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Different Demands, Same Goal: Promoting Transition Readiness in Adolescents and Young Adults With and Without Medical Conditions

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A B S T R A C T

Purpose: This study aimed to examine differences in transition readiness, self-involvement and parental involvement in completing medical tasks, and general self-efficacy between a sample of older adolescents and young adults (AYAs) with medical conditions and a sample of healthy peers. Relations among these variables were also examined.
Methods: The sample included 494 AYAs (mean age = 19.30 years, standard deviation = 1.33) who reported on their levels of transition readiness, self-involvement and parental involvement in completing medical tasks, and general self-efficacy.
Results: AYAs with medical conditions reported significantly higher levels of transition readiness and self-involvement in completing medical tasks and lower levels of parent involvement in completing medical tasks than healthy peers. Parent involvement in completing medical tasks indirectly related to transition readiness through AYA self-involvement in completing medical tasks for both AYAs with medical conditions and healthy peers.
Conclusions: AYAs with medical conditions appear to have greater transition readiness skills and demonstrate more independence in completing medical tasks than healthy peers. For AYAs with medical conditions and healthy peers, transition readiness appears to be enhanced as parents decrease their involvement in completing AYAs' medical tasks and AYAs increase self-involvement in completing these tasks. AYAs with medical conditions, as well as healthy peers, may benefit from programming delivered in primary care, specialty clinic, or educational settings that focuses on increasing AYAs' involvement in and responsibility for managing their health care.

IMPLICATIONS AND CONTRIBUTION

Although adolescents and young adults with medical conditions demonstrate greater independence for health care self-management than healthy peers, transition readiness may be enhanced via similar pathways for both groups. Providers in specialty, primary care, or educational settings may increase transition readiness by targeting the shift of responsibilities from parents to patients.

Emerging adulthood is marked by shifts toward greater autonomy, with many older adolescents and young adults (AYAs) living on their own for the first time and assuming more responsibility for their well-being. Transition readiness, or the degree to which AYAs self-manage health care responsibilities and demonstrate readiness to transfer from pediatric to adult providers [1], is salient during this phase. AYAs with medical conditions often have exposure to transition-focused education before transferring to adult providers [2–4]. AYAs without medical conditions are also expected to self-manage medical tasks. Healthy adolescents have demonstrated lower rates of health care utilization compared to peers with special health care needs [5], suggesting that they may have underdeveloped

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transition readiness skills. AYAs with medical conditions have likely had more experience in medical self-management, suggesting that their transition readiness skills are more advanced. Clarifying the nature of transition readiness in AYAs with and without medical conditions will likely inform health care practices and policies to promote adaptive functioning in adulthood for patients with a range of medical needs.

Allocation of parent-AYA treatment responsibility plays a role in transition readiness, with responsibilities shifting from parents to patients as AYAs demonstrate increased competence in health care self-management [6,7]. AYAs with medical conditions have health issues that may persist across development [8]. As such, allocation of parent-AYA responsibility has been examined in pediatric chronic illness samples [9–11], although without comparison to healthy peers. Illness management demands suggest that parent and AYA involvement may be higher for AYAs with medical conditions than that for healthy peers. Data comparing AYAs with and without medical conditions would contextualize whether AYAs with medical conditions self-manage below, equal to, or above what would be expected from healthy peers.

As parents decrease involvement in AYAs' health care, AYAs' self-efficacy (i.e., belief in one's ability to solve problems and complete tasks [12]) may increase and enhance transition readiness. Among college students, health self-efficacy is related to greater health responsibility [13]. Findings from AYA diabetes literature supported associations between self-efficacy and disease management [14–16]. In a sample of adults with and without chronic illnesses, patients with greater "activation" (i.e., self-efficacy, locus of control, and readiness to change) were more likely to engage in self-management behaviors for specific medical conditions and general health behaviors (e.g., exercising; [17]). For AYAs with chronic illnesses, the appropriate shift from parents to AYAs for control of issues related to AYAs' illness demands has been acknowledged as potentially enhancing transition readiness [18]. AYAs with medical conditions manage medical needs and typical demands of this developmental period [19], suggesting that they may have higher self-efficacy than healthy peers. Alternatively, parents of AYAs with medical conditions may be very involved in AYAs' health care management [20,21], resulting in lower AYA self-efficacy. It is unknown how AYAs with and without medical conditions compare on self-efficacy.

