Overarching Principles for All Transitions

Family-centered care is the acknowledged best practice model for families who have children/youth with special health care needs. It requires a commitment driven by a collaborative partnership between the family and professionals which enables children/youth to assume increasing ownership of the decision making process. Therefore:

- The transition process for children/youth with special health care needs and their family requires family-centered care which assures best practices, protocols and standards will achieve optimal outcomes including growth despite the difficulty inherent in any change.
- The transition of children/youth with special health care needs and their family requires a collaborative partnership between the family and the professionals involved.
- The transition activities for children/youth with special health care needs and their family begins with the initial referral and are ongoing as needed or requested.
- The transition of children/youth with special health care needs and their family requires the exchange of information and the transfer of those skills individually determined as appropriate.
- The transition of children/youth with special health care needs and their family is one of shared responsibility between the family and professionals with varying degrees of accountability over time.
- The transitions of children/youth with special health care needs and their family should be successful and celebrated. *J. Woll 2005*

THE HAWAI'I STATE TEAM

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HAWAI'I

Bridging the Transitions of CYSHCN to Adult Life

A Collaborative Project of the Hawai'i State Team

Bridging the Transitions of CYSHCN to Adult Life

Getting From One Place to Another…

When we think of "Transitions" we immediately think of the Big  the one that keeps parents up at night worrying  and the one that keeps youth up at night dreaming.  Our Champions Team from Hawai'i felt very strongly, that if you don't take care of all the little "t"ransitions along the way, the Big "T" will be a struggle and not the celebration it should be.

We began to focus on the little "t"ransitions. The first thing we wanted were "Overarching  Principles". We needed guidelines that would apply regardless of the transition, would apply to everyone involved, and were based upon the principles of family centered care and family professional partnerships.

We also got together to identify those particular "t"ransitions that could benefit from some attention, a ready-willing-and-able work team, and were in alignment with the Goals of the Champions for Progress.

"T"ransitions to Work On…

The Champions for Progress Incentive Award gives us an opportunity to bring members of the "choir" together and to provide opportunities for new leadership in our community. For each transition type, a work group team was created, team members were identified, and Co-Facilitators were assigned. Each group is being facilitated by a Parent and a recent graduate of our Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities (MCH LEND) Training Program.

Program to Program: We identified 17 core programs within the state who serve children and youth with special health care needs (CYSHCN). Our team is interviewing each agency to identify their intake and referral requirements, service delivery models, and family and referral expectations. All this will be incorporated into a manual, "The Rainbow Book II", for future training.

MD to MD: While every physician has his or her own way of doing things, the differences between practices can sometimes flounder families as well as other physicians. Our team is undertaking the task to devise a checklist and a recommended set of procedures for physicians to use as they provide care to the same child.

Hospital to Home: The number one request from families cross our state has been to have access to information. Our team decided to focus in on providing information to families whose children have been hospitalized and are being discharged into the community. We are creating a handy-dandy reference guide for families—written in collaboration with our state's MCH LEND trainees and parent partners. The guide is a topical index and will include a Personal Health Record Template.

Pediatric to Adult Health Care: Transition to Adulthood is the hottest topic across the country. So hot, that we in the 50th state (the closest state to the equator) are likewise working on our own Transition Checklist customized for our families with local information and local practices.

And last but not least…

Medicaid Fee for Service to Managed Care: Our state Medicaid Agency is in the process of transition our service system for Aged, Blind, and Disabled individuals from Fee for Service to Managed Care. Our team is working closely with the State Medicaid Advisory Council to establish transition guidelines, outreach protocols, and to provide training to prospective health plans.