

Healthy & Ready to Work

Because Everyone Deserves a Future

An MCHB Initiative Since 1996

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Products and Materials Developed by the MCHB HRTW Projects



Division of Services for Children
with Special Health Needs

January 2001

Healthy & Ready to Work

Because Everyone Deserves a Future

www.mchbhrtw.org

Promoting a comprehensive system of family-centered, culturally competent, community-based care for children with special health care needs who are approaching adulthood and may need assistance in making the transition from pediatric to adult health care and to post-secondary education and/or employment.

Healthy & Ready to Work (HRTW) is an initiative of the Division of Services for Children with Special Health Needs (DSCSHN) in the Federal Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS).

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Healthy & Ready to Work – An MCHB Initiative Since 1996

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Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
California Healthy and Ready to Work Transition Health Care Guide	A developmental approach to achieving self-sufficiency is presented. Parents and providers can use this developmental guide to teach CSHCN the self-care skills necessary to achieve optimal levels of self-sufficiency.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers
California Healthy and Ready to Work Training Resource (training handouts)	These handouts are used for all CA HRTW training sessions. Information contained in these handouts includes the CA HRTW Transition Assessment, CA HRTW Youth and Adult Community Resources Guide, and information on 504 Plans and ITPs.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers
California HRTW Transition Training Slides	These slides are part of the training package that can be used with outreach training sessions.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
California HRTW 504 Training Slides	These slides can be used as part of the training package for content on developing and implementing 504 plans.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers
CA HRTW Transition Clinic Procedure Guide	The description of the protocol used for the CA HRTW transition clinic services.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers
CA HRTW Transition Clinic forms	Forms used for the assessment, planning, and provision of transition services.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
California Healthy and Ready to Work Transition Health Care Assessment Guide	This guide contains 14 categories of self care competencies that can be used to assess the extent to which adolescents with SHCN are self sufficient in managing their own health care needs or the extent to which they will need additional training/support to become self sufficient.	HRTW-CA Cecily L. Betz, PhD, RN CA HRTW Project Director USC Dept of Nursing, USC UAP Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu, www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
CA HRTW Adult Outcomes Survey	Survey questionnaire (59 items) that can be used for clinical or research purposes to evaluate/assess long term outcomes in young adults with SHCN	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Health care professionals
Resource Referrals Checklist	Referral Checklist that can be used by HC professionals who make transition referrals. Referrals are listed according to the following categories: Health Services, Education Services, Employment Services, Community Living and Support Programs	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with SHCN/disabilities; health care providers

