA < 12 months prior to analysis; representing insufficient follow-up rather than attrition. While these results are correlative, not causative, the hypothesis that a clinic dedicated to HCT would improve transition readiness is plausible; and the positive result is clinically significant. Our next step is to correlate changes in TRA with transfer outcomes. Contact: Rebecca Overbury MD, MS; rebecca.overbury@hsc.utah.edu
Poster #9	Standardized Process for Reviewing Adult Admission Requests at a Free-standing Children's Hospital as a Means of Improving Safety and Outcomes <i>Rachel J. Peterson, MD; Carly Noel, MD; Michael Radcliffe; Nicole Brown, MD</i> Background: Patients with childhood-onset conditions (COCs) increasingly survive into adulthood and evidence shows that pediatric-based care has shown to improve outcomes for many of them. Like other children's hospitals, Cincinnati Children's Hospital Medical Center has seen growing numbers of adult-aged admissions, some in established approved adult care programs, but many reflecting delayed or incomplete transition to adult care. Ensuring appropriate adult admissions to pediatric hospitals, while supporting transition for those better suited for adult hospitals, improves care delivery and reduces stressors on clinical teams. Methods: Using quality improvement methodologies, we streamlined the review and approval process for adult admissions (≥ 25 years) at a quaternary children's hospital. Collaboration with a third-party team knowledgeable in both adult and pediatric systems helped identify patients who would benefit from transition. Stakeholder interviews revealed that the paper form was a key inefficiency, work was into an electronic form (via MS forms) and the EHR, enhancing standardization, tracking, and operational oversight. Results: We decreased the number of people involved from 7 to 2 and the number of steps from 9 to 4. Involving a singular team of individuals with pediatric and adult system awareness improved review objectivity. After 6 months, a total of 535 adults were reviewed. Of those, 26.7% (143/535) were not in approved adult programs and 15.4% of those were identified as potentially able to transition into adult care system for future admissions. One patient of the 535 was denied admission. The new process streamlined and tracked all reviews through a singular avenue, helping identify patients ready for transition. Our next stage will involve EHR transition identifiers to improve tracking for adults across the system. Conclusion: Pediatric systems caring for adults with COCs lack consistent transition-focused identification and review. Our novel review process shifts review to providers with multisystem expertise, improving equity in the process. Contact: Rachel J. Peterson, MD; Rachel.Peterson@cchmc.org
Poster #10	Validating Parent Readiness for Health Care Transition <i>Megan Gallagher, MPH</i> Background: Healthcare transition (HCT) is the process of helping adolescent and young adults (AYAs) move to adult healthcare. Transition readiness assessments (TRA's) are

	evidence-based tools for tracking AYAs' progress developing skills needed to manage their care in adult systems. A subset of AYAs is unable to manage their care because of physical and/or cognitive limitations. At age 18, legal guardianship is petitioned, and parents often serve in this role. These AYAs must transition to adult systems, and assessing 'transition readiness' must focus on the parent/legal guardian instead of the AYAs. Methods: We adopted a parent/legal guardian TRA from Children's Mercy. See the attached figure of the adopted TRA. Clinical and lived experience partners reviewed the TRA for initial face and content validity. Questions were modified and added, and construct validation is needed. Cognitive interviewing (CI) is a systematic method of assessing how a respondent interprets a question and selects a response. Common techniques include think-aloud protocol and verbal probing. CI is useful in establishing construct validity, ensuring a tool measures the intended construct: parent readiness to transition their adult child to the adult care setting. We will conduct CIs with a purposeful sample of parents/legal guardians whose AYA requires court-appointed legal guardianship. The CI guide includes the 17-question TRA and scripted verbal probing questions to understand how the interviewee interpreted each question and how they selected their response. Results: We anticipate conducting five CIs, modifying the questions based on findings, and conducting another round of five CIs. Conclusions: Cognitive interviewing is an effective and efficient method of ensuring construct validity of a modified TRA. Contact: Megan Gallagher, MPH; meganmgallagher@gillettechildrens.com
Poster #11	Exploring Caregiver Perceptions of Genetic Counseling Support during the Healthcare Transition for Individuals with Neurodevelopmental Conditions <i>Allison Kaiser, MS; Molly Lombard, MS, CGC; Jordyn Prell, MS, CGC; Lizzie Mealey, MS, CGC; Alison La Pean Kirschner, MS, CGC</i> Background: Neurodevelopmental conditions (NDCs) affect approximately 5-10% of the population. While genetic counselors (GCs) are integral to the initial diagnostic odyssey, caregivers and patients frequently experience a significant loss of support when moving to adult healthcare. The GC's role in longitudinal healthcare transition (HCT) remains underutilized and poorly defined, leaving a critical gap in care. Methods: A mixed-methods study utilized an online cross-sectional survey which was distributed to caregivers of individuals with NDCs via national, regional and local advocacy organizations and social media. Quantitative data from 123 respondents was analyzed using descriptive statistics. Fifteen semi-structured follow-up interviews were conducted. Qualitative data underwent thematic analysis to identify core challenges, caregiver-perceived barriers, and opportunities for GC involvement in HCT. Results: Seventy-seven percent of all caregivers desired GC involvement during transition, yet 70% were unable to define the GC's professional role (M =2.9/5). Psychosocially, 28.5% of caregivers lacked a clear explanation of the NDC in an adult context, contributing to high anticipatory anxiety. Caregivers who attended a GC session reported higher understanding on how their child's NDC might affect their future (M= 4.0/5, SD = 1.0) compared to those who had not (M= 3.1/5, SD = 1.4; p<0.001). Eighty-nine percent expressed interest in re-evaluating genetic test results or pursuing updated genetic counseling as their child approached HCT.

	Conclusions: This study aimed to characterize caregiver-perceived barriers to HCT for individuals with NDCs and to evaluate the perceived utility of genetic counseling during the transition process. Current diagnostic-focused genetic counseling leaves a support gap in the transition to adulthood. Caregivers strongly desire for GC re-engagement to navigate evolving clinical and reproductive needs. By adopting a proactive, longitudinal model, GCs can provide vital guidance and revisit unresolved diagnoses. This integration could reduce caregiver burden and ensure genomic medicine extends beyond the pediatric setting into lifelong management. Contact: Allison Kaiser, MS; alliekaiser11@gmail.com
Poster #12	Defining the Role of Social Work on Interdisciplinary Transition Teams <i>Susan Shanske, MSW; Caren Steinway, MSW, MPH; Olivia Teng, MSPH; Jack Chen MBS; Angela Berger, MSW; Stephanie Pratt, MSW; Terri Hickam, MSW, CCM; Reny Partain Sims, MSW, MPH; Symme Trachtenberg, MSW</i> Background: Pediatric to adult healthcare transition (HCT) comes with many complex systemic challenges and psychosocial stressors. Interdisciplinary teams are identified as the ideal model to deliver comprehensive HCT interventions, with special attention called to social workers who can drive care coordination and quality improvement work. Little has been published about the role and competencies social workers need to deliver quality HCT services. Methods: A modified survey-based Delphi study was conducted with 59 experts to achieve expert consensus on core competencies for social workers involved in transition work. Two literature reviews found 12 articles identifying ten competency themes. Need and feasibility of each competency was first provided by social work experts, followed by health professionals, young adults and parent/caregiver experts. Positive responses scoring greater than 80% consensus in both need and feasibility were kept for future phases. Results: Of the social work and health professionals, over 70% had 10+ years of experience. All young adults and half of parent/caregivers had experience working with a social worker during their transition to adult care. All competencies reached positive consensus for need in the first phrase except “Transition Programming & Evaluation” and “Population Needs Assessment”. In phase three, almost all competencies achieved positive consensus for need by other expert groups. In comparison, only two competencies (“Decision Making for IDD” and ‘Ethical Practice”) were ranked as feasible by more than one expert group. Conclusion: Overall, experts concurred with the eight core competencies social work experts identified as important for HCT. The discrepancy between expert groups on what competencies are both important and feasible may show the lack of understanding of what medical social workers are trained to do. Further research is needed to explore how interdisciplinary teams can better understand the knowledge and expertise that social workers bring to the interdisciplinary team. Contact: Reny Partain Sims, MSW, MPH; lpartain@choc.org
Poster #13	Patient Perspectives, Barriers, and Next Steps in a Health Care Transition Clinic for Pediatric to Adult Rheumatology - A Qualitative Study <i>Rebecca Overbury, MD</i> Background: In 2018, we introduced ACCORD (the Adult Center for Childhood Onset Rheumatic Disease) to focus on Health Care Transition for patients transferring care from pediatric to adult rheumatology. In ACCORD, one intervention is an adult rheumatologist who

