Preparing Adolescents with Asthma and Allergies for Transitions to Independent Living

Megumi J. Okumura, MD, MAS, FAAP
Divisions of General Pediatrics and General Internal Medicine
University of California, San Francisco

David R. Stukus, MD, FAAP, FAAAAI, FACAAI
Associate Professor of Pediatrics
Division of Allergy & Immunology
Nationwide Children’s Hospital and The Ohio State University College of Medicine
DISCLOSURE

• Neither Dr. Okumura nor Dr. Stukus have any relevant financial relationships with the manufacturer of any commercial product and/or provider of commercial services.
TRANSITIONS OF CARE: GENERAL CONSIDERATIONS

• Transitions is not unique to asthma or food allergy
• Improving transitions for patients with asthma and food allergies may also improve transitions to ALL patients that require disease management
WHY SHOULD WE CARE?

• Chronic conditions in childhood are prevalent
  – 16-31% have at least 1 chronic illness
  – 2-7% have serious disability
  – Over 7 million children have asthma
• >90% of children born today with severe chronic medical conditions will live to adulthood
• ~ 750,000 adolescents with chronic conditions are expected to transfer from pediatric to adult care
Health Status in 2007 Compared to 2001 in a follow up study of CSHCN

<table>
<thead>
<tr>
<th>Perceived health status (%)</th>
<th>2007</th>
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</thead>
<tbody>
<tr>
<td>Better</td>
<td>30.1</td>
</tr>
<tr>
<td>About the same</td>
<td>59.0</td>
</tr>
<tr>
<td>Worse</td>
<td>10.6</td>
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</tbody>
</table>

Okumura, M. J., A. O. Hersh, et al. (2012). "Change in Health Status and Access to Care in Young Adults With Special Health Care Needs: Results From the 2007 National Survey of Adult Transition and Health." *J Adolesc Health*. 

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Morbidity during the “Transition” to adult care can be prevented

- Improving the transition process is a way to ensure high quality care across the age spectrum
- Ensuring high quality care in the adult health care setting can decrease morbidity and mortality
- Decreasing morbidity and mortality can decrease acuity in cost and improve the lives of our patients
Crossing the Chasm: Health Care Transitions

• Defined as the “purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from the child-centered to the adult-oriented health care system.” —Blum RW, Garell D, Hodgman CH, et al. 
  Transition from child-centered to adult health-care systems for adolescents with chronic conditions. J Adolesc Health 1993;14(7):570-6.

• Consensus Statements by the AAP-ACP-AAFP to “transition patient” to adult focused health care (Pediatrics 2002)
TRANSITION ≠ TRANSFER

• Too often we focus on the event of transferring, but preparing a youth takes years

• With the help of the pediatric provider, we can ensure that our children, especially those with special health care needs make a smooth and purposeful transition and transfer to adult care
Challenges to transition exist on various levels

• Patient
• Family
• Provider
• System
Patient Challenges

• Neurocognitive development has not fully matured in most adolescents

• Patients with chronic diseases have an abrupt expectation at “age of majority” to undertake their own care

• Pediatric patients often do not have the skills to self-manage their own care
  • Only 40% of CSHCN report receiving any guidance (McManus et al, Pediatrics 2013)
Patient Challenges

• Aging out of child programs

• Loss of insurance

• Increased use of emergency services and loss of primary care

• Have significant unmet medical needs
Parent Challenges

• Parents are ill-prepared to navigate the adult health care system and adult programs

• Parents lose legal rights of their children at age of majority

• As parents age, they may not be able to care for their child
Provider Challenges

• Differences in provider roles
  – Pediatrics much more family centered (or patient excluded)
  – Adult Medicine much more patient centered (or family excluded)
  – Differences in subspecialist vs primary care roles

• Poor or non-existent communication between pediatric and adult providers
### Comfort: Being a primary care provider for patients with certain chronic illnesses