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Life Maps	Screening Tools and Teaching Sheets available for download from the internet and on CD-ROM (see CHOICES Transition Project for more complete description)	HRTW-KY TEACH Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	Health care providers wishing to track health promotion and vocational preparation from birth-21, family leaders
Transition Guidelines, Life Maps, and Teaching Sheets	Transition assessment and care guidelines, screening tools (Life Maps) which collect information and build awareness of issues. Easy-to-read format to use when family/teens indicate need for information on the screening Life Map. Guidelines, Life Maps, and Teaching Sheets have been created for ages 0-12 months, 13-35 months, 3-5 years, 6-10 years, 11-13 years, 14-16 years, and 17-21 years.	HRTW-KY TEACH Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers
Life Maps	Screening Tools and Teaching Sheets available for download from the internet and on CD-ROM (see CHOICES Transition Project for more complete description)	HRTW-KY TEACH Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	Health care providers wishing to track health promotion and vocational preparation from birth-21
Transition Timeline Form Developed by Children's Hospital, Boston, MIYD Transition Project	Transition plan, using timeline format, for use by providers in clinical settings. The form serves as a template for transition-related activities. Developed for use in two clinics at Children's Hospital, Boston.	HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 keenanp@a1.tch.harvard.edu	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>Adolescent/Young Adult Intake Form</p> <p>Developed by Children's Hospital, Boston, MIYD Transition Project</p>	<p>Form designed to identify medical, psychosocial, and insurance issues for patients who are transitioning from one developmental stage to another or from pediatric to adult centered care.</p>	<p>HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 keenanp@a1.tch.harvard.edu</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>
<p>Information about Transitions for Youth with Chronic Illness and Disabilities</p> <p>Developed by Children's Hospital, Boston, MIYD Transition Project</p>	<p>Fact sheet about transition.</p>	<p>HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 keenanp@a1.tch.harvard.edu</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>
<p>Curriculum Materials: Youth Leadership Training Materials</p>	<p>Powerpoint presentations with accompanying materials for youth delivery of the following workshops: What We Want Our (Fill in the Blank: Teachers, Parents, Health Care Providers, Legislators, Employers) To Know.</p>	<p>HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Dept of Human Services, Div. of Community & Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/cci/newcci/projects/matp/index.htm</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>Ready to Manage Your Own Health Care? (revised January 2000)</p> <p>Health Care Skills Check List and Interview Guide (Currently under revision)</p>	<p>A self-assessment tool for youth used to determine current skills/comfort in managing their own health condition. This form is designed to be used as a catalyst for health related discussions with a transition health nurse, educator or parent.</p> <p>A companion to this self-assessment is the <i>Health Care Skills Check List and Interview Guide</i>. This guide is used to explore in more depth and detail the issues raised in the self-assessment. It is a tool for understanding current level of health care skill and planning what skills need to be learned.</p>	<p>HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; school nurses; case managers; educators</p>
<p>Transition Tip & Tools PACER Center Publication (new version available summer 2000)</p>	<p>This book is a compilation of concise fact sheets related to the various aspects of transition for youth and young adults with disabilities and chronic illness. Each information section is designed to stand on its own. 1996, 2000</p>	<p>HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; school nurses; case managers; educators; professionals who work with youth who have ongoing health conditions</p>
<p>Health Care Screening for Adolescents and Young Adults</p> <p>Developed by Career Connections/HRTW</p>	<p>This is a questionnaire for youth with special health care needs. It helps identify health care transition issues by screening for health care resources, including insurance and medical home, current level of skill to manage medical treatment for chronic conditions, and potential mental health issues.</p>	<p>HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors</p>

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>Key Transition Questions</p> <p>Developed by Career Connections/HRTW and Southwest Ohio Transition Roundtable Education Work Group</p>	<p>This is a 4-fold double-sided "road map" written for parents and the professionals who work with them. It provides a time line for special education transitions, with prompt questions for parents to address with their children's education team. It addresses each transition in education.</p>	<p>HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors</p>
<p>Teen Health Workshop Guidelines</p> <p>Developed by Career Connections/HRTW</p>	<p>This is a format for a 2-3 hour workshop for teens with disabilities. It can be adapted for students with mild cognitive disabilities. It addresses disability acceptance, health care transition issues, notation, and the skills for managing a doctor's appointment.</p>	<p>HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors</p>
<p><i>Take charge for the future.</i></p> <p>Powers, L., Ellison, R., Turner, A. (1998).</p>	<p>A student-directed guide outlining steps for identifying and working towards the student's transition goals.</p>	<p>HRTW-OR Laurie Powers Director & PI Center on Self Determination/OHSU Community Solutions 3608 SE Powell Portland, OR 97212 503-232-9154, x 104/ fax 503-232-6423 powersl@ohsu.edu</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>

Guide Books/ Teaching Materials

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Youth from Teen Solutions (1999). Tips for professionals.	A handout listing tips for educators and health providers to consider when working with minority youth who have health conditions and disabilities. Generated by youth in the Teen Solutions Youth Group.	HRTW-OR Laurie Powers Director & PI Center on Self Determination/OHSU Community Solutions 3608 SE Powell Portland, OR 97212 503-232-9154, x 104/ fax 503-232-6423 powersl@ohsu.edu	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers and family leaders who are working with minority youth.
Youth from Teen Solutions (1999). Tips for starting a youth group.	A handout outlining the steps necessary for starting a youth group. Generated by youth in the Teen Solutions Youth Group.	HRTW-OR Laurie Powers Director & PI Center on Self Determination/OHSU Community Solutions 3608 SE Powell Portland, OR 97212 503-232-9154, x 104/ fax 503-232-6423 powersl@ohsu.edu	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers and family leaders who are interested in starting a youth group.
New member application package. M. Mendez (1999).	The new member application package includes questionnaires, handouts, consent forms and interview questions, and is used to screen, gather information, and orient new youth members to the youth group.	HRTW-OR Laurie Powers Director & PI Center on Self Determination/OHSU Community Solutions 3608 SE Powell Portland, OR 97212 503-232-9154, x 104/ fax 503-232-6423 powersl@ohsu.edu	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers and family leaders who are interested in starting or running a youth group.