	establishes care with patients in the pediatric rheumatology clinic. Our aim was to understand patients' experience in ACCORD, elucidate ongoing barriers to successful transition, and clarify patients' perspective on what constitutes a successful transition. Methods: This cross-sectional study included chart reviews and semi-structured interviews. Eligible interview participants were contacted for a 45-minute semi-structured virtual interview. The interview script focused on experiences with ACCORD, barriers to transition, and perspectives on successful transition. Interviews were qualitatively analyzed through a two-phase deductive content analysis. In phase one, data was deductively sorted by trained analysts, and bi-weekly meetings ensured reproducibility in coding. Overlapping or problematic codes were resolved. The codebook was developed and revised iteratively with data collection and input from all research team members. In phase two, two interviews were double coded independently (Kappa 0.78). The codebook was then applied to remaining interviews. Results: Fourteen interviews were analyzed. Participants voiced overwhelmingly positive experiences with the ACCORD clinic. Meeting the adult rheumatologist in the pediatric setting was unanimously a positive experience. Negative experiences were few. Lack of nursing support was noted. The greatest perceived barrier was navigating new physical environments (e.g. parking, finding the clinic, check-in process). Finally, there was no concordance on how to define a successful transition, but themes included the importance of clarity in communication, personalization of care, and a warm hand off. Conclusions: The patient experience of the ACCORD clinic was overwhelmingly positive. Introducing an adult rheumatologist in the pediatric clinic to focus on HCT was a well-received. Identified barriers of logistical uncertainty and lack of nursing support, are targets of future intervention. Contact: Rebecca Overbury, MD; rebecca.overbury@hsc.utah.edu
Poster #14	Nurse Care Coordination Results in Safe and Effective Transfer of Care for Young Adults with Chronic Neurologic Conditions <i>Craig DiPietro, BSN, AMB-BC; Jennifer Disabato, DNP, CPNP-PC, AC</i> Background- Transfer of care (TOC), the 5th of Got Transition 6 Core Elements, is a critical aspect of transition preparation and an identified barrier in a pediatric neurology clinic. Barriers included patient/family hesitancy, missing scheduled adult appointments, ongoing medication refill requests, and returning to the pediatric clinic. To address gaps, a full-time transition focused nurse care coordinator (RNCC) was integrated within the clinic to provide expert transition and transfer support and develop a streamlined process of education and coordination with patient/families, adult clinics, and scheduling. Methods- Review of gaps, both hospital and department stakeholder feedback informed RNCC interventions. 1) Developing a provider order for RNCC transfer support. 2) Outreach to assess readiness, barriers, self-management education, decision making, or proxy/guardianship support when indicated. 3) Adult practice identification, educate on referral/scheduling process, transition summary. 4) Medication refill and clinical advice plan until established with adult clinic. 5) Follow up on appointment adherence, resistance outreach letter 6) Education on initial visit actions and seeking ED/hospital services. Results- Successful TOC is defined by adult appointment attendance. In 2025, 349 YA's established adult neurology care. Followed by 68 in Q1 of 2026. Q1 of 2025 Care Everywhere (Epic) review resulted in 52/64 (81%) attending visit 2. Patient care coordination ranges 45-255

	minutes with an average age of 19y. RedCap patient satisfaction survey sent after the initial adult visit showed 16/17 YA's or guardians strongly agreed the level of support by the RNCC provided a smooth transition and transfer experience. Conclusion- Dedicated, transition (RNCC) within a pediatric subspecialty for patients with complex neurologic conditions enhances care delivery and ensures plan adherence for transition to transfer of care. Increased pediatric access, aligns with organizational goals to expand outpatient services. Contact: Craig DiPietro, BSN, AMB-BC; craig.dipietro@childrenscolorado.org
Poster #15	Preparing US Youth for the Transition to Adult Health Care: Differences by Individual, Family, and Health System Characteristics <i>Samhita M. Ilango, MSPH; Olivia R. Sappenfield, PhD, MPH; Lydie A. Lebrun-Harris, PhD, MPH; Margaret M. McManus, MHS; Patience H. White, MD, MA, FAAP, MACP</i> Background: Preparing youth for the transition to adult health care is important for ensuring continuity of care, addressing changing health care needs, and improving health outcomes. Research on subpopulation differences in access to services for adult health care transition (HCT) preparation is limited. This study assessed individual, family, and health system characteristics to determine which of these are associated with variation in the receipt of HCT preparation services among US youth. Methods: This cross-sectional study used data from the 2018-2022 National Survey of Children's Health, a nationally representative annual survey of parents/caregivers. We conducted bivariate analyses to examine receipt of services to prepare for adult HCT among youth 12-17 years (N=77,280) and multivariable logistic regression models to estimate associations with sociodemographic, health status, health care, and family covariates of interest. Results: Only 18% of youth received HCT preparation services from their health care providers. In adjusted analyses, receipt of HCT services varied by sociodemographic characteristics, with lower rates among males, younger youth, uninsured youth, youth from households with a high school education, and Hispanic, Non-Hispanic Black, and Non-Hispanic Asian youth. HCT preparation was more likely among youth with special health care needs (Adjusted Prevalence Ratio [aPR]=1.18, 95% Confidence Interval [CI]: 1.08-1.28) and those with access to care in a medical home (aPR=1.17, 95% CI: 1.09-1.25), compared with their counterparts without special health care needs or medical home access. State-level rates in HCT preparation ranged from 11% to 32%. Conclusions: HCT is uniformly low with subgroup variation that can inform improvement efforts. Potential opportunities to increase HCT preparation include improving access to medical homes and health insurance, strengthening provider incentives, and conducting needs assessments to better understand family barriers to HCT. Contact: Samhita M. Ilango, MSPH; silango@thenationalalliance.org
Poster #16	A multidisciplinary consult service to enhance care for adults with complex diseases of childhood in the inpatient healthcare setting <i>John Charles Nichols, MD; Betsy Hopson, PhD, MSHA; Carlie Stein, MD</i>

	Background: As more adults with complex childhood-onset diseases transition into adult care, many are admitted to hospitals where teams may be less familiar with their medical, communication, behavioral, and care coordination needs. Methods: In 2025, a southern academic center launched the STEP (Staging Transition for Every Patient) inpatient consult service – a multidisciplinary team including a Med-Peds physician, advanced practice provider, child life specialist, registered dietician, and social workers, with planned psychology and psychiatry involvement. The service provides behavioral and sensory support, staff communication strategies, complex care coordination, and discharge planning for patients with conditions such as cerebral palsy, spina bifida, muscular dystrophy, autism, intellectual disability, and technology dependence. The team functions as an extension of the established STEP Clinic, which offers longitudinal primary care and complex care coordination. Results: Program evaluation includes quantitative metrics (consult volume, length of stay, time to follow-up, readmissions) and qualitative measures of patient, family, and clinician experience. Early findings from patient and clinician feedback and case observations indicate that the STEP consult service improves patient experience, diagnostic clarity, behavioral stabilization, and care coordination. Clinicians report increased confidence in caring for neurodiverse and medically complex adults and are consulting the service earlier in hospitalization. Quantitative outcomes, including length of stay and readmission trends, are in progress. Conclusions: Coordinated interdisciplinary planning is paramount when caring for adults with complex childhood-onset conditions. A transition-focused multidisciplinary consult team can improve patient and provider experience by standardizing approaches to medical, behavioral, sensory, and communication needs. Effective components include integrating child life and behavioral specialists, using reproducible tools such as visual supports and social stories, and establishing reliable interdisciplinary communication pathways. Institutions may benefit from adopting similar models that prioritize proactive communication and link inpatient care with outpatient transition resources to improve care trajectories for this population. Contact: John Charles Nichols, MD; johncharlesnichols@uabmc.edu
11:15 AM	Platform Session 2: Health Care Transition Outcomes and Readiness Measures/Continuous Quality Improvement Program/Development/Models of Care/Innovations in Practice
Platform #2.1	The "ImPACT" of Clinic-Specific Transition Coaching on Referrals to a Centralized Transition Hub at an Academic Children's Hospital <i>Barbara Hepp BSN, RN, CPN, CCCTM; Shianne Goering, MHA; Shelly Heinrichs, LCSW; Juan Ramos, BS; Jennifer A. Disabato, DNP, CPNP-PC, AC; William C. Anderson III, MD</i> Background: The Improving Pediatric to Adult Care Transition (ImPACT) program at Children's Hospital Colorado both coaches clinical teams on transition best practices and provides direct care support to young adults (YA) and families referred by providers. Coaching promotes a team's capacity to transition their own population, while referrals to the centralized ImPACT Navigation Hub (INH) provide additional support beyond what the clinic has resources to provide. Referrals are not limited to clinics that have undergone coaching, although coaching promotes referrals.

	Methods: Clinic self-identified for coaching from the INH, with early adopters being clinics with some internal transition infrastructure. The INH referral patterns of clinics that started coaching in 2022-2023, and then subsequently successfully completed INH coaching, were compared to their referral patterns in 2024-2025. Results: Twelve clinics started INH coaching in 2022-2023 and completed all phases of INH clinic coaching. There was a 54% reduction of referrals to the INH for additional transition support services after completing INH coaching (107 in 2022-2023; 49 in 2022-2023). Seven of the 12 clinics had an identified nurse champion or care coordinator to support transition. Those clinics with this nursing support during transition preparation and transfer had a 74% reduction in INH referrals, while those who did not had a 11% increase in referrals after coaching. Conclusion: Developing internal clinic-specific transition best practices through INH-coaching led clinics to formalize transition workflows and overall reduced the subsequent referrals to a centralized transition hub for additional support. Transition-dedicated nursing support was key to maintaining internal clinic transition processes, while the lack of transition-dedicated support led to an increase in referrals to the INH. Contact: Barbara Hepp BSN, RN, CPN, CCCTM; Barbara.Hepp@childrenscolorado.org
Platform #2.2	From Avoidance to Access: A New Approach to Blood Draws in Autistic Adults <i>Kristin Cooper, MD; Jessie Schiering BSN, RN, Christopher Hanks, MD</i> Background: Autistic adults are at high risk for procedure-related anxiety as sensory sensitivity, unpredictability, communication challenges, and prior negative experiences may intensify avoidance of needle-based procedures. Despite the high need, autistic individuals are underrepresented in needle-phobia research. Standard workflows rarely incorporate autism-informed accommodations. Autistic adults report barriers to accessing healthcare, including inflexible procedures and environments that do not accommodate sensory or anxiety-related needs, contributing to avoidance of blood testing and delayed care. There is need for novel, scalable laboratory processes to improve venipuncture tolerance and access for autistic adults. Methods: We describe a novel approach to improve access to laboratory services for autistic adults. Instead of standard walk-in lab processes, patients enrolled in the Center for Autism Services and Transition (CAST) were offered schedulable laboratory visits. During scheduling, accommodation needs, communication preferences, need for caregiver presence, and prior lab experiences were recorded. Upon arrival, patients are escorted to a private space, and phlebotomy is performed by laboratory staff using identified accommodations. Descriptive statistics were collected. Results: To date, 17, 27, and 9 CAST lab visits were completed in 2024, 2025, and 2026, respectively. Of these, 70% of patients were on medications that have regular monitoring recommendations. Over half of these were more than 2 years since their last lab results. Data of total CAST lab visits and total routine walk-in lab visits are summarized below. Conclusions: Our novel laboratory visit process for autistic adults shows promise in helping

