

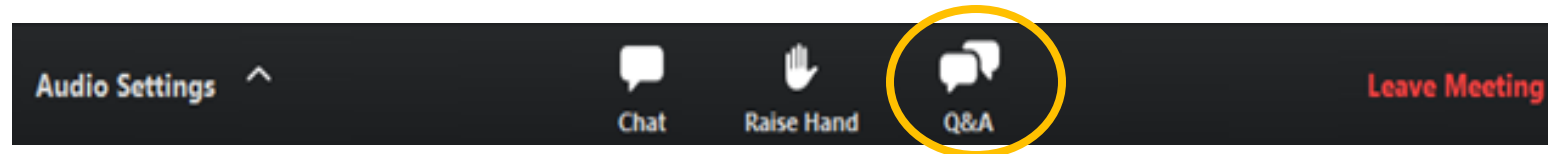
# Building Patient-Centered Care in School-Based Health Centers:

## Supporting Student Transitions from Pediatric to Adult Healthcare

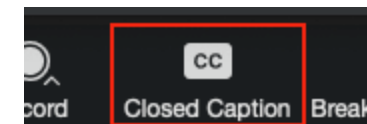
Tuesday, March 24, 2026

# REMINDERS

- All attendees are in listen-only mode.
- To ask a question during the session, use the “Q&A” icon that appears on the bottom of your Zoom control panel.



- To turn on closed captioning, click on the “CC” button.



- Please complete evaluation poll questions at the end of the presentation.

# Today's Presenters



**Addie Van Zwoil, PhD, LCSW/LMSW**  
Vice President  
School-Based Health Alliance



**Theresa Dominguez, MPH**  
Director  
School-Based Health Alliance



**Donnie Greco, BA**  
Associate  
School-Based Health Alliance



## Our Initiatives

For more than 20 years, the School-Based Health Alliance has been at the forefront of efforts to advance child and adolescent health. Our collaboration with national, state, and local partner organizations has yielded a multitude of resources, learning collaboratives, and initiatives that have helped to establish and enhance school-based health care as a critical component of community health.

### OUR WORK

## We are continually making An impact

Through our initiatives, we have been able to empower school-based health providers with the knowledge, tools, and resources necessary to respond effectively to the unique health needs of children and adolescents. By building their capacity and promoting best practices, we have not only improved the quality of care provided but also helped to establish a strong foundation for future generations.

Our work has had a profound impact on the development of school-based health care and the broader community. By investing in this critical area of healthcare, we have been able to help promote the well-being of children and adolescents and create a healthier, more prosperous future for all.

Learn More About Our  
Work at  
<https://www.sbh4all.org/>

# Learning Objectives

## Participants will be able to...

- Define patient-centered care in the school-based health context and identify strategies to engage students as active participants in their care.
- Explain how School-Based Health Centers can support students in developing skills to manage their own health care during and after high school.
- Apply the GOT Transition<sup>®</sup> framework to strengthen or develop transition practices within their school-based health center.

# Session Overview

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Why student-focused, patient-centered care matters

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Engaging students, parents, guardians, and caregivers

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Preparing students for independence in health management

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The GOT Transition<sup>®</sup> framework

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Examples and implementation strategies from the field

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Discussion and next steps

# Why This Matters

- Including children in their healthcare when cognitively able from a young age can help increase understanding of their health while also reducing fear
- Adolescence is a critical period for developing health independence.
- Many students lose continuity of care after graduation.
- SBHCs can bridge the gap between pediatric and adult care systems.
- Patient-centered care helps students build trust, autonomy, and confidence in managing their own health.



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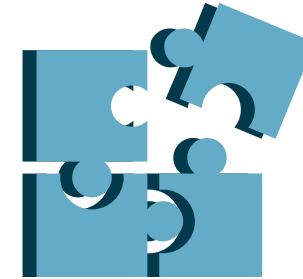
Source: Richard C. Adams, Susan E. Levy, COUNCIL ON CHILDREN WITH DISABILITIES; Shared Decision-Making and Children With Disabilities: Pathways to Consensus. *Pediatrics* June 2017; 139 (6): e20170956. 10.1542/peds.2017-0956  
<https://publications.aap.org/Citation/Download?resourceId=38683&resourceType=3&citationFormat=0>

# Seeing Students as the Primary Patient

- Prioritizing engaging parents, guardians, and caregivers over students shifts the role of the student.
- Patient-centered care requires seeing the student as the patient.
- Use consistent, developmentally appropriate messaging
- Build direct communication and shared decision-making with children and youth.
- Encourage reflection:
  - Do I speak to the student or about the student?
  - How do I involve them in their care plan?