<table>
<thead>
<tr>
<th>Chronic Condition</th>
<th>Internists</th>
<th>Pediatricians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic pain</td>
<td>43%</td>
<td>16%*</td>
</tr>
<tr>
<td>Depression</td>
<td>54%</td>
<td>29%*</td>
</tr>
<tr>
<td>Hypertension</td>
<td>91%</td>
<td>31%*</td>
</tr>
<tr>
<td>Diabetes type I</td>
<td>68%</td>
<td>44%*</td>
</tr>
<tr>
<td>Asthma</td>
<td>85%</td>
<td>86%</td>
</tr>
<tr>
<td>Complex congenital heart</td>
<td>16%</td>
<td>42%*</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>15%</td>
<td>38%*</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>32%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Proportion being comfortable or very comfortable treating
* p< .001

Okumura MJ et al. JGIM. 2008 Oct;23(10):1621-7
# Cultural differences between adult and pediatric providers

<table>
<thead>
<tr>
<th></th>
<th><strong>PEDIATRIC</strong></th>
<th><strong>ADULT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age related</td>
<td>Growth and Development, Future oriented</td>
<td>Maintenance Optimize present</td>
</tr>
<tr>
<td>Philosophy</td>
<td>Family-Centered</td>
<td>Patient-Centered</td>
</tr>
<tr>
<td>Approach</td>
<td>Proactive, paternalistic</td>
<td>Reactive, Collaborative</td>
</tr>
<tr>
<td>Decision making</td>
<td>With family</td>
<td>With patient</td>
</tr>
<tr>
<td>Insurance</td>
<td>Entitlement</td>
<td>Qualify/eligible</td>
</tr>
<tr>
<td>Non-adherence</td>
<td>More assistance</td>
<td>More tolerance</td>
</tr>
<tr>
<td>Culture</td>
<td>Prevention, health oriented, team approaches</td>
<td>Maintenance, disease specific, specialist oriented</td>
</tr>
</tbody>
</table>
Overcoming these challenges: The role of the pediatric provider

– Individualized interventions that can be used to improve morbidity and care receipt to our patients.
  • Transition planning
  • Care coordination strategies (Medical Home)
  • Community Agency Support

– Generalists (Pediatricians, Family Physicians, Nurse Practitioners) can assist in helping youth with transitions
Subspecialty care

• Ideally this is done in conjunction with generalists and subspecialists

• The adult medicine world relies on the patient to have BOTH a general primary care doctor and a subspecialty doctor

• Subspecialists in internal medicine are MUCH less likely to provide medical homes for patients than their pediatric counterparts
First step: Starting early and knowing you are not alone

- Resources exist for our families and patients
- Preparing patients early is key to success
  - If you do not ask how they are preparing, how do you know what a patient/family does not know?
  - Patients and parents rely on you to tell them how to prepare
- Thinking about what our patients need
Preparation for adult roles takes time

- Most pediatricians focus on the last visit, but acute issues arise making this event difficult
- **Transition planning** is a purposeful process, screening patients and families to make sure everything is in place before the **transfer event**
- Not all aspects of care have to change at the same time
  - Primary care transfer
  - Subspecialty transfer
  - School changes (going off to college, work, living)
AAP/AAFP/ACP Clinical Report on
Health Care Transition (HCT)

- 2011 Clinical Report: joint policy by AAP/AAFP/ACP
- All youth, starting at age 12
- Algorithmic structure with
  - Branching for youth with special health care needs
  - Application to primary and specialty practices
- Extends through transfer of care to adult medical home and adult specialists

Age 12 – Youth/family aware of policy
Age 14 – HCT planning initiated
Age 16 – Preparation of youth/parents for “adult approach to care” and discussion of timing for transfer
Age 18 – Transition to adult-focused services: approach to care
Age 18-22 (26) – Transfer of care to adult medical home and specialists with transfer package

“Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home” (Pediatrics, July 2011)
6 Core Elements of Transition

1. Transition Policy
2. Transition Tracking and Monitoring
3. Transition Readiness
4. Transition Planning
5. Transfer of Care
6. Transfer Completion

- Develop Transition Policy
- Track progress
- Assess skills
- Develop transition plan
- Transfer documents
- Confirm completion

www.GotTransition.org
1. Transition Policy – You decide...