	accomplish needed lab testing by reducing sensory overload, waiting time, and procedural distress commonly associated with walk-in laboratory visits. <i>Contact: Kristin Cooper, MD; kristin.cooper@osumc.edu</i>
Platform #2.3	Creating Continuity: Development and Early Findings of a Lifespan Down Syndrome Care Model Integrating Transition Readiness <i>Kristin Olson, MD PhD MPH; Betsy Hopson, PhD MSHA; Madeline Eckenrode, MD; Snehal Khatri, MD; Carlie Stein Somerville, MD</i> Background: As life expectancy for individuals with Down syndrome (DS) increases, coordinated, guideline-based lifespan care is critical. Fragmentation during the pediatric-to-adult transition contributes to lapses in preventive care, unrecognized behavioral health changes, and suboptimal outcomes. To address these gaps, the University of Alabama at Birmingham (UAB) established a lifespan DS program spanning pediatric and adult services, with the adult clinic embedded within the Staging Transition for Every Patient (STEP) Program. Methods: The program was developed using a Community-Based Participatory Action Research approach, informed by a statewide caregiver needs assessment and guided by a steering committee of families, advocacy partners, and clinicians. The pediatric clinic (birth–18 years) launched in July 2024 and begins formal transition planning at age 14. A STEP provider administers the TRAQ, PHQ-9, and GAD-7 for verbal patients and the Zarit Burden Interview (ZBI) for caregivers of non-verbal patients. At age 18, patients transition to the adult DS clinic, receiving interdisciplinary care guided by GLOBAL Adult DS Guidelines, including Med-Peds primary care, neurology evaluation for dementia and regression, social work, nutrition, psychiatry, and psychology. Annual dementia screening with the NTG-EDSD begins at age 40. Results: The STEP DS cohort comprises 62 adults (ages 18–55; 50% ages 18–25; 18% ≥40), 74% Medicaid-insured, and 29% non-verbal. Comorbidities include hypothyroidism (42%), congenital heart disease (31%), obstructive sleep apnea (23%), and Autism Spectrum Disorder (23%). Mean TRAQ among verbal adults was 2.34, indicating low transition readiness. Among caregivers of non-verbal patients, mean ZBI was 27.6, with 29% reflecting moderate-to-severe burden. Two adults were diagnosed with DS Regression Disorder and successfully treated with IVIG. Conclusions: Embedding structured transition, behavioral health, and aging-related assessments across pediatric and adult DS clinics supports early identification of psychosocial and aging-related concerns and offers a replicable model for integrated lifespan DS care. <i>Contact: Kristin Olson MD PhD MPH; kmolson@uabmc.edu</i>
Platform #2.4	Transition Readiness in Adolescents and Young Adults with and Without Chronic Medical Conditions: Where are the Strengths and Gaps? <i>Angela B. Combs, PhD; Francesca St. Pe, MA; Cathleen Odar Stough, PhD</i> Background: College is a unique developmental period of transition and adjustment for adolescents and young adults (AYAs). Healthcare transition readiness is essential for effective health management among AYAs with and without chronic medical conditions (CMCs). The current study explored differences in transition readiness between AYAs with CMCs and without as well as where AYAs demonstrate strengths and challenges in transition skills.

	Methods: Participants were 1437 AYAs aged 18-24 (62.6% female, 75.5% White, and 94% non-Hispanic) and were recruited through an online research system at a large midwestern university. Participants completed a self-report measure of healthcare transition readiness (Transition Readiness Assessment Questionnaire, TRAQ). A one-way ANOVA was calculated to identify whether group differences emerged on the TRAQ between AYAs with or without a medical condition overall. Mastery of transition skills were calculated by taking the percentage of respondents who endorsed the highest score out of the total number of respondents for each item. Results: Transition readiness significantly differed between AYAs with and without a CMC ($F[1, 1417] = 26.02, p < .001$) with AYAs with a CMC displaying greater transition readiness overall ($M = 4.02$ compared to $M = 3.77$). Students reported at least 70% mastery in skills related to answering questions by healthcare providers (83.8%), using neighborhood stores and services (76.5%), taking medications correctly and independently (73.9%), and communicating symptoms (71.2%). AYAs reported lowest mastery in skills related to knowing what their health insurance covers (13.3%), applying for health insurance when coverage is lost (17.3%), and making a list of questions before their visit (18.3%). Conclusions: While AYAs, especially those with CMCs, show strengths in communication and medication skills, significant gaps remain in healthcare navigation and insurance literacy. Targeted interventions focused on these areas may improve readiness for independent healthcare and support smoother transitions into adult healthcare systems. Contact: Angela B. Combs, PhD; abcombs2018@gmail.com
	Breakout Sessions
Breakout Session #1	Operationalizing the TRAQ: An Interactive Workshop on Practical Tools for Health Care Transition Readiness <i>Betsy Hopson, PhD, MSHA; David Wood, MD, MPH</i> Goal(s): The Transition Readiness Assessment Questionnaire (TRAQ) has been adopted in hundreds of clinical settings and used in dozens of research studies, yet clinicians frequently struggle with how to operationalize it in routine practice. Despite national consensus recommendations supporting structured transition readiness assessment beginning at age 12 to 14, only 21.7% of adolescents with special health care needs receive the services needed to prepare for adult-oriented care. This interactive workshop will equip clinicians, program leaders, and care teams with a practical, evidence-informed framework for using the TRAQ to guide transition counseling, goal-setting, and stage-matched intervention. The session will move beyond the questionnaire itself to demonstrate how the TRAQ integrates with the Transtheoretical Model of Behavior Change and Motivational Interviewing to produce meaningful clinical conversations. Participants will work through a case-based example illustrating iterative TRAQ administration, score interpretation, use of the supplemental importance and confidence scales, and documentation of goals via a TRAQ Companion Individualized Transition Plan (ITP). Small-group discussion will help attendees adapt the framework to their own clinical settings, including pediatric subspecialty, primary care, and adult transition clinics. Key take-home messages:

	1. The TRAQ is most effective when paired with a structured counseling framework rather than used as a stand-alone screening tool. 2. Stage-matched counseling and Motivational Interviewing techniques meaningfully improve patient engagement and self-efficacy. 3. The supplemental importance and confidence scales identify modifiable barriers that traditional readiness scoring may miss. 4. Documenting goals in a TRAQ Companion ITP supports continuity, accountability, and warm handoffs to adult care. 5. Operationalizing the TRAQ does not require additional clinic time when integrated into existing workflows. Intended audience: Pediatric and adult clinicians (physicians, advanced practice providers, nurses, social workers, psychologists), transition program directors, care coordinators, and trainees involved in caring for adolescents and young adults with special health care needs. Contact: Betsy Hopson, PhD, MSHA; betsy.hopson@childrensal.org
Breakout Session #2	The Lived Experience Model: Utilizing Patient Advocate with Lived Experience to Transform Transition Care <i>Cameron Tovin, BS; Rochelle Baer, LCSW; Jairo Arana, BS; Jonathan Tolentino, MD, MS-HPE</i> Session Significance and Goals: The transition from Pediatric to adult healthcare can be overwhelming for individuals with intellectual and developmental disabilities. While clinical teams work to address medical complexity, patients often struggle to feel comfortable in healthcare settings due to past negative experiences, accessibility, sensory sensitivities and communication barriers. These barriers can interfere with care by leading to reduced patient adherence and physician trust. There is a need for a care approach for this population that fosters support and addresses individuals unified barriers and challenges for more efficient and effective care. This session aims to provide a model for clinics to integrate Patient Advocates with lived experiences into their standard model of care, creating a unique interdisciplinary team. Participants will learn how to recruit, train, and utilize advocates to improve patient outcomes. Participants will also understand the benefits integrating a Patient Advocate with lived experience, including improved communication, trust, representation, and visibility within healthcare settings. Key Take-Home Messages: • Value of Shared Identity: Understand how lived experience and discussing personal anecdotes can break down clinical barriers and encourage patient transparency and compliance. • Integrating Patient Advocate into the Clinical Workflow: Practical steps for incorporating a non-clinical advocate into a multidisciplinary medical team. • Patient Empowerment: How individuals with lived experience become specialized patient advocates, teaching patients to speak up for their own medical needs through role modeling. Intended Audience: Physicians, Nurses, Social Workers, Clinic Staff, Patient Advocates, and healthcare students interested in neurodiversity and transition medicine. Contact: Cameron Tovin, BS; cht44@miami.edu
Breakout Session #3	From the Inside: The Role of Inpatient Teams in Supporting Pediatric to Adult Transition <i>Susan Shanske, MSW; Rachel Peterson, MD; Ashley Jenkins, MD</i> Goal: Transition from pediatric to adult healthcare continues to be an area of growing practice and research as children with childhood onset chronic conditions (COCC) age into adulthood.