# Engaging Students and Families

- Balance confidentiality and family engagement.
- Clarify the role of each partner: student leads, family supports.
- Provide family education on adolescent autonomy.
- Use joint visits or family sessions to encourage communication- think how to do this in the school-based health setting:
  - At the end or beginning of the visit, call the parents, guardians, or caregivers via phone, video call if capable
  - Have staff connect to identify best time
  - Possibly have the parent come in if that is preferred for a portion of the visit
  - Help families understand what services are available and how they can work together to achieve shared outcomes



# Setting Students Up for Success

## Elementary School (Age ~ 5-10)

### *Build Comfort and Trust*

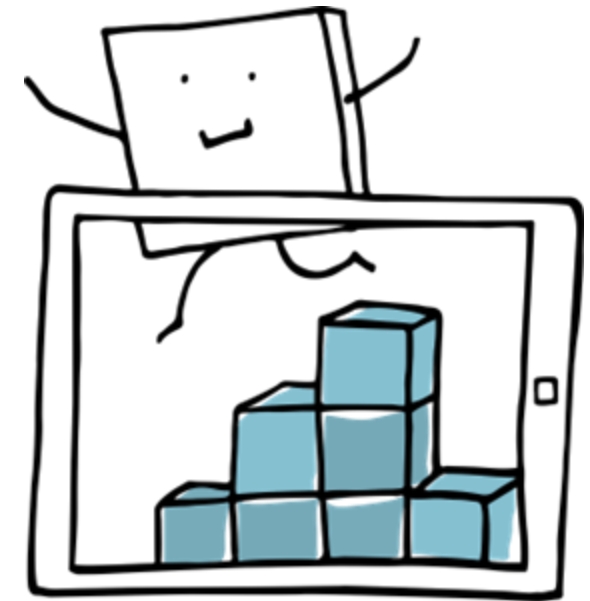
- Introduce the SBHC as a **safe, supportive place**
- Encourage students to **name feelings and basic needs**
- Normalize asking adults for help
- **Begin age-appropriate conversations about health and wellness**

# Setting Students Up for Success

Middle School (Ages ~ 11-13)

*Build Awareness and Skills*

- Introduce the idea of **growing independence** in health care
- Teach students to **describe symptoms and concerns**
- Encourage participation in visits and basic decision-making
- Reinforce trusted adult support



# Setting Students Up for Success

High-School (Ages ~ 14-18+)

Build Independence and Readiness

- Engage students in **transition planning conversations**
- Teach skills: appointment scheduling, understanding medications/ refill requests, follow-up, and insurance basics
- Support youth to **lead parts of their visit**
- Prepare for **handoffs to adult care** and community providers, and embed transition preparation into senior year wellness visits

# Introduction to the GOT Transition<sup>®</sup> Framework

- A structured, evidence-informed model for supporting youth as they transition to adult care.
- Adaptable to SBHCs for preparing students to manage care independently.
- Six Core Elements:
  1. Transition Policy/ Guide
  2. Tracking and Monitoring
  3. Readiness Assessment
  4. Transition Planning
  5. Transfer of Care
  6. Transition Completion