Surveys/Assessment Tools

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Survey Forms	Written forms for teens, families, young adults, and health care and vocational services staff with questions about activities, expectations for the future, barriers to independence and health care, knowledge and use of resources, functional abilities, and suggestions for transition programming.	HRTW-KY CHOICES Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	Those developing surveys related to adolescent-to-adult transition issues
Surveys of Young Adults (generic form and one with additional questions for cardiology patients)	Printed forms with questions focusing on health care providers, health insurance, general health, school, work, income, barriers to work, transportation, functional status, activities, expectations when growing up, referrals from pediatric to adult services. Results will be available in March, 2000.	HRTW-KY TEACH Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	Those interested in following young people with disabilities as they transition from pediatric to adult services.
Transition Guidelines, Life Maps, and Teaching Sheets http://commissionkids.state.ky.us/transition.htm	Transition assessment and care guidelines, screening tools (Life Maps) which collect information and build awareness of issues with teaching materials. Easy-to-read format to use when family/teens indicate need for information on the screening Life Map. Guidelines, Life Maps, and Teaching Sheets have been created for ages 0-12 months, 13-35 months, 3-5 yrs, 6-10 yrs, 11-13 yrs, 14-16 yrs, and 17-21 yrs.	HRTW-KY TEACH Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; and health care professionals interested in transition from birth to adulthood

Surveys/Assessment Tools

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>Patient Transition Survey: Cystic Fibrosis Program</p> <p>Developed by Children's Hospital, Boston, MIYD Transition Project</p>	<p>Needs assessment survey designed to identify needs of adult patients in a children's hospital-based cystic fibrosis clinic. This is an interviewer-administered survey.</p>	<p>HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 keenanp@a1.tch.harvard.edu</p>	<p>Health care providers</p>
<p>Patient Transition Survey: Sickle Cell Program</p> <p>Developed by Children's Hospital, Boston, MIYD Transition Project</p>	<p>Needs assessment survey designed to identify needs of adolescent and young adult patients in a children's hospital-based sickle cell anemia clinic. This is an interviewer-administered phone survey.</p>	<p>HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 keenanp@a1.tch.harvard.edu</p>	<p>Health care providers</p>
<p>Needs Assessment Findings Report</p>	<p>Report of the statewide Needs Assessment</p>	<p>HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Dept of Human Services, Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/ci/newcci/projects/matp/index.htm</p>	<p>All audiences</p>

Surveys/Assessment Tools

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Ready to Manage Your Own Health Care? (Revised January 2000)	A self-assessment tool for youth used to determine current skills/comfort in managing their own health condition. This form is used as a catalyst for health related discussions with a transition health nurse or educator.	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; school nurses; educators
Health Care Screening for Adolescents and Young Adults	This is a questionnaire for youth with special health care needs. It helps identify health care transition issues by screening for health care resources, including insurance and medical home, current level of skill to manage medical treatment for chronic conditions, and potential mental health issues. Developed by Career Connections/HRTW	HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors
Stress Management Workshop Evaluation Form	This form is tailored to developmentally handicapped youth. It assesses their evaluation of a workshop on stress management. Developed by Career Connections/HRTW	HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors

Surveys/Assessment Tools

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>Survey of Comprehensive Transition Team Practice</p>	<p>This is a 2-page survey of the respondent's experience of transition team membership. It is intended to illustrate team coordination to meet the specifications of IDEA 97.</p> <p>Developed by Career Connections/HRTW Survey</p>	<p>HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors</p>

Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Adolescent transitions: A nursing concern.	An overview article on issues impacting adolescents with special health care needs in transition.	<p>HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org</p> <p><i>Pediatric Nursing</i>, 24 (1), 23-28. (Article). Betz, C. L., (1998).</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
Facilitating the transition of adolescents with chronic conditions from pediatric to adult health care and community settings.	This article provides a broad overview of the health care issues affecting adolescents with special health care needs in transition.	<p>HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org</p> <p><i>Issues in Comprehensive Pediatric Nursing</i>, 21(2), 97-115. Betz, C.L., (1998, April -June)</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders

Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Adolescents with chronic conditions: Linkages to adult service systems.	This article provides information about adult services available to meet the needs of ASHCN in transition.	<p>HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing, USC UAP Southern CA Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrw.org</p> <p><i>Pediatric Nursing</i>, 25 (5), 473-476. Betz, C. (1999)</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
Transition to Adulthood. In W. Nehring, S. Roth, & D. Natvig (Eds.). Core Curriculum for Nurses in Developmental Disabilities and Mental Retardation.	This chapter provides a standard of care for nurses who provide services to adolescents with mental retardation in order to facilitate their successful transition to adulthood.	<p>HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing, USC UAP Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrw.org</p> <p><i>American Association in Mental Retardation</i>. Betz, C.L., (1999, in press)</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; nurses

Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>504 Referrals: An underutilized resource for students with special health care needs.</p> <p><i>Journal of Pediatric Nursing</i>, 13 (6) Betz, C. L. (1998, December)</p>	<p>This editorial provides information for pediatric nurses on the use of 504 plans for ASHCN.</p>	<p>HRTW-CA Cecily L. Betz, PhD, RN CA HRTW Project Director USC Department of Nursing, USC UAP Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu, www.cahrtw.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; pediatric nurses</p>
<p>504 Referrals and plans: Implications for pediatric nurses. Betz, C. L. (under review).</p>	<p>This article provides an overview on the development and implementation of 504 plans for ASHCN who are general education students and for students in special education who are about to leave the secondary school setting.</p>	<p>HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>
<p>Healthy Futures</p>	<p>Monograph of CA HRTW Needs Assessment conducted during the planning year (year 1) of California Healthy and Ready to Work.</p>	<p>HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>

Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p><i>"Who's going to do this when I'm not around?" Parents of young adults with special health care needs speak out on transition.</i></p> <p>Prepared by Jaimie Ciulla Timmons, James P. McIntyre, Jr., Jean Whitney-Thomas, and John Butterworth (Institute for Community Inclusion/UAP, Boston); Produced by MA Department of Public Health, Division for Special Health Needs</p>	<p>Report of a needs assessment of young adults and parents of adolescents and young adults with disabilities or special health care needs.</p>	<p>HRTW-MA Nicole Roos Coordinator, MIYD MA Dept of Public Health 250 Washington Street, 4th Floor Boston MA 02108 617-624-5955 nicole.roos@state.ma.us</p>	<p>State agencies, state policymakers, community organizations, schools, health care providers, family leaders, families, youth</p>
<p>Transition to Adulthood in a Pediatric Setting: Perspectives of Patients with Cystic Fibrosis.</p> <p>Authors: Carolyn Jacobs, Julie Zack, Peter Keenan, Kathy Harney, S. Bryn Austin, Andrew Colin, and S. Jean Emans.</p>	<p>Abstract describing findings of a transition-focused needs assessment of adolescents and young adults with cystic fibrosis who receive care in a children's hospital-based cystic fibrosis clinic. (Presented at the annual meeting of the Society of Adolescent Medicine in Washington, DC, in March 2000.)</p>	<p>HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 keenanp@a1.tch.harvard.edu</p> <p>Journal of Adolescent Health, 26 (2), 85. (February 200).</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders</p>
<p>Critical action research: A model for social work knowing.</p> <p>Depoy, E., Hartman, A., and Haslett, D.</p>	<p>Journal article</p>	<p>HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Department of Human Services Bureau of Health, Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ Fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/cci/newcci/projects/matp/index.htm</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; researchers; policymakers; educators</p>

Social Work (Sept. 1999)

Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>The life histories of adolescents with special health care needs in transition as told by their parents: A qualitative study.</p> <p>DePoy, E., Hartman, A., Francis, C., Gilmer, D.</p> <p><i>Social Work & Health Care</i> (in press)</p>	Journal article	<p>HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Dept of Human Services, Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/ccl/newcci/projects/matp/index.htm</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; researchers; policymakers; educators
<p>Adolescents with Disabilities & Chronic Illness in Transition: A Community Action Needs Assessment.</p> <p>DePoy, E., Gilmer, D., Haslett, D.</p>	Journal article	<p>HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Department of Human Services Bureau of Health, Division of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ Fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/ccl/newcci/projects/matp/index.htm</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; researchers; policymakers; educators
<p>Families find that health care is vital in transition planning. Article in Pacesetter</p>	Article by Caryn Pernu in Pacesetter, Vol.4, No.2, 2000, a PACER Center newsletter.	<p>HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044</p>	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; educators