- Helps define your scope of practice

- Starting point for parents to discuss the future with pediatricians

- Gives both the provider and family an “end goal”
2. Transition Tracking / Monitoring

- Registries can ensure regular visits for youth who need more support
- Front desk staff/administrator can ensure that “transition milestones” are met
- Registries allow follow up post-transfer
<table>
<thead>
<tr>
<th><strong>Patient Name:</strong></th>
<th><strong>Date of Birth:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Diagnosis:</strong></td>
<td><strong>Transition Complexity:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Low, moderate, or high</td>
<td></td>
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</table>

**Transition Policy**
- Practice policy on transition discussed/shared with youth and parent caregiver

**Transition Readiness Assessment**
- Conducted transition readiness assessment
  - Date
  - Date
  - Date
- Included transition goals and prioritized actions in plan of care
  - Date
  - Date
  - Date

**Medical Summary and Emergency Plan**
- Updated and shared medical summary and emergency plan
  - Date
  - Date
  - Date

**Adult Model of Care**
- Decision-making changes, privacy, and consent in adult care discussed with youth and parent/caregiver (if needed, discussed plans for supported decision-making)
  - Date
- Timing of transfer discussed with youth and parent/caregiver

**Selected Adult Provider**
- Name
- Clinic
- Phone
- Fax
- First appointment/completed

**Transfer of Care**
- Prepared transfer package including:
  - Transfer letter, including effective date of transfer of care to adult provider
  - Final transition readiness assessment
  - Plan of care, including goals and actions
  - Updated medical summary and emergency care plan
  - Legal documents, if needed
  - Condition fact sheet, if needed
  - Additional provider records, if needed
- Sent transfer package
  - Date
- Communicated with adult provider about transfer
  - Date
- Elicited feedback from young adult after transfer from pediatric care
  - Date
3. Transition Readiness

- Diagnostic tools to guide interventions
- Surveys in the waiting room
- Homework for the next visit
4. Transition Planning

- Done concurrently with transition preparation
- Gives time for both youth and families to acknowledge areas that need to be addressed prior to transfer
- Identify family needs based on future activities
  - School/work trajectory
  - Future primary/subspecialty care planning
  - Insurance
  - Social programs
Giving parents and youth a roadmap

+ Action Plan
+ Portable Medical Summary and Emergency Care Plan
+ Condition Fact Sheets
+ Resource Directories
Resources Directory

- Medical
- Educational
- Vocational
- Independent Living
- Home Care
- Guardianship
- Insurance & SSI
- Financial Planning
- Advanced Directives
- Relationships/Sexuality
Resources

• General and disease specific “time lines” for parents and youth: http://www.sickkids.ca/Good2Go/For-Youth-and-Families/Transition-Tools/Help-Them-Grow-so-They're-Good-2-Go-Timelines/Index.html

• http://www.gottransition.org
Asthma

- Affects ~9% of adolescents 15-21 years old
- Male:Female ratio switches during adolescence
- Leading cause of ED visits, hospitalizations
- Mortality rate (per million)
  - Age < 18 = 2.5
  - Age > 18 = 14.1

2014 CDC data: [http://www.cdc.gov/asthma/most_recent_data.htm](http://www.cdc.gov/asthma/most_recent_data.htm)
Accessed August 4, 2016
Food Allergies

• Affect 6-8% of children and 4% of adults\(^1\)
• Children: milk, egg, wheat, soy, peanut
• Adults: peanut, tree nuts, fish, shellfish
• Leading cause of anaphylaxis outside hospital setting
  – Mortality rates (per million)\(^2\)
    ▪ Age < 19 = 3.25
    ▪ Roughly 20 deaths per year

**Are College Students at Risk for Bad Outcomes?**

- Scant published data regarding outcomes of adolescents living independently with asthma and food allergy

- Factors associated with asthma morbidity/mortality:
  - Nonadherence to asthma controllers
  - Poor inhaler technique
  - Exposure to triggers (smoking!)