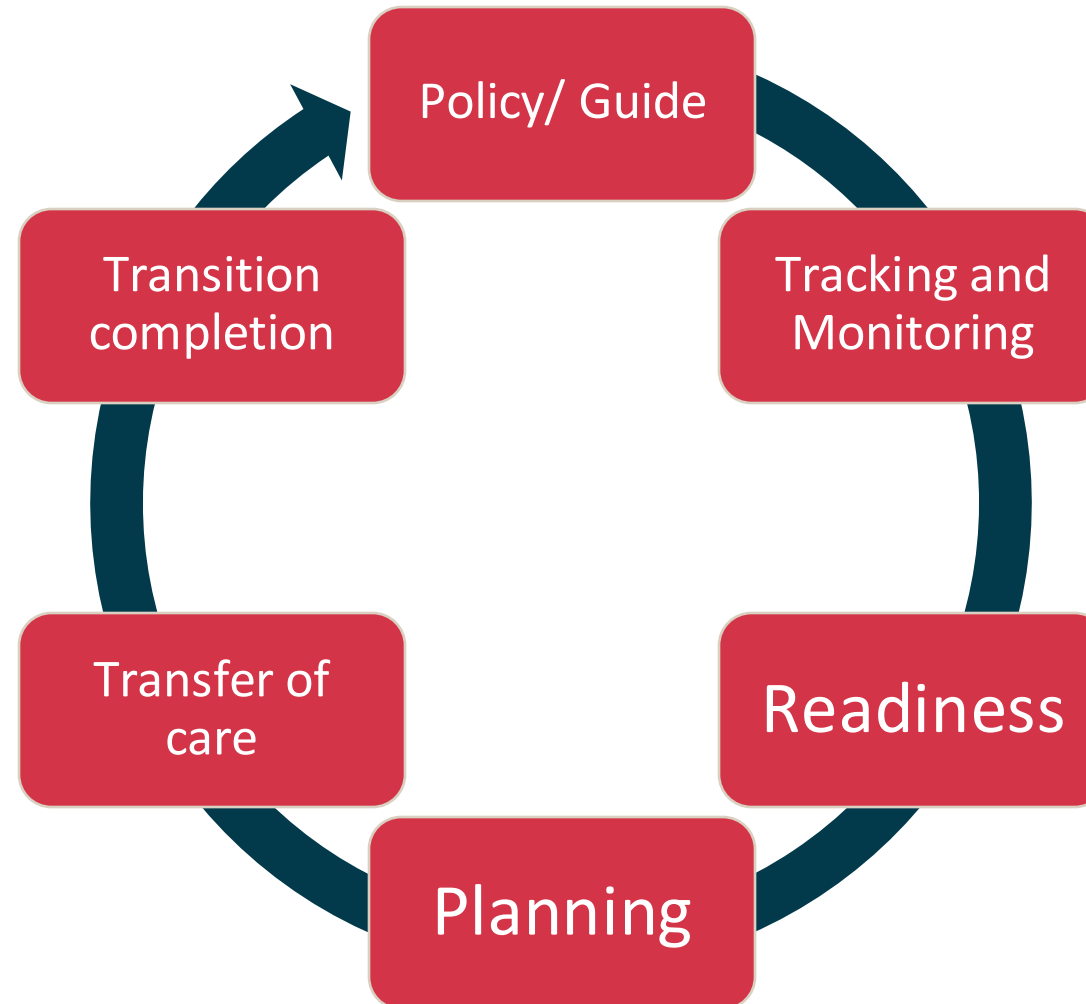


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*White P, Schmidt A, Shorr J, Ilango S, Beck D, McManus M. Six Core Elements of Health Care Transition™ 3.0.  
Washington, DC: Got Transition, The National Alliance to Advance Adolescent Health; July 2020.*

# Introduction to the GOT Transition<sup>®</sup> Framework

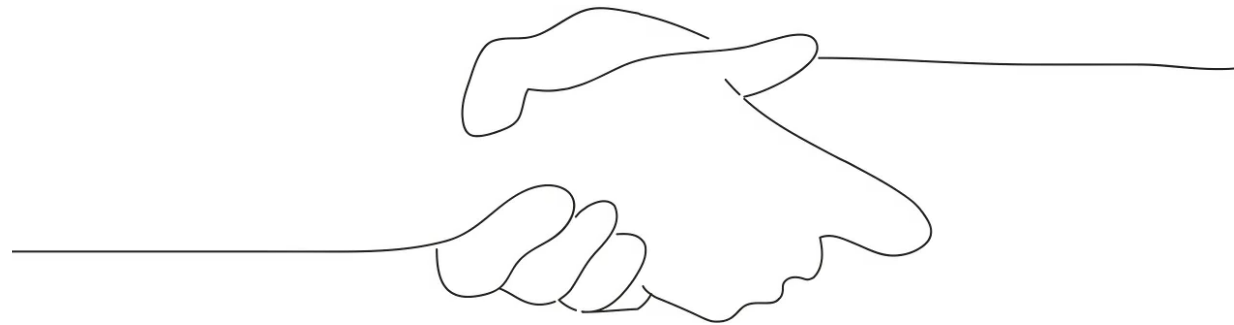
## The Six Core Elements



# Healthcare Transition Timeline

## Ages 12-13

- Support the student in **learning about their health condition, medications, and allergies.**
- Support the student by **providing opportunities** for questions about their health.
  - What is your SBHC currently doing with this age group?



Source: HCT Timeline-Youth and Young Adult: <https://gottransition.org/resource/?hct-timeline-youth-young-adults>

# Healthcare Transition Timeline

## Ages 14-15

- Find out what students know about their health, health care, and family medical history.
- Support students understanding of their health and what to do in case of an emergency.
- Engage students in making appointments at the SBHC and ordering prescription refills (either by phone, online, or through an app).



Source: HCT Timeline-Youth and Young Adult: <https://gottransition.org/resource/?hct-timeline-youth-young-adults>

# Healthcare Transition Timeline

## Ages 16-17

- Ensure students are provided the conditions to make appointments, communicate questions, and refill medications.
- Talk with students about their privacy rights when they turn 18.
- Discuss medical summary with student
- Discuss with the student and parents, guardians, or caregivers about the age desired to transfer to a new doctor for adult care.



Source: HCT Timeline-Youth and Young Adult: <https://gottransition.org/resource/?hct-timeline-youth-young-adults>

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# Healthcare Transition Timeline

## Ages 18-21

- Transition students to a new adult provider, if needed.
- Update the medical summary with the student while confirming they have a copy/ access to a copy.
- Confirm the student has connected with a new provider
- Review any additional changes at 18 that could impact the student.