	Best practice guidelines focus primarily on outpatient, with less attention paid to support required during admissions. To address this, hospital systems have created new inpatient care models aimed at providing age-specific care support as well as generating a new touchpoint to support patients and families as they navigate the transition process. The Pediatric to Adult Transition Care in the Hospital (PATCH) Collaborative is a group of inpatient providers who connect and idea-share around how to reach the needs of the patients in the systems they must navigate. To start, the PATCH Collaborative is seeking to explore and describe the scope of the topic. Our goals for the session are to: (1) share the origin story, mission, and vision of the PATCH learning collaborative and (2) facilitate discussion about how inpatient care should be more explicitly addressed and supported in the larger pediatric to adult healthcare transition landscape. Participants should take home understanding of various models of care that currently exist in the inpatient realm and an ability to identify care needs unique to transition age youth in hospital settings, both pediatric and adult. This includes concrete improvement ideas for how to broach transition discussions during acute hospitalizations and ways to look at systems issues to create models that support safe and high-quality care in all settings. Intended audience: Any providers or team members who support adults with COCCs in the inpatient realm or have a passion for inpatient/hospital-based care as an avenue of meeting patients and families and supporting transition discussions and care there. Contact: Susan Shanske, MSW; susan.shanske@childrens.harvard.edu
Breakout Session #4	Nothing About Us Without Us: Centering Self-Advocates in IDD Transition Education <i>Vithalani Vrunda, MD; Kathryn Jordan Kemere, MD MS</i> Goals: Despite increasing recognition of the importance of healthcare transition and longitudinal adult care for individuals with intellectual and developmental disabilities (IDD), formal education in IDD care remains limited across medical education spaces. Existing curricula often focuses primarily on disease-specific management and frequently excludes individuals with disabilities from the educational process itself. As a result, many trainees report limited confidence in communication, accessibilities, systems navigation, and patient-centered approaches to caring for adolescents and adults with IDD. This interactive session will explore practical approaches for developing and implementing multimodal IDD curricula that highlights self-advocate and family advocates as educators and partners in teaching. Using examples from an existing curriculum incorporating case-based learning, self-advocate video perspectives, panel discussions, and active learning exercises, participants will discuss strategies for integrating lived experience into various educational initiatives. Participants will brainstorm scalable and adaptable methods to incorporate such education at their institutions to promote communication, patient autonomy, accessibility, and systems-based understanding. Key take-home messages: 1. Lived experience perspectives help learners recognize assumptions surrounding autonomy, communication, and quality of life in individuals with IDD. This, in turn, promotes more authentic, patient-centered learning experiences focused on accessibility than traditional didactic approaches alone.

	2. Educational innovation in IDD care does not require large-scale curricular overhaul or significant dedicated IDD curricula; meaningful inclusion of self-advocates can begin with small, scalable interventions. 3. Early exposure to disability-informed care, which focuses not only on medical management but also patient autonomy and participation in community experiences, may help reduce health disparities experienced by adults with IDD. Intended Audience: This session is intended for clinical educators, clerkship and residency leadership, faculty involved in undergraduate or graduate medical education, and healthcare professionals interested in developing patient-centered curricula focused on IDD and transition to adult healthcare. Contact: Vithalani Vrunda, MD; vrunda.vithalani@bcm.edu
	Platform Session 3: HCT Training and AEA
Platform #3.1	Inclusion in Action: A Simulation-Based Curriculum Co-Designed with Self-Advocates Improves Medical Student Readiness to Care for Patients with Intellectual and Developmental Disabilities <i>Madeline Eckenrode, MD; Betsy Hopson, PhD; Carlie Stein Somerville, MD</i> Background: Successful healthcare transition for adolescents and young adults (AYA) with intellectual and developmental disabilities (IDD) depends on self-advocacy and shared decision-making. Unfortunately, the adult providers they encounter often lack training to partner across diverse communication and cognitive abilities. People with IDD experience well-documented healthcare disparities driven in part by limited disability-focused medical education. We developed Inclusion in Action, a simulation-based curriculum integrated into the University of Alabama at Birmingham (UAB) Clinical Reasoning and Integrated Skills Program (CRISP) for first year students in partnership with United Ability, a local day program for adults with IDD. Methods: 18 participants with IDD were trained as standardized patients (SPs) and integrated into a one-hour simulation for first-year medical students. Faculty facilitators received structured training and led post-encounter debriefings. Students completed pre- and post-simulation surveys assessing IDD-specific knowledge (12-item clinical vignette assessment) and attitudes, comfort, and clinical confidence (19-item Likert scale). Paired-samples t-tests compared matched responses; independent-samples t-tests compared full cohorts. Results: 204 first-year medical students participated; 51 completed pre-tests and 15 completed both pre- and post-tests. Knowledge scores improved significantly (paired pre-mean 9.47, post-mean 10.20 of 12; $p=0.006$). Item-level gains were largest for identifying trusted sources of medical information (+38 percentage points), federal IDD definitions (+34), and supported decision-making (+26). Significant improvements were observed in self-rated training adequacy (+1.33; $p<0.001$), confidence providing accommodations (+1.13; $p<0.001$), confidence taking a medical history from a patient with IDD (+1.07; $p=0.003$), and competence to care for a patient with IDD (+0.93; $p<0.001$). Student feedback emphasized desire for longitudinal IDD content. Conclusions: Successful transition requires preparing AYAs with IDD to advocate for themselves as well as training the providers who will care for them. A simulation co-designed with self-advocates produced measurable gains in students' IDD knowledge, training

	adequacy, and clinical confidence, offering a scalable, community-partnered approach to closing the provider-side gap. Contact: Madeline Eckenrode, MD; meckenrode@uabmc.edu
Platform #3.2	Caregivers' Experiences Supporting Individuals with Down Syndrome Transitioning to Adulthood in Texas <i>Kelsey Karasinski, MS, GC; Blake Vuocolo, MS, CGC; Ellen Fremion, MD; Claire Crawford, PhD, LCSW, APHSW-C; Farah Ladha, MS, CGC; Mike Roberts</i> Background: As life expectancy for individuals with Down syndrome increases, more families must navigate the complex transition to adulthood. Inadequate transition is associated with poorer health, reduced employment opportunities, and lower quality of life. Caregivers play a central role in this process, yet limited research has examined their experiences, particularly in Texas, where high uninsured rates, long Medicaid waiver waitlists, and lack of Medicaid expansion may create unique barriers. This study explored caregivers' experiences supporting adolescents and young adults with Down syndrome during transition to adulthood in Texas. Methods: Fifteen semi-structured interviews were conducted with 16 caregivers (including one parent-parent dyad) of individuals with Down syndrome aged 14-30 years residing in Texas. Participants were recruited via the Baylor Transition Medicine Clinic, the Down Syndrome Association of Houston, and social media postings. Interviews explored experiences with healthcare transition, education and employment planning, Medicaid waivers, legal planning, and community integration. Transcripts were coded using ATLAS.ti, analyzed using thematic analysis, and mapped to the Social-Ecological Model (SEM). Results: Saturation was reached at 13 interviews. Four major themes emerged: (1) parents need more structured guidance to navigate medical and social transition; (2) medical and community support services are difficult to access and may not meet individuals' needs; (3) planning for adulthood is constrained by individual, social, and structural limitations; and (4) transition medicine clinics can improve healthcare transition through coordinated care. Conclusions: Caregivers of individuals with Down syndrome in Texas experience multilevel barriers during transition to adulthood across education, employment, healthcare, and policy systems. Findings highlight the need for earlier structured guidance, expanded inclusive employment opportunities, improved access to transition medicine clinics, and policy reforms addressing Medicaid waiver delays and administrative burdens. Improving transition outcomes will require coordinated, family-centered approaches across healthcare, education, and community systems. Contact: Kelsey Karasinski, MS, GC; karasinskik@gmail.com
Platform #3.3	Medical Student Perspectives on a Required IDD/Neurodiversity Curriculum: Lessons from Early Implementation <i>Kylie Cullinan, MD; Melise Eyman, BA; Olivia Fox; Joan Reisch, PhD; Emily Bufkin, MD</i> Background: A multimodal Intellectual and Developmental Disabilities (IDD) and Neurodiversity (ND) curriculum was developed at UT Southwestern Medical Center to address gaps in disability-focused undergraduate medical education. Implemented in July 2025 within the required Ambulatory Care clerkship, the curriculum includes a two-hour workshop, half-day clinical experience, and optional community engagement activity. The workshop uses case-based learning, self-advocate perspectives, and adaptive communication and clinical skills training to promote person-centered, inclusive care for patients with IDD/ND.

	Methods: Clinical medical students completed an anonymized MedHub-based evaluation of the IDD Workshop, including Likert-scale items and free-text prompts: “Major Strengths of the presentation” and “Suggestions for Improvement.” Evaluations from July 2025 to April 2026 were collated, including 176 workshop evaluations and 58 substantive narrative comments. Free-text responses were analyzed together using a frequency-informed, AI-supported qualitative content analysis approach, with each comment serving as the unit of analysis. Two generative AI tools reviewed the same de-identified dataset using structured prompts to generate preliminary codes, candidate themes, coding matrices, and theme counts. The student author and faculty mentor reviewed AI outputs against the original comments, compared convergence and divergence, merged overlapping categories, removed vague or weakly supported themes, and finalized themes supported by at least three unique comments. Results: Five major themes were identified: engaging, well-structured session design and delivery (25/58, 43.1%); lived experience as an essential teaching strategy (18/58, 31.0%); practical clinical strategies for IDD/ND care (11/58, 19%); opportunities for deeper practice, additional resources, and implementation refinement (8/58, 13.8%), and IDD/ND education fills a perceived curricular gap (6/58, 10.3%). Because comments could be assigned to more than one theme, percentages do not sum to 100%. Student feedback suggests the curriculum’s interactive structure, integration of lived experience, and actionable clinical strategies were highly valued. Contact: <i>Kylie Cullinan, MD</i>; kylie.cullinan@utsouthwestern.edu
	Break
	Poster Session 2
Poster #1	Needs Assessment to Improve Inpatient Care and Transitions for Young Adults with Autism and/or Intellectual and Developmental Disabilities <i>Georgia Farrell, MD; Cassandra Cousineau, MA; Alyssa Consigli, RD, CPHQ; Keith Robinson, MD, MHCDS</i> Background: Young adults with autism spectrum disorder and/or intellectual and developmental disabilities (IDD) are at increased risk for adverse inpatient experiences and outcomes, particularly during transitions between pediatric and adult care. In rural academic health systems, limited specialty resources and variable provider exposure may contribute to care gaps. To inform targeted quality improvement (QI) interventions, we conducted a needs assessment to identify provider and patient reported barriers and priorities for inpatient care of young adults with autism and IDD. Methods: We conducted a needs assessment focused on inpatient pediatric and adult hospital settings. Provider surveys were distributed via REDCap to 135 inpatient physicians (attendings and residents across internal medicine, family medicine, and pediatrics). Patient and caregiver surveys were distributed through statewide community partners. Informal input was gathered through conversations with community partners, inpatient nursing, therapy, and ancillary staff. Qualitative data underwent thematic analysis. Results: 39 provider surveys were received. 8 patient/caregiver surveys were received and 3 caregivers additionally participated in structured interviews. Preliminary findings identified several recurring themes. Communication barriers were frequently described, including limited