- Factors associated with food allergy mortality:
  - Teenagers
  - Severe asthma
  - Peanut or tree nut allergy

  — *Delayed administration of epinephrine*
SELF-MANAGEMENT OF ASTHMA AND FOOD ALLERGIES

• Avoidance of triggers
• Recognition of symptoms
• Availability and use of rescue medications
• Use of daily treatment plan
• Use of symptom treatment plan
• Routine follow up with physician
• Maintenance of overall health/sleep
ROLE OF THE CLINICIAN

1. Recognize the factors that may negatively impact teenagers as they transition to independence
2. Anticipate their needs as they leave home
3. Help teens prepare for these challenges
4. Start discussing early!
5. Role play, practice, provide resources
DISTRACTIONS ABOUND WITH INDEPENDENT LIVING

Non-adherence Exposures
- Not taking meds
- Ignoring symptoms
- No refills
- No doctor visits

- Class schedule and studying
- New social interactions
- Intimacy
- Drugs
  - Alcohol
  - Tobacco
- Exercise
- Diet
- Sleep
- Work schedule
ASTHMA
POLL

• Which of the following barriers are most common among adolescents with asthma?
  – Improper inhaler technique
  – Inconsistent use of daily controllers
  – Poor recognition of symptoms
  – Ongoing exposure to known triggers
Asthma: Common Triggers

- Indoor allergens – dorm room
- Outdoor pollen – need air conditioning
- URIs – increased susceptibility (fatigue/stress)
- Weather changes
- Tobacco smoke
- Pollution – inner city campuses, bus routes
- Perfumes/cologne

- Roommates!!!!
TRIGGERS: HOW WE CAN HELP

• Remind anyone with allergies to adopt existing avoidance measures in new living space
• Provide letter requesting air conditioning or other accommodations
• Discuss harmful effect of smoke
  – Social situations
  – Active smoking
  – Hookah and marijuana
**Asthma: Symptoms**

- May begin with cough – can be subtle/chronic
- Nocturnal awakenings
- Wheezing, chest tightness
- Respiratory distress

- Delayed use of albuterol increases risk for poor response to treatment
<table>
<thead>
<tr>
<th></th>
<th>Well Controlled</th>
<th>Not Well Controlled</th>
<th>Very Poorly Controlled</th>
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</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong></td>
<td>&lt;2 days/wk</td>
<td>&gt;2 days/wk</td>
<td>Throughout the day</td>
</tr>
<tr>
<td><strong>Nighttime awakenings</strong></td>
<td>&lt;2 x/month</td>
<td>1-3x/week</td>
<td>&gt;4 x/week</td>
</tr>
<tr>
<td><strong>Interference with normal activity</strong></td>
<td>None</td>
<td>Some limitation</td>
<td>Extremely limited</td>
</tr>
<tr>
<td><strong>Short acting beta-agonist use</strong></td>
<td>&lt;2 days/week</td>
<td>&gt;2 days/week</td>
<td>Several times/day</td>
</tr>
<tr>
<td><strong>FEV\textsubscript{1} or peak flow</strong></td>
<td>&gt;80% pred/personal best</td>
<td>60-80% pred/personal best</td>
<td>&lt;60% pred/personal best</td>
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<td><strong>Questionnaires</strong></td>
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<td></td>
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<td>0</td>
<td>1-2</td>
<td>3-4</td>
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<tr>
<td>ACQ</td>
<td>&lt;0.75</td>
<td>&gt;1.5</td>
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<tr>
<td>ACT</td>
<td>&gt;20</td>
<td>16-19</td>
<td>&lt;15</td>
</tr>
</tbody>
</table>
Asthma: Rescue Medication

- Albuterol often not available
  - Exercise
  - Social encounters
- No one “outgrows” asthma completely
- Use albuterol prior to known triggers
  - Exercise
- Inappropriate technique and inconsistent spacer use
SYMPTOMS: HOW WE CAN HELP

• Review common symptoms and their past medical history (triggers, ED visits, etc)
• Discuss importance of early treatment with albuterol
• Get them off the nebulizer!
• 2007 NHLBI Guidelines
  – 2-6 puffs of SABA every 3-4 hours for 24-48 hours for home use
• 2016 Global Strategy for Asthma Management and Prevention
  – 2-4 puffs of SABA every 20 min for 1 hour
  – 2-4 puffs of SABA every 3-4 hours with good response
**Rescue Meds: How We Can Help**

- Please
- **Please**
- *I beg of you*

Do not teach patients that albuterol is an ‘emergency’ inhaler

- Educate patients that albuterol is a ‘rescue’ or ‘reliever’ inhaler
  - If you have asthma, you will need albuterol
- When patients are taught ‘emergency use only’
  - Removes empowerment for self management
  - Delayed administration
  - Rush to the ER
RESCUE MEDS: HOW WE CAN HELP