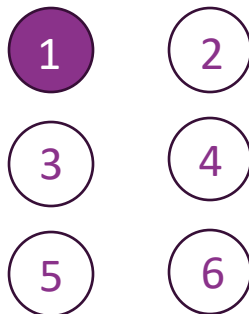
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Source: HCT Timeline-Youth and Young Adult: <https://gottransition.org/resource/?hct-timeline-youth-young-adults>

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# Core Element 1

## Transition Policy



**Purpose:** A written policy establishes a formal approach to health care transition and communicates expectations to students, families, and staff. It helps ensure that the transition from pediatric-focused care toward adult-centered care is routine and supported.

### Policy should include:

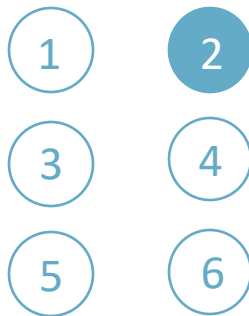
- Philosophy: Every student deserves a supported transition
- Roles: What students, families, and health center staff/providers are responsible for
- Confidentiality/consent: What changes at age 18 and how information sharing works
- How it's shared: Posted and reviewed routinely (not just filed away)

# Core Element 2

## Tracking and Marketing



**Purpose:** Identify students who need transition support and track progress through key transition steps.



### Tracking & Monitoring

- Identify students who need transition support (e.g., age 16+, nearing graduation)
- Use a registry to track key transition milestones and dates
- Monitor progress (readiness assessment → plan → referrals/connection to adult care)
- Use tracking to guide outreach: *who is due next?*

# Core Element 3

## Readiness Assessment



**Purpose:** Assess and strengthen students' self-management skills so they are prepared to navigate adult health care systems.

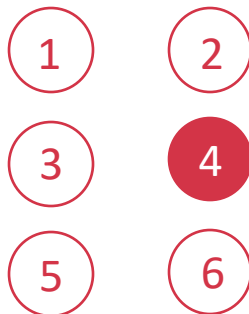


### Transition Readiness

- Assess student readiness for managing health care (starting in adolescence)
- Identify strengths and skill gaps (meds, appointments, communication, insurance)
- Provide coaching/resources to build self-management skills
- Repeat assessments over time to show growth and guide next steps

# Core Element 4

## Transition Planning



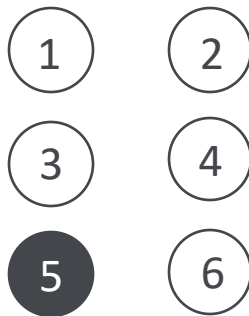
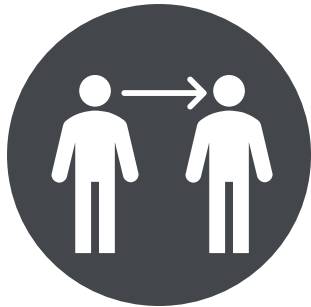
**Purpose:** Turn readiness results into an individualized plan with goals, action steps, and supports that prepare the student for transfer.

### Transition Planning

- Create an individualized transition plan based on readiness results
- Document goals, action steps, and timelines (student-led when possible)
- Build key transition tools (medical summary, medication list, crisis plan as needed)
- Coordinate referrals and warm handoffs to adult providers/services

# Core Element 5

## Transfer of Care



**Purpose:** Support a coordinated handoff to adult care by ensuring the student has needed information, referrals, and follow-through.

### Transfer of Care

- Prepare students for what changes in adult care (privacy, independence, expectations)
- Send essential information (medical summary, transition plan, key records)
- Support referral completion: scheduling and first appointment follow-through
- Use warm handoffs when possible to reduce drop-off