	access to individualized communication strategies and inconsistent shared understanding across care teams. Sensory and environmental mismatches were commonly reported contributors to patient distress. Additional themes included a lack of standardized inpatient supports for patients with autism and/or IDD and provider discomfort or training gaps, particularly in adult care settings. Conclusions: This needs assessment identifies system-level gaps in inpatient care for young adults with autism and/or IDD. Findings are being used to guide both systems level improvements and development of just in time, point of care educational resources embedded into clinical workflows. This approach offers a pragmatic, scalable model for improving inpatient care quality and equity for this population in rural academic health systems. This could also act as a catalyst to align inpatient transition supports with outpatient system supports. Contact: Georgia Farrell, MD; georgia.farrell@uvmhealth.org
Poster #2	Creation of the BRIDGE (Building Readiness, Independence and Direction for Growth and Engagement) Program: A Patient-Facing Interactive Platform in EPIC's Care Companion Feature <i>Dava Szalda, MD, MDHP; Alyia Dambrosio; Adam Greenberg, MSN, CRNP; Lindsey Albenberg, DO; Maria Ricci, BS; Sarah Hadley, MBA, RN; Jacquiel McDonald, MSN, RN, NI-BC, SSGI-CAP; Eric Crews, BS; Roxanne Xin; Jenna Borges; Sweta Parmer, PhD; Eden Pontz; Oluwasemilore Oladipo, MHA, CPHQ; Richard Chung, MD</i> Background: Transition to adult care remains a consistent priority and difficult to operationalize in large Children's hospitals. Quality improvement initiatives often engage providers in transition-related activities, which is essential, but relies on provider time, comfort, and engagement. We developed a direct-to-patient interactive technology-enabled platform to support adolescent and young adult self-management education and skill development. Methods: Working with subject matter experts and human-centered design engineers, we undertook qualitative interviews with patients and providers to determine content, modality, and cadence of the educational tasks. We reviewed nationally available educational items (e.g. Got Transition) to identify pre-existing materials. We worked with CHOP's EPIC Care Companion team to design the type and cadence of tasks with a goal of full integration into existing electronic health records. Results: Qualitative interviews were conducted with 9 patients, ages 16-31 and 6 parents. Based on qualitative data, content reviews, and discussion with advisory groups (patient and provider) a customized Care Companion program was developed consisting of videos, games, infographics, and more traditional "handouts" about adolescent and young adult health care skills and transition preparation. Core educational domains engage patients with topics like healthcare control, responsibility, and self-efficacy. The tool allows auto-enrollment by age and structured patient education messaging via the patient portal. Enrollment can begin at age 13 with a max enrollment age of 19, delivering education every 1-3 months to both patients and parents. Aspects of the tool (enrollment and engagement) will be available to providers via existing "Transition Manager" build. Conclusion: Direct to "consumer" interactive transition program will be launched in summer 2026. Future iterations of the work will assess acceptability to patients and families as well as transition outcomes based on level of engagement. Version 2.0 will focus on developing education for patients with developmental disabilities.

	Contact: Dava Szalda, MD, MDHP; szaldad@chop.edu
Poster #3	The Six Core Element Approach to Health Care Transition: A Scoping Review of Interventions and Measures <i>Annie Schmidt, MPH; Samhita Ilango, MSPH; Peggy McManus, MHS; Patience White, MD, MA</i> Background: The Six Core Elements (6CE) is a structured, customizable health care transition (HCT) approach recommended by professional organizations. It outlines basic components of HCT preparation, transfer of care, and integration into adult-centered care and is available in three packages: Leaving (transitioning youth to adult care), Staying (transitioning youth to an adult approach to care without changing clinicians), and Integrating (integrating young adults into adult care). Methods: We conducted a scoping review to uncover how the 6CE are being implemented and evaluated. We searched PubMed and Google Scholar to identify HCT interventions incorporating the 6CE between 2014-2025. We abstracted and synthesized the HCT intervention activities, identifying the most common activities aligning with each CE, and sorted the measures used into process and outcome measures. Results: We identified 77 articles implementing the 6CE. Almost all (97%) implemented CEs in the Leaving package, about half (47%) implemented CEs in the Integrating package, and only 3% of studies implemented CEs in the Staying package. Most studies (76%) used outcome measures to evaluate their intervention, most commonly measuring transition readiness assessment scores, patient/family feedback/experience/satisfaction, and adult clinic utilization. About half (53%) of studies used process measures to evaluate their intervention, most commonly measuring overall implementation of the 6CE, followed by use of a transition readiness assessment. About half (54%) of studies that included a comparison group found statistically significant positive results. Not all studies tested for statistical significance. Conclusion: The 6CE have been widely implemented across a variety of settings and populations, demonstrating feasibility and improved outcomes. Studies generally implemented some but not all 6CE. The broad variety of measures used reflects the lack of consensus on HCT measures. Contact: Annie Schmidt, MPH; aschmidt@thenationalalliance.org
Poster #4	What is Inpatient Transition Care? A Scoping Review of Inpatient Care Delivery Models <i>Susan Shanske, MSW, LICSW; Anna Q. Allen, MD; Jacob Wagner, MD; Rachel J. Peterson, MD; Ruchi Doshi, MD, MPH; Yasmin Chowdhury Marcantonio, MD, MPH; Ahmet Uluer, DO, MPH; Ashley Jenkins, MD MSc</i> Background: Adults with childhood onset chronic conditions (COCC) are admitted to both pediatric and adult hospitals due to challenges addressing their unique overlapping pediatric and adult acute care needs. National healthcare transition (HCT) guidelines largely exclude the inpatient setting. We aimed to understand the structure and implementation of inpatient care delivery models in both settings for adolescents and adults with overlapping pediatric and adult acute care needs. Methods: We conducted a scoping review to identify literature about inpatient care for patient populations with overlapping pediatric and adult acute care needs including adults with or without COCC in pediatric hospitals or children or adolescents in adult hospitals. Using a

	comprehensive search strategy co-developed with a medical librarian, articles were uploaded into an online review platform. A group with subject matter and methodological expertise conducted a 2-stage screening process through abstract and then full-text review. One author adjudicated conflicts. We used the Consolidated Framework for Implementation Research (CFIR) to design our data extraction tool enabling identification of multi-level factors necessary for the design and implementation of the identified models. Results: We identified 2,289 abstracts from inception to December 1, 2025. We excluded 2,099 at abstract phase and 170 at full-text phase resulting in inclusion of 20 articles. Most were from the U.S. The majority described programs in free-standing pediatric hospitals or pediatric hospitals embedded in adult hospitals. Four described broad consultation models; 11 were condition specific. Five described transient services created during the COVID-19 pandemic to address system constraints. CFIR elements were identified throughout the 20 articles. Conclusions: We identified 20 inpatient models for varying populations of adolescents and adults with COCCs hospitalized in predominantly pediatric hospital settings addressing issues ranging from fertility to palliative care to HCT. Paucity of implementation-specific data reported currently limits the ability to translate these care delivery models. Contact: Susan Shanske, MSW; susan.shanske@childrens.harvard.edu
Poster #5	Implementation of a Transition of Care Pathway for Patients with Neuromuscular Diseases; A Quality Improvement Project <i>Hattie Foster, RN; Jessica Green Ray, LSW; Meghan Moore Burk PT, DPT, PhD; Carolyn Kelley PT, DPT; Paige E. Naylor, PhD; Zach Arcona PsyD; Sen Vo, RN; Laura Watne MS, RD; Oren Kupfer, MD; Molly McCoy, MD; Michele L. Yang, MD; Melissa Wright, MD; Melissa Gibbons, CGC; Alexandra L. Kilgore MD; Anne Stratton, MD; Susan Apkon, MD; Kelli C. Johnson, CPNP</i> Background: The transition from pediatric to adult healthcare presents significant challenges for young adults with neuromuscular diseases, including disruptions in care, loss to follow-up, and difficulty navigating adult healthcare systems. Historically, our patients experienced barriers transitioning to adult care to include lack of resources, poor understanding of adult systems, guardianship, and insurance changes, with approximately 25% of patients never scheduling an adult specialty care appointment after referral. To address this gap, the Neuromuscular Program at Children's Hospital Colorado implemented a dedicated Transition of Care Pathway, including a Transition Clinic, as part of a quality improvement (QI) initiative. Methods: This QI project aimed to improve transition education and planning for patients with neuromuscular disease. Dedicated time for the nurse and social worker was allotted during the multidisciplinary clinic for transition education and planning, beginning at age 15. Medically and psychosocially complex patients were offered dedicated transition clinic visits via telehealth with the Neuromuscular Nurse Practitioner and Social Worker. The Transition of Care pathway included patient tracking, documentation, emergency preparedness planning, and coordination with adult providers. Target measures included $\geq 90\%$ transfer of care, with patients establishing care with an adult provider within 1 year of referral, and $\geq 90\%$ patient satisfaction with the transition pathway survey. Results: During the implementation period of April 2023 to April 2026, 48 patients (87%) successfully transferred care, defined as completion of an appointment with an adult