• Review proper inhaler technique at every office visit
• Discuss importance of spacer to maximize medication delivery to lungs
• Practice, practice, practice!
  – Have them demonstrate for you
Asthma: Daily Controllers

• Non-adherence to controllers common
  – Forgetfulness
  – Don’t pick up from pharmacy
  – Inconsistent routine
  – Failure to appreciate long term consequences***
  – Side effects
  – Misconceptions re: need to use daily, side effects
  – Improper technique
**Daily Meds: How We Can Help**

- Assess adherence
- Discuss daily routine
  - Store meds by tooth brush
  - Set reminder on cell phone
  - Asthma apps for smartphone
- Suggest automated pharmacy refill reminders
  - Transfer all prescriptions to new pharmacy
- Inquire about concerns, side effects
Asthma: Action Plan

• Use of written treatment plan recommended for all patients
• Hallmark of effective self-management
• Should clearly indicate:
  – When to start treatment
  – What to do
  – When to seek emergency care
• Often under utilized
  – 25% of 18,000 asthmatic children in Chicago schools have plan\(^1\)

GREEN Zone → All systems clear
RED Zone → Too late, seek care

**ACTION PLAN: HOW WE CAN HELP**

- Update and review action plan at every visit
- Discuss importance of having this available in future
- Encourage active involvement
  - Role play scenarios
- Mobile health apps available
Asthma: Overall Health Maintenance

- Poorly controlled asthma = frequent nocturnal awakenings
  - Poor sleep quality
  - Daytime somnolence
  - Poor concentration
  - Poor school performance

- Exercise is good!

- Routine physician appointments recommended for anyone with asthma
**OVERALL HEALTH: HOW WE CAN HELP**

- Many teens unaware of how poor asthma control may affect other parts of their life
  - Fatigue
  - Inability to concentrate
  - Restricted activities

- Make it personal
  - Inquire about their past experiences or concerns
  - Place into context they can relate to

- Don’t talk at them, talk with them!
Food Allergies
**Poll**

- Which of the following poses greatest risk for anaphylaxis in a teenager with peanut allergy?
  - Smelling peanut butter
  - Peanut shells on floor of restaurant
  - Sitting next to someone eating peanut snack
  - Eating at restaurant that uses peanut oil
SELF-MANAGEMENT OF FOOD ALLERGIES

• Avoidance of allergens
  – Communication with food handlers
  – Reading labels
  – Casual contact

• Recognition of symptoms

• Availability and use of epinephrine
**Food Allergies: Avoidance**

- Must maintain strict avoidance at all times
- Every meal or snack represents potential exposure
- Cross contact with food prep equipment can transfer protein
- Highest risk: restaurants, food prepared at gatherings
AVOIDANCE: HOW WE CAN HELP

• Discuss risks of ingestion with various exposures
• Suggest having safe food/snacks available
• Provide documentation for college
• Suggest meeting with school administrators, RA, cafeteria BEFORE start of school
Food Allergies: Communication

• Food handlers at dorms, cafeteria, restaurants need to be aware

• Hidden sources of exposure
  – Asian restaurants
  – Salad bar/buffet
  – Bakeries/ice cream parlors

• Teens at risk: peer pressure, don’t want to stand out
COMMUNICATION: HOW WE CAN HELP

• Discuss sources of hidden exposure
• Raise awareness of challenges in speaking up
  – New social encounters
  – Dating
• Role play
  – Dining out
  – Social gatherings
• Inquire about past challenges
Food Allergies: Reading Labels

• Every packaged product must clearly state these ingredients:
  – Milk, egg, wheat, soy, peanut, tree nut, fish, shellfish

• Other food allergens may be harder to identify

• No laws on what “may contain” actually means
READING LABELS: HOW WE CAN HELP

• Review importance of reading labels
  – Even if ingested before – ingredients may change
  – Common terms for allergens (esp if not Top 8)

• “May contain” vs “Processed in a facility”
  – Determine best strategy for each patient
  – Good rule of thumb:
    ▪ Avoid “may contain” and “shared equipment”
    ▪ Likely safe “same facility”
**Food Allergies: Casual Contact**