# Core Element 6

## Transition Completion



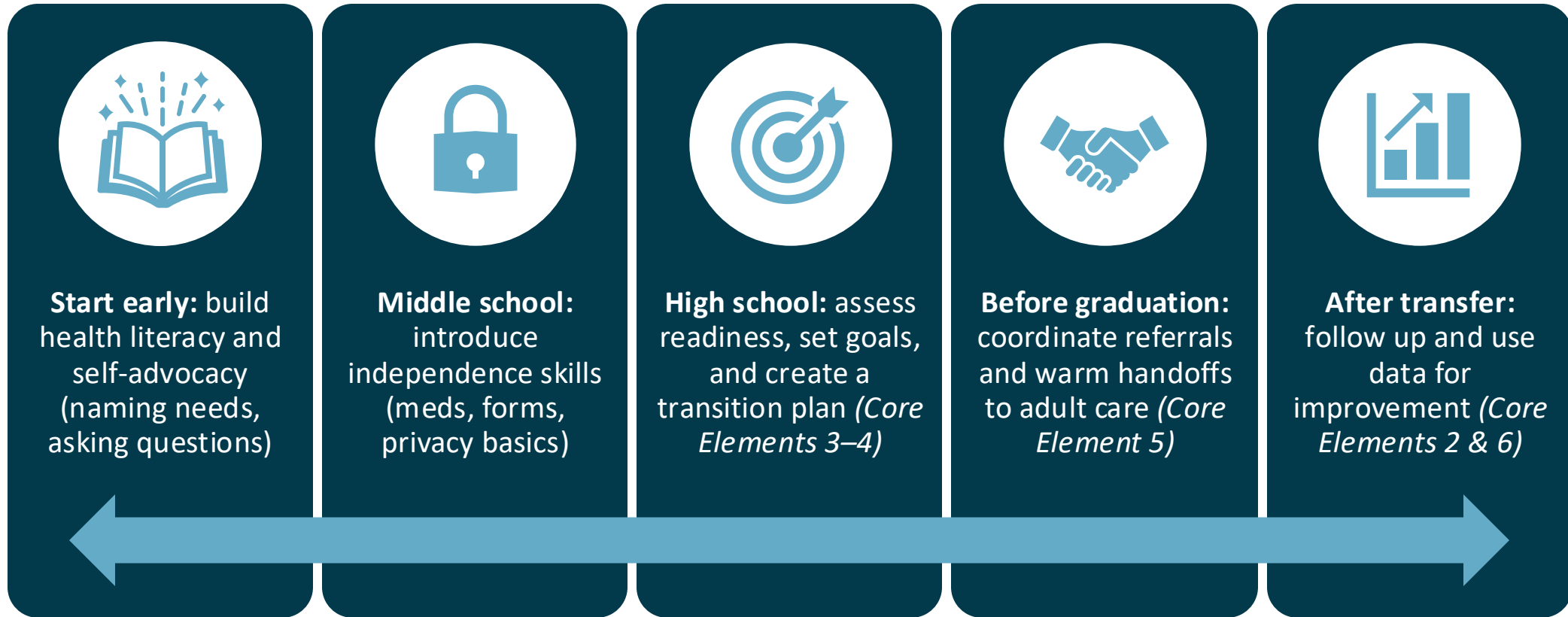
**Purpose:** Confirm the student successfully connected to adult care and use feedback and data to improve the transition process over time.



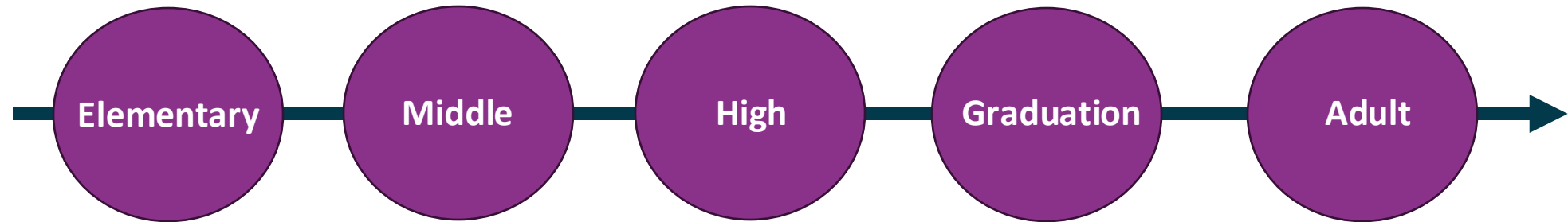
### Transition Completion

- Confirm the student successfully connected to adult care/services
- Follow up after transfer: Did they attend the visit? Do they feel supported?
- Capture feedback to improve your transition process
- Use data for quality improvement (completion rates, gaps)

# Health Care Transition as a Developmental Process

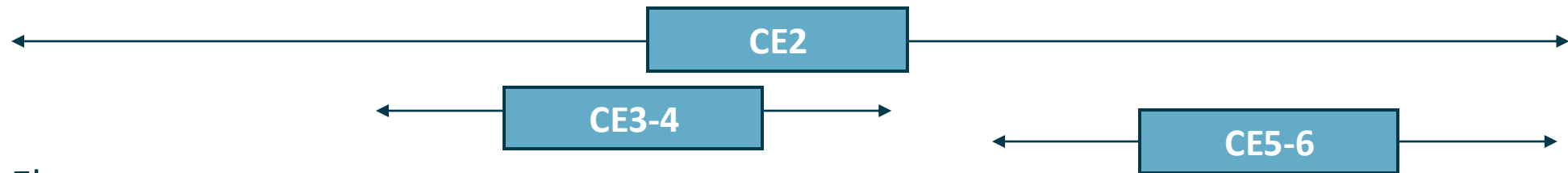


# Timeline



**Skills:** Health Literacy → Independence → Navigation

**Supports:** Education → Planning → Referral → Follow-up



CE = Core Element



# Implementation Opportunities

- 1 Integrate transition planning into routine workflows.
- 2 Develop partnerships with local clinics and youth-serving organizations.
- 3 Use existing tools: GOT Transition and SBHA Toolkit.
- 4 Track metrics such as readiness completion or post-graduation connection rates.

