

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

October 14 - 17, 2007

Promising Practices: Building Data Capacity for Transition Progress and Practices

PAT HEU: Hello. And I'll be speaking about what the state performance measure on transition.

We have transition guiding principles for Hawaii state team. And our Hawaii state team also includes Family Voices of Hawaii, the American Academy of Pediatrics Hawaii chapter and University of Hawaii Department of Pediatrics. But let me start by sharing these pictures by a medical school student who was in special education and she responded to the question what does it mean to be an adult. She said becoming an adult is "being responsible to clean your room and doing the dishes and getting a job."

These are the transition guiding principles and they were written by Josie Wall of Family Voices of Hawaii. The guiding principles include that the children, that the transition of children youth with special healthcare needs and their family requires a collaborative partnership between families and professionals involved. This partnership is a shared responsibility with varying degrees of accountability over time.

And the foundation for successful transition begins in early childhood or at the first referral.

And in your handout there is a full set of the transition guiding principles. This is our approach for Hawaii transition activities. And starting off on the very left side we have the -- on the very right side is the goal that youth with special healthcare needs will transition to adult life including adult healthcare work and independence.

Taking a step before that, we wanted youth and families to have a transition plan and work toward adult life. We wanted professionals to assist and support youth with special healthcare needs and their families and transition.

And we wanted healthcare providers to facilitate the transition. And the step before that is that we wanted to increase the knowledge and skills for families, the professional partners, like care coordinators, and also healthcare providers regarding transition.

And so that's how our activities all lead to our goal. This is our state performance measure. And it's the degree to which the action plan that supports or facilitates the transition of children, youth with special healthcare needs to adult life is implemented.

We have seven activities listed. There's the scoring is from zero to four. I'll go over the activities shortly. And for scoring it's zero for activities have not begun and the range is

that the activities have just begun, are progressing, are well established or are sustained.

Next slide. One of our activities was to develop a rainbow book resource guide. And this is what our resource guide is like. On the right side of the screen is the index, and it has a whole range of services, and it includes the original brochures from each of the programs so that people who see it are able to really grasp the program better.

Our rainbow book addresses the need for access to resource information. And this was based in our Title V needs assessment in which families said they wanted access to information and they wanted the providers who worked with them to have access to this information and to provide it to families.

We have had workshops with the various programs and agencies and also various disciplines training together. And so there was also the cross-exchange of information and actually finding out who else they are working with or should be working with.

We've had a web-based evaluation, one of the monkey surveys, and it was done two to six months after the training and the findings were very positive.

For navigating the system training, we've had Family Convergence 2006 Conference, and there were sessions on successful parent/child physician partnerships, transitioning life after early intervention and transitioning life after high school.

We've had workshops in natural supports for families. Next week we'll have a workshop for family leaders on training practices and tips.

In the future, there will be training on the transition from early intervention to special education. For our youth advisory council, the purpose is to advise the HILO project, which is the state implementation grant, and also to build skills of personal leadership, self-determination and community advocacy, and our youth advisory council is intended to include both youths with disability and those within affinity or relationship with an individual with a disability.

For our best practices on transitioning, this is more of our system level one. We're still at the beginning. But we are working with providers and health plans and Medicaid and developing protocols and service models for transition. We've had a briefing with the internal medicine pediatric physicians as to how they -- what their ideas were for the transition from youth to adult healthcare. We have also had a discussion with the health, the Medicaid Health Plan medical directors who run the Pediatric Council of the American Academy of Pediatrics, Hawaii chapter.

We've also developed a four-page personal health record also in your handout. And this is to help to facilitate the transition between healthcare providers. It helps when there's a brief summary versus many volumes of a medical records.

Our transition training for residents, we've had -- it's been for both pediatric and family practice residents on the medical home role supporting families through their transition process. Residents present information and their medical home case scenarios related to transition to adult life. We've also had new conference presentation with national experts, including Kathy Hackett back there, and we also provided rainbow book training for residents so at the very beginning of their training they're aware about the state and community resources.

For our transition planning workbook, this is the workbook in your packet. It's a top story guide about the planning process for transition. And it includes tasks and decisions such as adult, such as insurance. It includes health and other resources, what services they revenue, what will they need in the future.

It has items that the families can also identify that the child or youth needs, such as for health and life skills such as making an appointment with a doctor or going to a pharmacy and being able to fill prescriptions.

The top story guide also has a activity time line so that families can create a work plan on how to address the issues over a period of time.

So no matter where the family is at the time that they start thinking about transition, they're able to start and knowing what the goal is they can figure out what their plan is to work toward it.

Putting it all together, this is what our logic model looks like. And all the activities were on the left side. And this is how we hope to build the skills and knowledge for the families, health providers and for other professionals involved with the family.

And finally, this is one of the other transition guidelines from Josie Wall, and she says, "The transition of children and youth with special healthcare needs and their families should be successful and celebrated."

And this is what we're working toward. Thank you.

(Applause)

[END OF SEGMENT]