	neuromuscular physician. Among patients seen in the dedicated transition clinic, 1 patient did not transfer care. Patient satisfaction has been 100% among respondents, though survey response rates remain limited. Conclusions: A structured transition pathway, including a dedicated transition clinic and focused support from nursing, social work, and Neuromuscular providers, improved continuity of care for young adults with neuromuscular disease. Ongoing work is needed to increase survey responses and further assess barriers. Contact: Hattie Foster RN, BSN, AMB-C; Hattie.Foster@childrenscolorado.org
Poster #6	Creation of a Transition Manager: A Comprehensive EPIC Interface to Operationalize the Six Core Elements of Transition in a Large Pediatric Health System <i>Adam Greenberg, MSN, CRNP; Richard Chung, MD; Dava Szalda, MD, MDHP; Lindsey Albenberg, DO; Alyia Dambrosio; Maria Ricci, BS; Jacquiel McDonald, MSN, RN, NI-BC, SSGI-CAP; Eric Crews, BS; Feihan Xin, MSHI; Oluwasemilore Oladipo, MHA, CPHQ</i> Background: The Six Core Elements can be challenging to consistently implement and track, especially for patients followed by multiple specialists. Prior efforts to leverage the EMR included creation of Healthy Planet Reports (Tracking), electronic dissemination of Transition Readiness Assessment Questionnaire (TRAQ) v4.2 (Readiness), and Storyboard alerts via Smart Data Elements (Transfer Completion). However, gaps remain within the EMR for Policy Review, Planning, and Transfer of Care. Additionally, there has been limited line of sight within the EMR across specialties engaged in transition-related activities. We aimed to decrease variation in transition and transfer activities by leveraging existing and new EPIC tools and developing a cohesive provider-facing interface for transitional care. Methods: We convened stakeholders from primary care, multiple specialties, and partners from our data and EPIC departments. We catalogued specialty-specific transition workflows, including their use of EPIC-based tools. Our EPIC analyst evaluated existing EPIC functionality and newly released EPIC Transition tools, including the Transition Manager (TM) and Transition Readiness Assessment (TRA), to maximize established workflows and minimize unnecessary custom build development, while leveraging new functionality to evolve and standardize transition-related tools and processes supporting project aims. Stakeholder feedback was solicited for functionality and layout of new EPIC tools. Results: In March 2026, we launched a standard TM and TRAQ 6.0 to 10 divisions. TM is viewable within any encounter and houses TRAQ responses, Transfer of Care, and Transfer Completion status in a view-only environment. We customized TM and TRAQ to meet specialty-specific needs, incorporating review of transition policy and goal setting, while limiting TRAQ dissemination to yearly. All data elements within TM can be extracted for metric collection. Conclusion: EPIC can support and streamline implementation of the Six Core Elements across specialties, with customizations to improve alignment of transition activities. Metrics will be used to assess transition progress. Contact: Adam Greenberg, MSN, CRNP; greenberga1@chop.edu
Poster #7	Retrospective Analysis of Health Care Transition Services/Supports Provided by Peer Navigators with Developmental Disabilities <i>Christine B. Mirzaian, MD, MPH; Rowan Smith, MPH; Julia Ismael, MA; Cecily L. Betz, PhD, RN, FAAN</i>

	Background: Young adults with intellectual and developmental disabilities often lose their social services and supports and healthcare services as they transfer from pediatric to adult-focused health care and transition into adulthood. Programs to facilitate the transition process are necessary to attempt to connect this community with the supports necessary to be active members of their chosen community. This innovative service-training peer navigator program trained self-advocates with developmental disabilities as peer navigators to provide comprehensive health care transition services and supports to transition-aged youth and young adults with intellectual and developmental disabilities and their families Methods: Data on the comprehensive health care transition (HCT) services provided by peer navigators with developmental disabilities were extracted from the records of 74 transition-aged youth and young adults, ages 17 to 20 served from 1.1.2023 to 4.1.2025. Data were gathered using the Peer Navigator Retrospective Survey composed of 30 closed and free text items, which were inputted into a REDCap database. Data extracted included demographics, profile of HCT referrals and outcomes related to the transfer of care, education, employment, independent living, transportation, social/recreational options and contact characteristics. Findings: Total number of referrals provided were 268 in the following types of HCT services: transfer of care referral (86), health care guidance (53), education (87), independent living (29), employment (22), transportation (8), social/recreational (3), and regional center (15) and HCT guidance (53). The total number of service outcomes reported were 160, of which 43 were health care (i.e. passport completed, transfer of care provider identified). Conclusion: Peer navigators with developmental disabilities after having received HCT navigation training were capable and successful with providing HCT services to youth and young adults, ages 17 to 20 and their families. Numerous HCT outcomes were identified. Contact: Cecily L. Betz, PhD, RN, FAAN; cbetz@chla.usc.edu
Poster #8	Peer Navigation Transition Training: Profile of Training Outcomes <i>Ben Schwartzman, PhD; Aneli Torres, MPH; Cecily L. Betz, PhD, RN, FAAN</i> Background: Transition-aged youth and young adults (YYA) with intellectual and developmental disabilities (IDD), particularly those from Black and Hispanic communities, face disparities in access to transition services (California Department of Developmental Services Purchase of Service Data, 2025). The Peer Navigation Transition Training (PNTT) program was developed to address these inequities by training young adult self-advocates with IDD ("Transition Navigators") to co-facilitate culturally and linguistically responsive workshops. These trainings draw on Navigators' lived experiences with employment, postsecondary education, independent living, healthcare, and social relationships. Methods: PNTT workshops were co-delivered virtually by three CHLA UCEDD staff and five Transition Navigators. YYA with IDD, families, and professionals from Los Angeles County were invited to attend. Over 400 community members participated in workshops over 18 months; 76 participants (15 Spanish-speaking, 61 English-speaking) consented to surveys assessing training effectiveness. Pre- and post-surveys evaluated transition goal-setting, knowledge of how to access community resources, and participant satisfaction. Results: At baseline, self-advocates reported goals primarily in social skills and self-advocacy (100%), but none reported goals related to employment or postsecondary education (0%). Family members reported broader goal-setting, including employment (67%) and education

	(55%). Professionals reported varying confidence in supporting YYA with IDD in attaining goals in each transition area. Post-workshop, knowledge of how to access transition resources increased across all groups and domains. The largest gains were observed in transportation and healthcare. Improvements were also seen in self-advocacy and community living, while postsecondary education gains were modest. Conclusion: Findings suggest PNTT improves participants' ability to navigate transition systems while maintaining high engagement and satisfaction. Peer-led, culturally responsive training may help reduce disparities and improve access to services. However, findings should be interpreted with caution given the small sample size, and further research with larger samples is needed to validate these results. Contact: Ben Schwartzman, PhD; bschwartzman@chla.usc.edu
Poster #9	Preliminary Findings of Pre-Transfer Activities of Youth and Young Adults with Spina Bifida Enrolled in the Movin' On Up Transition Program <i>Cecily L. Betz, PhD, RN, FAAN</i> Background: Concerted efforts have been underway to develop and implement health care transition programs and services to facilitate the transfer of care to adult primary and specialty care providers and the transition to adulthood. In response to this need, a health care transition program was developed and implemented for adolescents and emerging adults who aged out of the CHLA Spina Bifida program. This health care transition program, entitled Movin' On Up was initiated in 2011. Methods: Data were extracted from the charts of those who have received health care transition services from 6.1.2023 to 6.1.2025. The data extraction tool is composed of demographic items, and items about provision of health care transition services provided prior to transfer and major health-related issues the year prior to transfer that include ED, hospitalization and clinic attendance prior to the transfer experience. The sample of this investigation was composed of 244 youth and young adults, with spina bifida or related neural tube defects ages 10 to 20 years who received transition services from 6.1.2023 to 6.1.2025. Results: Study descriptive findings presented reveal the scope of transition issues addressed beginning with youth, ages 10 through the transfer of care at 21. Prominent among the scope of 26 types of referrals were adult-focused health care provider (n=149; 63.1%); IEP support (138; 58.5%); Department of Rehabilitation (77, 32.6%); Disabled Student Services (74;31.4%). Across the life span of this sample, 18 outcomes reported include enrolled in community college (27; 40.3%); accessed adult-focused providers (20; 29.9%). Conclusion(s): This snapshot of this ongoing health care transition program reveals the broad scope of biopsychosocial and lifestyle needs of youth and young adults with spina bifida, ages 10 to 20 years. Contact: Cecily L. Betz, PhD, RN, FAAN; cbetz@chla.usc.edu
Poster #10	Structured Health Care Transition in the Pediatric Ventilator Clinic <i>Meredith Rooker RN, CPNP-PC/AC</i> Background: Youth with medical complexity who require long-term ventilator support are increasingly surviving into adulthood; however, structured health care transition (HCT) processes remain inconsistent and often inadequate. Limited clinician confidence, poor