# Menti Poll:

**Question 1:** What mindset shift is most important when working with youth transitioning to adult care?

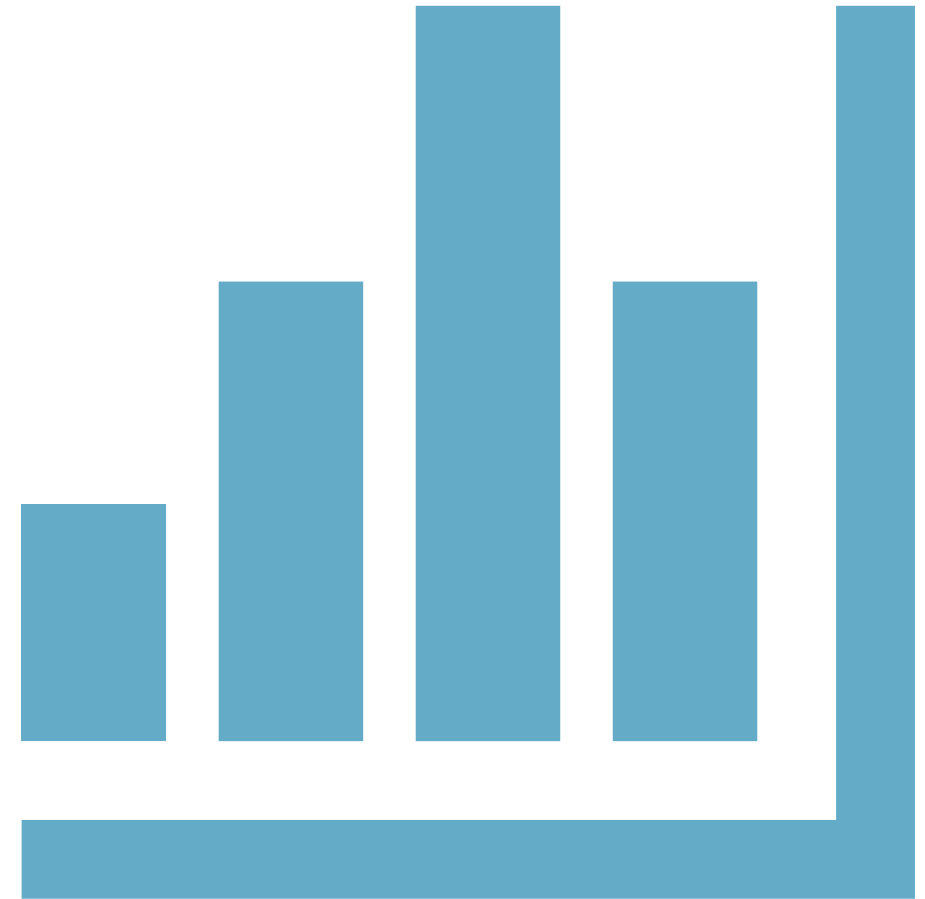
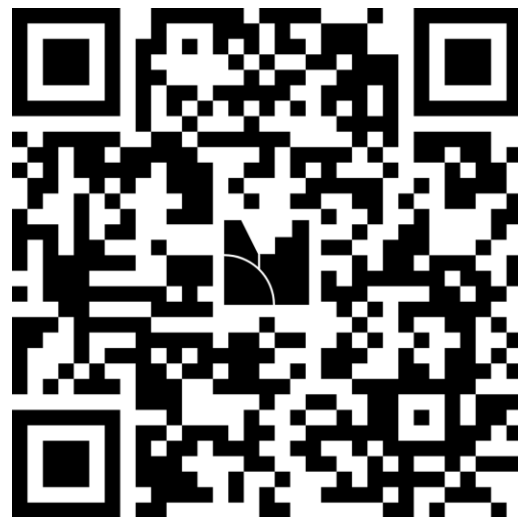
Please log on to [Menti.com](https://www.menti.com) and enter code: **6178 9511**



# Menti Poll:

**Question 2:** How confident do you feel engaging youth differently than adults?

**Please log on to Menti.com and enter code: 6178 9511**



# FACILITATING HEALTH CARE TRANSITION FOR ADOLESCENTS IN SCHOOL-BASED HEALTH CENTERS:

## AN EXAMPLE APPROACH

# Meet the School-Based Health Center Staff:



**Patricia Bailey, RMA**  
Registered Medical  
Assistant, Billing Manager



**Jackie Rincon, MSN,  
APRN, FNP-BC**  
Clinical Manager, Family Nurse  
Practitioner



**Arden Baldinger, BS,  
RDN, LDN**  
Public Health Registered  
Dietician



**Marcey Hernandez,  
MSW, LCSW**  
Licensed Clinical Social Worker



**Rachel Hogue,  
MSW, LCSW**  
Licensed Clinical Social Worker



**Susan Buechele, DNP,  
APRN, CPNP-PC, IBCLC**  
Director, Pediatric Nurse  
Practitioner



**Robert Miller, MD, FAAFP**  
Medical Director, Family  
Physician

To enhance Proviso Township High School students' academic performance and healthy lifestyle choices by providing medical, mental health, and preventive health care services.