- Highest risk for anaphylaxis comes from ingestion
- Airborne reactions rare → almost always being cooked on stovetop + asthma
- Touch → may cause localized hives, swelling
- Touch and transfer to face → facial swelling
- Food proteins may remain on surfaces
  - Effective: Soap and water or commercial wipes
  - Ineffective: Hand sanitizer or gels
Casual Contact: How We Can Help

• Teens may be unaware of risks from various exposures

• Review hidden sources:
  – Peanut: dog food, egg rolls, bird seed
  – Wheat: Play dough
  – Fish: caesar dressing, worcestershire sauce
  – Egg: mayonnaise, marshmallows

• Educate regarding cleaning of surfaces and food preparation equipment
**Food Allergies: Intimacy**

- Food allergens can be transferred through saliva and intercourse\(^1,2\)
  - Peanut remains in saliva after meal until next non-peanut meal is eaten\(^3\)
- Alcohol may impede judgement & affect timing and severity of reaction

INTIMACY: HOW WE CAN HELP

• Teens may be reluctant to discuss with parents
• Medical providers can introduce concepts and speak in generalities
  – Allow for questions and follow up
• Drug and alcohol use should be discussed in greater context
  – Use examples of other “patients”
FOOD ALLERGIES: SYMPTOMS

• Immediate onset & reproducible
• Hives, swelling common
• Wheezing, coughing, vomiting, passing out
• Can occur with exposure to trace amounts & with cross contact

• Anaphylaxis
Skin and/or Mucosa
- Pruritus
- Flushing
- Hives
- Angioedema

Respiratory Compromise
- Dyspnea
- Wheeze
- Stridor
- Hypoxemia

Hypotension/End-organ Dysfunction
- Collapse
- Syncope
- Incontinence

Acute onset of illness (minutes to several hours with involvement of:

- Skin symptoms occur in >80% of cases of anaphylaxis**
- Absence of skin symptoms does not exclude anaphylaxis
- These criteria will satisfy almost all cases
Two or more that occur rapidly after exposure to likely allergen:

**Skin and/or Mucosa**
- Pruritus
- Flushing
- Hives
- Angioedema

**Respiratory Compromise**
- Dyspnea
- Wheeze
- Stridor
- Hypoxemia

**Hypotension/End-organ Dysfunction**
- Collapse
- Syncope
- Incontinence

**Persistent GI Symptoms**
- Vomiting
- Abdominal Pain

• If patient is *KNOWN* to have allergy *and* exposure, then GI symptoms more applicable
This applies to the *RARE* patient with acute hypotension *AND* known allergy *AND* known exposure

- Most children/teens do not have hypotension
- Unlikely to apply in the field
  - i.e. symptoms after receiving allergen immunotherapy injection in office setting
SYMPTOMS: HOW WE CAN HELP

• Review prior history
• Discuss likely scenarios – timing of onset, types of symptoms
• Place into context
  – Food allergy reactions almost always occur immediately surrounding meal or snack
**FOOD ALLERGIES: TREATMENT**

- First line therapy for anaphylaxis = Epinephrine!!!
- Provides rapid resolution of all symptoms
- Side effects are minimal when administered IM at recommended dosages
  - 0.15 mg < 25 kg
  - 0.3 mg > 25 kg
- Majority of deaths from anaphylaxis are associated with delayed or lack of epinephrine administration
- Recommended observation in ED **at least** 4 to 8 hours

FOOD ALLERGIES: TREATMENT

• Adolescents much less likely to be prepared to treat anaphylaxis

• Factors associated with not carrying autoinjector
  — Wearing tight clothes
  — Exercise
  — College students with prior anaphylaxis = 87% don’t carry!

• Improper technique common

TREATMENT: HOW WE CAN HELP

• Discuss use of epinephrine for anaphylaxis at each encounter
• When in doubt, use epinephrine!!!
• Practice with training device – have them show you
• Role play for scenarios where epi may not be convenient to carry
CONCLUSIONS

• Successful self-management of asthma and food allergies is challenging
• Start preparing teenage patients early
• Practice, anticipate, and practice again
• YOU can be an incredible source of information and empowerment for teenagers transitioning to independence!
RESOURCES

- www.foodallergy.org/resources/teens
- http://www.allergyhome.org/handbook/

American Academy of Pediatrics
Thank you