		952-838-9000 / fax 952-838-0199 TTY 952-838-0190 Toll free 888-248-0822 dhovey@pacer.org www.pacer.org	
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Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<i>"Projects explore the health connection to transition"</i> Article	Article on health issues and transition in Point of Departure, Vol.4, No.1, a TATRA newsletter	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Parent Information Centers, VR & educational professionals, family leaders
<i>"Revised Rule Helps Minnesotans with Severe Disabilities in Employment"</i> Article	Article on the Extended Employment rule defining rights and protections for people with severe disabilities in Pacesetter, Summer 1999, Vol. 22, Issue 2.	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
<i>"Supplemental Security Income (SSI): Put It To Work For You"</i> Article	Article on SSI by Cathy Urbain in Point of Departure, Vol.4, No.2, a TATRA newsletter	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd.	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; Parent Centers; VR & educational professionals

		Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org www.pacer.org	
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Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Teens Speak Out Survey	A survey of teens with chronic illness and disabilities in transition. A collaborative work by PACER Center and the Minnesota Children with Special Health Needs Program.	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; educators
The Role of a Family Transition Resource Coordinator: A study by PACER Center's Project Youth	Examined in this paper is the value of a formally designated and trained parent Resource Coordinator in the transition planning process for youth and young adults with disabilities. 1999	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Families; health care providers; family leaders; educators; school administrators
"Adolescents Want Control of Their HealthCare" by Carol Igoe, MS HRTW Ohio Career Connections for Students at Lighthouse Youth Services	This article describes transition issues in health, from an adolescent and family perspective. It also summarizes survey results from HRTW projects. This is an upbeat and colorful newsletter that addresses	<i>Window on Wellness</i> , Spring 2000. Pages 4-7 For Copies call Louise Fisher 614-876-7090	Adolescents and young adults with disabilities, families, health care providers, educators

	health issues for women and girls with disabilities. Published quarterly.		
"The Benefits Game" developed by Debbie Dase, MS, United Cerebral Palsy of Greater Cincinnati and Christopher Sabine, MSW, HRTW, Ohio	A colorful workbook about basic benefits for persons with disabilities, with a Large Die and challenge questions for competing teams of students.	HRTW Ohio Career Connections for Students 1501 Madison Rd Cincinnati OH 45206 csabine@pol.com	Special Education High School students

Policy Papers/ Reports/ Articles

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
"Parents as partners: Understanding and promoting the multicultural aspects of parent involvement in transition planning." Article	Article summarizing the results of a survey that examines the roles minority parents assume in transition planning for their children and how this profile matches the level of importance school professionals place upon various transition activities. Geenen, S., Powers, L. & Lopez-Vasquez, A. (1999)	HRTW-OR Laurie Powers Director & PI Center on Self Determination/OHSU Community Solutions 3608 SE Powell Portland, OR 97212 503-232-9154, x 104/ fax 503-232-6423 powersl@ohsu.edu	Professionals (particularly school professionals) who are seeking information to enhance collaboration with minority parents and the effectiveness of transition services for minority youth.

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
California Department of Rehabilitation-consumer version	Information sheet on department services for consumers	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with SHCN/disabilities; health care providers
California Department of Rehabilitation for professionals	Information sheet on department services for professionals	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Health care providers
CA HRTW Newsletter	The first and second issues of this newsletter were published within the last 6 months. A number of topics on health care transitions are presented.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
California Healthy and Ready to Work – Nutrition Information	Nutrition handouts for adolescents	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
CA HRTW Program Overview Brochure	Provides a brief overview of the project.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
CA HRTW Transition Services Brochure	This brochure is distributed to health care professionals to advertise the transition services available through CA HRTW.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Centers for Independent Living- consumer version	Information sheet on services available for consumers	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with SHCN/disabilities; health care providers
Centers for Independent Living- professional version	Information sheet on services available for professionals	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Health care professionals
Disabled Student Services- consumer version	Information sheet for consumers	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with SHCN/disabilities; health care providers

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Disabled Student Services- professional version	Information sheet for professionals	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Health care professionals
Social Security Administration- consumer version	Information sheet on Social Security Administration-consumer version	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with SHCN/disabilities; health care providers
Social Security Administration- professional version	Information sheet on Social Security Administration-professional version	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Health care professionals