Little research has empirically examined a cross-diagnostic theory of how transition readiness develops. Based on conceptual and empirical work on relations between AYA-parent involvement in completing health care tasks, self-efficacy, and transition readiness [6,7,22,23], an a priori model of how transition readiness develops is proposed. Consistent with the Social-Ecological Model of AYA Readiness for Transition (SMART model [7]), our model includes modifiable patient and parent variables, which may be targets of intervention to enhance transition readiness. Our model extends the SMART model by empirically testing theorized, ordinal relations among variables that likely increase transition readiness in AYAs with diverse medical needs. Given expected high parental involvement in managing health care needs in childhood [6], our model identifies parental involvement as theoretically preceding and contributing to AYA assumption of responsibility for their health care and development of self-efficacy. As parental involvement decreases, AYA involvement in self-managing health care responsibilities and independently problem-solving (i.e., self-efficacy) is expected to increase [6,19,24]. In turn, greater AYA responsibility and self-efficacy for performing medical and general tasks should facilitate greater transition readiness. As outlined in the SMART model [7], there may be differences in how this process unfolds depending on AYA medical status.

The present study evaluated this theorized model in AYAs with and without medical conditions, with the goal of contextualizing and generalizing prior literature examining transition readiness in specific illness groups. It was hypothesized that (1) AYAs with medical conditions would have higher levels of transition readiness and parent and AYA involvement in completing medical tasks than healthy peers and (2) the relation between parent involvement and transition readiness would be mediated by AYA involvement and self-efficacy. Given equivocal prior findings and lack of theoretical precedence, comparisons between AYAs with and without medical conditions on self-efficacy were exploratory, as were analyses examining whether indirect effects were moderated by medical status.

Methods

Procedures

The institutional review board at the investigators' university approved study procedures before recruitment. Participants were recruited at a university in the Southeastern United States and were invited to enroll through an online research pool, which included a study description. Inclusion criteria were being enrolled in a psychology course with a research participation requirement and being between 18 and 25 years. Participants came to the researchers' laboratory where they completed informed consent forms and study measures. Study measures were hosted on a secure, online survey system (Qualtrics). Participants received 1 hour of research credit for course completion as compensation for their time.

Measures

Transition readiness. Transition readiness was assessed using the Transition Readiness Assessment Questionnaire (TRAQ [25]). AYAs responded to items about perceived abilities to complete health care behaviors and activities of daily living using a five-point Likert scale ranging from *No, I do not know how* to *Yes, I always do this when I need to*. The overall TRAQ score and five subscale scores (i.e., Appointment keeping, Tracking health issues, Managing medications, Talking with providers, and Managing daily activities) were calculated by averaging each AYA's responses. Higher scores indicated greater skill acquisition. Internal reliability was good to excellent for the overall TRAQ score ($\alpha = .90$), Appointment keeping ($\alpha = .82$), Managing medications ($\alpha = .81$), and Talking with providers ($\alpha = .88$) subscales, acceptable for the Managing daily activities ($\alpha = .70$) subscale, and questionable for the Tracking health issues ($\alpha = .63$) subscale.

Adolescent and young adult and parent involvement in medical tasks. AYAs' self-involvement and parent involvement in completing medical tasks were measured using the AYA version of the Readiness to Transition Questionnaire [9]. AYAs responded to items about their involvement in completing health care activities (e.g., scheduling appointments) and parallel items about parental involvement in completing these tasks. Items