# Introduction

- Transitioning from pediatric to adult health care poses challenges for all adolescents, especially those experiencing poverty, unstable housing, or lack of insurance
- These youth are less likely to receive transition support, increasing their risk of care gaps
- Evidence demonstrates that structured transition programs in SBHCs improve health outcomes and continuity of care [1,2]

# Why Transition Planning Matters

- Every adolescent will eventually move to adult care
- Without structured support, transitions can lead to increased ER visits, medication errors, and lapses in care
- Only 17% of youth currently receive structured transition support [2,3]



# Guidelines

- Leading national organizations (AAP, SAHM, AAFP, ACP, ANA, SPN, SBHA) recommend early, proactive, and individualized transition planning [1,2,7,8,9,10]
- Key elements include collaboration among youth, families, and providers plus development of self-management skills [4,7,8,9]

# Role of SBHCs

- SBHCs are trusted by adolescents/families and provide integrated care
- Evidence shows SBHCs promote continuity, especially for at-risk youth [1,3,7,11]
- May serve as medical home or collaborate with primary care providers
- Encouraged to integrate transition planning such as using *Got Transition*, AAP guidelines or other evidence-based guidelines or toolkits
- The SBHA endorses and promotes transition guidelines, providing implementation tools and training [1,11]

## Example Implementation at Our SBHC

- We adopted a Transition of Care (TOC) policy
- Providers identify graduating students annually
- Transition discussed at appointments
- Started with a limited readiness question set
- Students receive TOC packet, letter, and referrals
- All steps documented in EHR and TOC spreadsheet
- Director and school distribute TOC packet to all students
- Policy, TOC packet, and data reviewed annually for quality improvement

# Barriers & Challenges We Experienced

## Barriers & Challenges

- Limited staff training & capacity for added workload
- Student engagement
- Caregiver, guardian, and parental engagement
- Insurance issues
- Confidentiality issues
- Starting conversations early
- Health literacy
- Referral network



# Lessons We Learned

- Start small and expand
- Use readiness assessments even if partially
- Adapt evidence-based guidelines
- Build relationships with adult/family medicine providers
- Transition Packet consolidates resources
- Annual review essential
- Track students and outcomes; use feedback
- Team communication and partnerships are key

# Conclusion

- Transition support is vital
- SBHCs are uniquely positioned to bridge the gap with structured, evidence-based approaches benefiting youth, families, and health systems [1,4]



# References

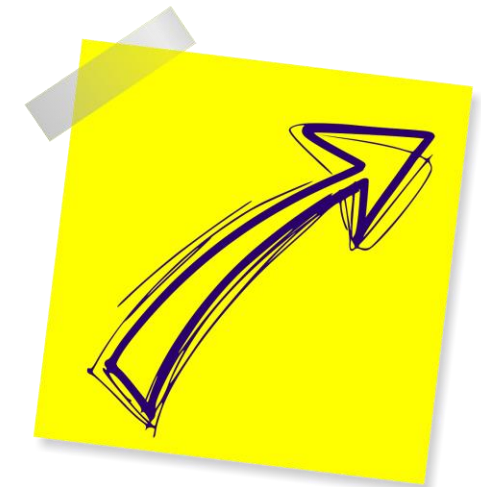
1. National School-Based Health Alliance. (2021). School-based health center standards. <https://www.sbh4all.org>
2. American Academy of Pediatrics, American Academy of Family Physicians, & American College of Physicians. (2018). Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*, 142(5), e20182587. <https://doi.org/10.1542/peds.2018-2587>
3. Love, H., Soleimanpour, S., & Schlitt, J. (2021). The impact of school-based health centers on access to care for vulnerable adolescents. *Journal of Adolescent Health*, 69(6), 950–956. <https://doi.org/10.1016/j.jadohealth.2021.07.035>
4. Zlotnick, S., Tam, V., & Sloyer, P. (2022). Evaluating health care transition outcomes in school-based health centers serving marginalized youth. *Journal of School Health*, 92(10), 1045–1052. <https://doi.org/10.1111/josh.13217>
5. Yin, L., Jameson, E., & Carter, T. (2023). Social determinants and health care transition: Addressing barriers among adolescents in underserved communities. *Pediatrics*, 151(3), e2022056789. <https://doi.org/10.1542/peds.2022-056789>
6. Society for Adolescent Health and Medicine. (2016). Transition for young adults with special health care needs. *Journal of Adolescent Health*, 58(2), 241–242. <https://doi.org/10.1016/j.jadohealth.2015.11.007>
7. Got Transition. (n.d.). Six core elements of health care transition. <https://www.gottransition.org>
8. American Academy of Family Physicians. (n.d.). Policy on Transitioning Adolescents and Young Adults into the Adult Health Care System.
9. American College of Physicians. (n.d.). Guidance for adult internists on adolescent transitions (in collaboration with AAP and AAFP).
10. American Nurses Association, & Society of Pediatric Nurses. (n.d.). Standards and resources for nurses supporting adolescent transitions.
11. National School-Based Health Alliance. (2022). Transitioning youth to adult health care: SBHC strategies webinar. <https://www.sbh4all.org>

Thank you!  
Questions?