	coordination between pediatric and adult providers, and the absence of standardized workflows contributes to fragmented care and unsuccessful transfers to adult health systems. Purpose: The purpose of this quality improvement project is to implement and evaluate a structured HCT program in a pediatric ventilator clinic to improve clinician confidence and increase referrals to adult providers for youth with medical complexity. Methods: This project will be conducted in a multidisciplinary pediatric ventilator clinic within a large pediatric health system in Texas. The intervention consists of three evidence-based components: (a) clinician education on the Six Core Elements of Health Care Transition, (b) implementation of a standardized electronic transition medical summary, and (c) provider-to-provider transition meetings between pediatric and adult pulmonology teams. John Kotter's 8-Step Change Theory will guide implementation, while the Consolidated Framework for Implementation Research (CFIR) will provide the theoretical framework for identifying barriers and facilitators to change. Clinician confidence will be measured using the Grundy Confidence Scale, and referral outcomes will be tracked through clinic records. Results: Expected outcomes include increased clinician confidence in delivering transition care, improved collaboration between pediatric and adult providers, greater use of standardized transition tools, and an increase in successful referrals to adult care services. Conclusion: Implementing a structured HCT program has the potential to improve transition processes for ventilator-dependent youth by enhancing provider preparedness, strengthening interdisciplinary communication, and promoting continuity of care. Findings may inform future transition initiatives for medically complex populations and contribute to the growing body of evidence supporting structured HCT programs. Contact: Meredith Rooker RN, CPNP-PC/AC; Meredith.Rooker@UTSouthwestern.edu
Poster #11	Refining measurement of the time gap between pediatric and adult care to capture diverse health care transition processes <i>Beth Garland, PhD; Jordyn Babla, BS; Albert C. Hergenroeder, MD; Blanca Sanchez-Fournier, BA; Mary Majumder, JD, PhD; Constance M Wiemann, PhD</i> Background: Continuity of care is a key outcome of health care transition (HCT), and the interval between pediatric and adult care visits is frequently used as a marker of successful transfer. However, transition is a process rather than a discrete event. Many adolescents and young adults experience periods of overlapping pediatric and adult care or continue to receive selected services in pediatric settings while establishing a relationship with an adult provider. These patterns complicate measurement of gaps in care and may lead to over- or underestimation of transition success. This abstract refines measurement of the time gap between pediatric and adult care visits by developing an approach that accommodates diverse HCT pathways. Methods: As part of a larger intervention study examining transition outcomes up to two years post-intervention, researchers identified cases in which the relevant pediatric and adult encounters for calculating transition-related gaps were unclear. A multidisciplinary team representing five health care disciplines conducted iterative chart reviews and discussions to characterize transition trajectories, define stages of transition, and establish rules for identifying encounters used in gap calculations.

	Results: Four transition statuses were identified: (1) still in pediatric care, (2) in transit/overlapping care, (3) transitioned to adult care, and (4) lost to follow-up. The resulting framework distinguishes intentional overlap in care from true delays in establishing adult care and provides guidance for selecting encounters used in gap calculations. Illustrative cases included young adults from different specialties who established care with adult providers while continuing pediatric aspects of care (e.g., infusion, medication, emergency) and patients receiving simultaneous pediatric and adult services during periods of acute illness. Conclusions: Accurate measurement of care gaps requires recognition of overlapping and non-linear transition pathways. This framework may improve the validity of HCT outcome measurement and facilitate more meaningful comparisons across transition programs and models of care. Contact: Beth H. Garland, PhD; bhgarlan@texaschildrens.org
Poster #12	Health Care Transition Program Development: Improvement Strategies in a Tertiary Epilepsy Center <i>Ashley McCool, MPH; Roha Khalid, MD; Ahmed Awad, MD; Tanika Middleton, BSN, RN, CCM; Sam Arroyo</i> Background: Provision of Health Care Transition (HCT) services in the clinical setting is necessary as adolescents with complex and chronic health conditions reach adulthood. Got Transition's Six Core Elements of Health Care Transition and the Child Neurology Foundation's 8 Common Principles identify components of HCT for clinical teams to incorporate into practice and patient care. To refine and implement structured transition services, a tertiary epilepsy center at a pediatric health care system adopted a multi-year cycle of improvement strategy. Methods: A multidisciplinary workgroup created transition guides for patient families. Educational content was tailored to the epilepsy patient population and customized to transition stage, life milestones, and resources supporting transition to adulthood. On an annual basis, the guides were provided to patient families starting at the age of 15 at follow-up visits. 2 years after the implementation of the guides using a quality improvement approach, a 16-week evidence-based practice pilot explored the impact of readiness on transition success. The Transition Readiness Assessment Questionnaire (TRAQ) was assigned to established patients ages 17 and older with follow-up visits in the epilepsy clinic. Results: Alongside discussions with providers introducing and/or continuing to plan for HCT, over 1,000 guides were given to patient families. In the pilot, 133 TRAQs were completed with 72% assignment rate and 84% completion rate. Manual efforts in workflows were required but automation where possible resulted in efficiency and effectiveness of processes. Incorporating existing functionality in the EMR and tools available allowed for ease of implementation. Conclusion(s): HCT programs and services take time to design, implement, and evaluate outcomes. Strategic alignment, physician and operational leadership support, multidisciplinary team collaboration, and partnership with adult providers and patient families are key drivers of implementation success. Different improvement methodologies can be leveraged to develop transition services and interventions. Contact: Ashley McCool, MPH; ashley.mccool@childrens.com
Poster #13	Health Care Professionals' Perspectives in Addressing Self-Management During Health Care Transitions

	<i>Catherine A. Harwood, MSSW; Cara Young, PhD, APRN, FNP-C, FAANP, FAAN; Manu Raam, MD; Stephanie Key, APRN, DNP; Lin Li, PhD; Kristin Cleverley, RN, PhD, CPMHN(C), FAAN; Linda Tirabassi Mathis, PhD, RN, CPNP-PC; Sharon Hudson, PhD; Brooke Allemang, PhD, RSW; Lynn Kysh, MLIS, MPP; Jennifer Emilie Mannino, PhD, RN; Benjamin Schwartzman, PhD; Jihye Lee, PhD; Cecily Betz, PhD, RN, FAAN</i> Background: A cornerstone of successful health care transition (HCT) is the ability to engage in self-management, which is defined as the knowledge, skills, and behaviors required to care for one's condition. Health care professionals (HCPs) play a critical role in supporting youth and young adults (YYA) by fostering self-management skills, facilitating coordinated transitions, and tailoring care to YYA's developmental needs. Practice standards guide HCP responsibilities in the provision of HCT services. Limited evidence addresses HCP's involvement in self-management during HCTs. The purpose of this scoping review is to determine the extent of HCP's involvement in self-management during the health care transition process for YYA with childhood onset chronic conditions. Methods: This scoping review followed the Joanna Briggs Institute (JBI) Reviewer's Manual. MEDLINE, Embase, CINAHL, PsycINFO, Cochrane CENTRAL, and Web of Science databases were searched for studies published between 1980 and 2025. Within Covidence, two independent reviewers screened titles, abstracts, and full texts against inclusion and exclusion criteria. Data were extracted, cleaned, and analyzed. Results: A total of 108 studies were included in the final sample. A heavy concentration of relevant literature within predominantly physical health conditions was identified. Almost all studies were conducted within North America and Europe. Most studies were cross-sectional by design, with substantial proportions of qualitative, quantitative, and mixed-method studies present. Underexplored areas included developing countries, HCP demographics, YYA with IDD and mental health diagnoses, and HCP-targeted interventions to improve YYA self-management. Conclusion: Although HCP perspectives were examined, their active engagement in self-management knowledge and skill development in YYA was largely absent from the literature. The extent to which professionals are involved with facilitating YYA self-management competencies were not examined. Understanding the impact of HCT service provision upon YYA outcomes will be hampered by the extent to which professionals implement HCT recommendations until professional practice is better examined. Contact: Catherine Harwood, MSSW; caharwood@utexas.edu
Poster #14	Patient and Clinician Identified Solutions to Promote Lifelong Specialized Care of Adults with Congenital Heart Disease <i>Anushree Agarwal, MD; Katelyn Macholl, MS; Alice Qian, BS; Juhi Mehta, BS; Pranav Ahuja, BS; Karina Buenrostro, BA; Kevin Sun MS; Daniel Dohan PhD; Michelle Gurvitz MD; Megumi J. Okumura MD MAS</i> Background: Patients with adult congenital heart disease (ACHD) experience significant gaps in guideline-recommended specialized care, leading to higher morbidity and mortality. We evaluated barriers and facilitators to specialized care, with a focus on designing and evaluating holistic, patient-centered solutions. Methods: We purposely sampled a demographically and geographically diverse group of ACHD patients and clinicians in the United States. We conducted semi-structured interviews

	guided by the Capability, Opportunity, Motivation, and Behavior model and the Theoretical Domains Framework. All interviews were audio-recorded, professionally transcribed, coded by 2 independent coders, and analyzed using rapid qualitative analysis. Results: We interviewed 54 participants (37 patients and 17 clinicians). For patients, the median age was 32 years; 57% were women, 62% were people of color, and 35% had gaps in care of more than 3 years. Clinicians were mostly cardiologists (44%), nurse practitioners (24%), and allied health professionals. Findings were organized into six interdependent categories: healthcare system and institutional structure; knowledge and education; sources of support; personal development; identity and personal resources; and ACHD's placement in one's life. Two novel findings emerged: a paradoxical facilitating role of parental language barriers and the complex impact of caregiver support on patients' independent care skills. Participants highlighted the pediatric-to-adult transition as a distinct point of vulnerability, where differences in outreach practices between care systems placed recently transitioned patients at risk of disengagement. Conclusion: We provide an in-depth understanding of ways to support ACHD patients and promote lifelong specialized care as they transition through various stages of life, with the potential to reduce gaps in ACHD care and improve outcomes. Contact: Anushree Agarwal, MD; anu.agarwal2@ucsf.edu
Poster #15	Acceptability and Feasibility of a Digital Health Intervention for Adults with Congenital Heart Disease: A Pilot Study <i>Joseph Valente, BS, BCPA; Keerthana Banala, Karina Buenrostro, Sedona Koenders, Lindsay Alano, Rong Duan, Kim Parang, Karina Manayan, Katia Bravo-Jaimes, Mark D. Norris, Leigh Reardon, Philip Moons, Megumi Okumura, Michelle Gurvitz, Anushree Agarwal</i> Objective: To pilot test the acceptability and feasibility of a digital health intervention to support lifelong healthcare for adults with CHD. Methods: Using a community-based participatory research and a behavioral theory-based approach, we developed and piloted a digital tool, Empower My Congenital Heart (EmpowerMyCH), within the web and mobile-based Eureka Digital Research platform at UCSF. Intervention components include exhibits (expert and peer-developed learning modules on CHD-related topics such as finding specialists or navigating visits, tests, procedures, etc.), peer support, and a digital medical passport. Participants receive an exhibit with study measure surveys every two months. Participant satisfaction with the digital tool is measured at six months using the Client Satisfaction Questionnaire-8 (CSQ-8), a validated survey with scores ranging from 8 to 32; higher scores indicate higher satisfaction with the digital tool. Results: Of the 519 participants recruited, 495 were eligible adults with CHD, 445 consented, and 6 withdrew. The median age was 43 (ranging from 20 to 85) years, and 30.1% were males. The survey completion rate was highest at 88.7% during the first two months after enrollment and at 53.5% at 8 months. Of the five exhibits delivered so far, over 87% of participants rated the exhibits as helpful. Participants found the exhibits readable, easily accessible, motivational, useful, and educational. The median (25th, 75th) CSQ-8 score was 21 (18, 25) among 144 participants who completed the survey. Conclusions: EmpowerMyCH appears to be acceptable to most adults with CHD to support and educate them in navigating their healthcare. The tool and its contents are accessible, user-

	friendly, and responsive to the needs of the CHD community, resulting in high satisfaction rates. Contact: Joseph Valente, BS, BCPA; joseph.valente@ucsf.edu
	Platform Session 4: Continuous Quality Improvement/Program Development/Models of Care/ Health Care Transition Outcomes and Readiness
Platform 4.1.	Early Stage Implementation of a Multidisciplinary Virtual Transition Clinic for Congenital Heart Disease <i>Kerri Pastor, MSW, LCSW; Stirling McDavid, CPNP; Lunise Benjamin, DNP, NP-C; Laura Noonan, MD; Sarah Mabus, MLA; Andrew Dailey Schwartz, MD, MPH</i> Background: Young adults with congenital heart disease (CHD) are at increased risk for morbidity, mortality, and loss to follow-up during transition to adult care. Structured transition programs aim to improve lifelong engagement in congenital cardiac care. Methods: A combined quaternary pediatric and adult CHD center developed a multidisciplinary telemedicine transition clinic for adolescents and young adults ages 12–25. Visits were conducted by a nurse practitioner and clinical social worker and included a Transition Practicum Questionnaire (TPQ), individualized cardiac education, psychosocial assessment, and tailored goal setting to support transition readiness and self-management skills. Results: Between November 2025 and May 2026, 53 patients completed transition visits with a mean visit length of 53 minutes and median age of 19 years. Patients represented diverse developmental and psychosocial needs, including individuals requiring caregiver support or guardianship. TPQ scores demonstrated variable transition readiness, with a mean score of 68% (range 40–92%). Significant knowledge gaps were identified: only 23 patients accurately identified their cardiac diagnosis, and 49 were unable to distinguish between a general cardiologist and an adult congenital heart disease (ACHD) specialist. Among female participants, most reported uncertainty regarding reproductive and pregnancy-related cardiac counseling. Psychosocial assessment revealed high perceived independence despite ongoing gaps in healthcare knowledge and privacy understanding. Operational barriers included limited staffing resources, outdated contact information, and challenges identifying eligible patients within the electronic medical record. Conclusions: Early implementation of a multidisciplinary pediatric cardiology transition program identified substantial medical and psychosocial transition knowledge gaps among transition-age patients. Findings support the importance of structured, multidisciplinary transition programs that integrate psychosocial assessment and individualized education into CHD care. Contact: Kerri Pastor, LCSW; Kerri.Pastor@advocatehealth.org
Platform 4.2.	Ready or Reluctant? Perceptions, Attitudes, and Readiness for Epinephrine Autoinjector Self-Carry in Pediatric Populations <i>Chumeng Wang, BS; Michelle Y. Lee, BScA; Thritha Anand, BS, MPH; Zoe Hardie; Sujani Srinivasan; Stephanie Sustaita; Pooja Varshney, MD</i> Background: Delayed epinephrine use in pediatric anaphylaxis leads to preventable harm, with correct epinephrine autoinjector (EAI) use noted in only 16–32% of cases. Although caregivers and physicians agree that children ages 9–11 are developmentally appropriate to begin transition to EAI self-carry and self-administration, training is often inconsistent, leading to low

	caregiver confidence. Several knowledge gaps exist in relation to EAI self-carry and administration, including absence of existing frameworks to assess readiness and paucity of educational materials tailored to supporting this transition. Methods: Patient-caregiver dyads (ages 9-21) completed an 18-item survey assessing readiness for EAI self-carry and self-administration, including questions from the Food Allergy Quality of Life Questionnaire. Patient-caregiver confidence was measured before and after EAI training using a Likert scale. Clinic staff completed REDCap surveys on factors influencing readiness for self-carry. Results: Nineteen patient-caregiver dyads were surveyed (mean patient age 12.3 ± 2.9 years). Patients reported high confidence in recognizing anaphylaxis symptoms (4.16/5), though 32% had never practiced EAI self-administration, and only 21% had practiced within the past year. Before training, patient confidence in self-administration was 2.89/5 and caregiver confidence was 3.89/5; after training, confidence increased to 4.11/5 and 4.53/5, respectively. Most caregivers felt EAI self-carry education should begin in late elementary (47%) or middle school (47%). Clinic staff identified age, maturity, anaphylaxis recognition, and proper EAI technique as key factors in determining readiness for self-carry, with most approvals occurring ages 11-18. Reported barriers included limited clinic time for EAI education and poor patient understanding of EAI action plans. Conclusion: EAI training significantly improved both patient and caregiver confidence in self-administration. These findings highlight the importance of structured transition education, regular practice, and developmentally appropriate readiness assessments to support safe EAI self-carry in pediatric patients. Contact: Chumeng Wang, BS; chumeng@utexas.edu
Platform 4.3.	Building Provider Capacity and Integrated Legal Process Support to Improve Healthcare Transitions for Youth with Chronic Conditions <i>Alberta Kaichian MSW, LCSW, CCTP, C-DBT; Isabela Garcia, LLM; Bertha S. Hayden, Esq.; Rachel Cuevas; Debra Lotstein, MD, MPH, FAAP, FAAHPM; Courtney Porter, MPH, CPHQ</i> Background: Youth with chronic conditions frequently encounter complex legal decisions as they transition to adulthood, yet caregivers and clinicians often lack accessible, developmentally appropriate guidance to navigate these processes. Traditional transition efforts focus primarily on patient education, leaving a critical gap in provider facing resources and cross sector collaboration. Center for Healthy Adolescent Transition (CHAT) sought to address these challenges by developing integrated legal process supports and building clinician capacity to deliver informed, person-centered guidance. Methods: CHAT developed and implemented a multi layered model of patient and family education, direct legal assistance, and clinician training and resources. To support, CHAT partnered with a nonprofit legal services organization. Families first attended an educational workshop on available options to support decision-making provided by CHAT social worker. Families were then invited to additional direct legal assistance workshops led by the legal organization. Conservatorship workshop offered eligibility screening, legal education, and guided form completion. Supported Decision Making (SDM) workshop enabled patients to complete SDM agreements and/or power of attorney documents onsite. To support building clinician capacity, training and educational opportunities were provided. Clinician-facing tools, including decision tree, were developed to support discussions.

	Results: To date, 184 caregivers have attended an educational workshop. Total of 105 families participated in conservatorship workshops, with 102 completing and filing or preparing conservatorship forms for court submission. Four SDM workshops have supported 15 families. More than 200 clinicians have participated in training or educational opportunities. Conclusions: The interdisciplinary model reduced legal barriers by integrating social work and legal expertise into a streamlined, culturally responsive structure focused on expanding provider capacity and increasing access to legal process support. Families gained clearer understanding of legal options and more timely access to appropriate interventions. Ongoing refinement of workshops, tools, and individualized support continues to broaden access for families who would otherwise face barriers during transition to adulthood. Contact: Alberta Kaichian, MSW, LCSW, CCTP, C-DBT; akaichian@chla.usc.edu
Platform 4.4	Development of a Core Health Care Transition Outcomes Set for Adolescents and Young Adults with Juvenile Idiopathic Arthritis Transitioning from Pediatric to Adult Rheumatology Care <i>Jennifer Chi, MHS; Courtney Wells, PhD, MSW, MPH, LGSW; Tova Ronis, MD; Bryce B. Reeve, PhD; Philip van der Wees, PhD, PT</i> Background: Juvenile Idiopathic Arthritis (JIA) is a chronic condition that manifests in childhood and requires ongoing care. As adolescents with JIA grow into adulthood, they must transfer from pediatric to adult rheumatology providers to receive developmentally appropriate care. However, gaps in care during this time can lead to worse health outcomes, increased emergency visits, and higher costs. Although professional guidelines recommend “health care transitions” to prepare patients for this eventual transfer, systematic implementation in the U.S. has been difficult. This study aimed to identify a core set of important outcomes for health care transitions, based on input from young adults with JIA, parents/caregivers, and pediatric and adult rheumatology clinicians. Methods: This study used an exploratory mixed-methods approach. Patient partners from the Young Patients’ Autoimmune Research and Empowerment Alliance were consulted at key stages throughout the project. Potential outcomes and outcome measures were identified through literature reviews, six qualitative interviews, and a focus group. Then, 19 participants completed a three-round Delphi study to identify consensus priority outcomes and outcome measures. Results: A total of 54 potential outcomes and 59 outcome measures were identified from literature reviews and qualitative interviews. Following the Delphi study, the final core set includes 10 outcomes across all areas of the Quadruple Aim framework. Two associated outcome measures were also identified as highly relevant. Three secondary outcomes are also included. Conclusion: The core outcome set was identified in a consensus-driven manner by key groups involved in healthcare transitions. The core set provides a practical starting point for implementing or improving health care transition programs for adolescents and young adults with JIA while allowing flexibility for individual needs. Contact: Jennifer Chi, MHS; chijt@gwu.edu