[Subuechele@luc.edu](mailto:Subuechele@luc.edu)

# G.O.T. Transition – SBHC Next Steps:

- **Assign a Transition Lead** and select one site, age group, or service to pilot
- **Confirm when transition planning begins** and who is responsible
- **Align daily workflow** so transition conversations occur during routine visits
- **Standardize referrals and follow-up** to adult care
- **Document consistently** and identify required data elements
- **Review policies for gaps** (consent, confidentiality, family engagement)
- **Commit to one improvement** to implement within 60 days



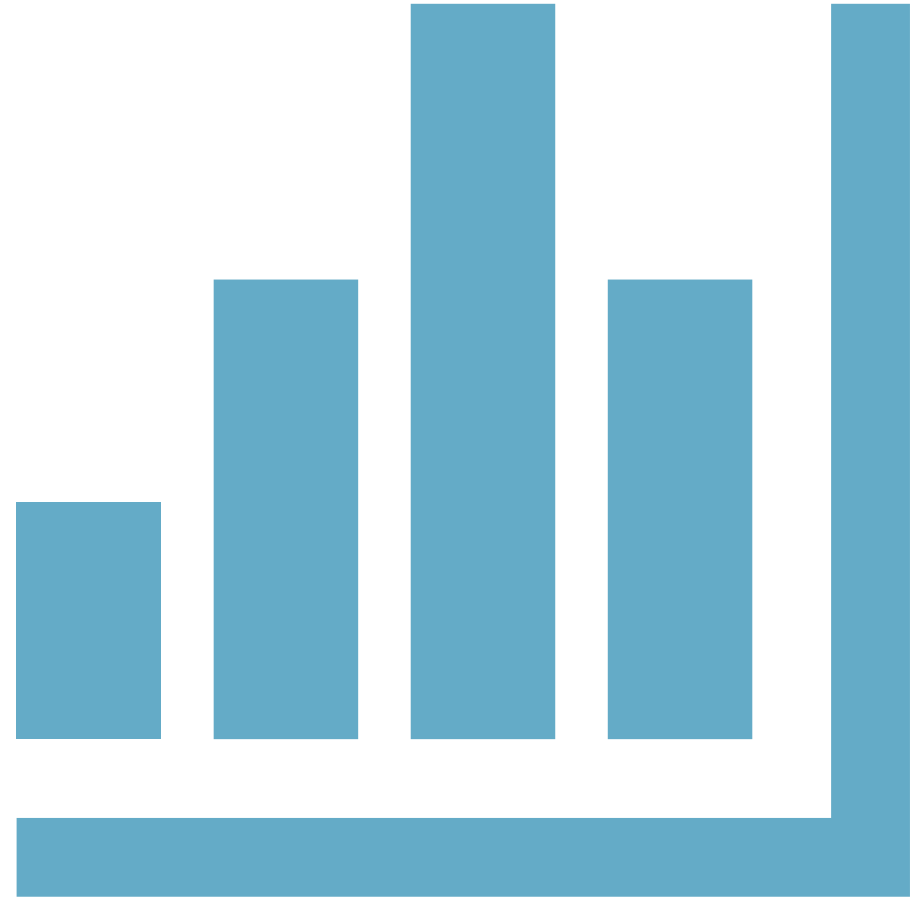
# References

- [Health Care Transition: Home – SBHA Toolkits](#)
- Healthcare Transition Timeline: [HCT Timeline-Youth and Young Adult](#)
- [Got Transition® - Six Core Elements of Health Care Transition™](#)
- What is Healthcare Transition 101: [https://youtu.be/7c\\_J8x\\_R-zM?si=tmceUvXtVvtiXxos](https://youtu.be/7c_J8x_R-zM?si=tmceUvXtVvtiXxos)
- Transition to Adult Care – Well Teens and Chronic Illness - [Transition to Adult Care – SAHM](#)
- Examples from the field:
  - Transition Readiness Assessment - [Sample Readiness Assessment-Children’s National SBHC](#)
  - Sample Policy - [Sample Welcome and Care Policy-Children's National SBHC](#)

# Questions & Answers



# Please complete our Zoom poll





**2026**

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