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Various Newsletters	Printed newsletters which are sent to teens at the Commission and Shriners' Hospital that relate to transition issues. Included are descriptions of resources or transition activities going on in communities, an interview with an adult with disabilities who is working, health promotion information, and games. Also available electronically.	HRTW-KY TEACH Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us	All who are interested in developing newsletters for young people
Transitions: A Guide on Getting Older at Children's Hospital Developed by Children's Hospital, Boston, MIYD Transition Project	A brochure for youth and families, describing transition to adulthood and the steps toward successful medical transition.	HRTW-MA Peter Keenan Children's Hospital Adolescent Medicine 300 Longwood Avenue Boston, MA 02115 617-355-4191 Keenanp@a1.tch.harvard.edu www.youngwomenshealth.org/transitions.html	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders
Maine Adolescent Transition Partnership bookmark	A bookmark describing the MATP project with information on how to contact the project for assistance with transition issues.	HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Department of Human Services Bureau of Health Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ Fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/cci/newcci/projects/matp/index.htm	All audiences

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Do You Have Questions About Life After High School?	Poster to advertise the MATP project as well as the Maine committee on Transition	HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Department of Human Services Bureau of Health Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ Fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/cci/newcci/projects/matp/index.htm	Guidance counselors, educators, school administrators, state and private agency providers, health and allied health providers
Looking Ahead – a quarterly newsletter	A newsletter for transition age youth with disabilities and ongoing health conditions and their families. Back issues of Looking Ahead in English, Spanish, and Hmong	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; educators
Looking Ahead. vol. 1, issue 2	Back issues of Looking Ahead in English, Spanish, and Hmong	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
You Can Help!	A brochure for School nurses to inform them of the resources available to youth with chronic illnesses.	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	School nurses
Paving the Road to a Brighter Future when Your Child has a Disability	This is a double fold two-sided glossy "road map". It was developed by a group of parents and professionals to help parents encourage competency in their children to maximize independence in adulthood. It is a time line for development of adult life skills. Health care professionals or other professionals can use it as a counseling tool or for anticipatory guidance for transition. Developed by Career Connections/HRTW and the Long Term Home Work Group of the Southwest Ohio Transition Roundtable.	HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors
TRANSITION FACTS "Take charge of health care":	A 2-sided information card for physicians and other professionals to use as a handout for anticipatory guidance for adolescent patients with disabilities and other long term conditions. Also a tool/checklist for adolescents and their families to develop health care consumer skills. Gives list of skills and resources for further information. Developed by Career Connections/HRTW and the Health Care work group of the Southwest Ohio Transition.	HRTW-OH The Division of Adolescent Medicine at Children's Hospital Medical Center, 513-636-4681.	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors

Newsletters/ Brochures/ Pamphlets

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
TRANSITION FACTS Milestones to Employment	A 2-sided information card for physicians and other professionals to use as a handout for anticipatory guidance for adolescent patients with disabilities and other long term conditions. Also a tool/checklist for adolescents and their families to develop employment skills. Gives list of skills, resources and role of IEP. Developed by Career Connections/HRTW and the Job Creation work group of the Southwest Ohio Transition Roundtable	HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors
Key Transition Questions	This is a 4-fold double-sided "road map" that provides a time line for special education transitions, with prompt questions for parents to address with their children's education team. It addresses each transition in education. Developed by Career Connections/HRTW and Southwest Ohio Transition Roundtable Education Work Group.	HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors
Youth from Teen Solutions (1999). Example of Teen Solutions Newsletter.	An example of the Teen Solutions newsletter, which contains articles and artwork generated by youth members.	HRTW-OR Laurie Powers Director & PI Center on Self Determination/OHSU Community Solutions 3608 SE Powell Portland, OR 97212 503-232-9154, x 104/ fax 503-232-6423 powersl@ohsu.edu	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; and family leaders who are interested in starting or running a youth group.

Resource Guides

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
California Healthy and Ready to Work Youth and Adult Community Resources Guide	This guide provides an overview of the public adult services available for students with SHCN to assist them in making the transition to adulthood.	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrtw.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; and family leaders
Ready for Life Resource Database for Youth in Transition MATP staff	This Service Tapestry Database is a searchable collection of agencies and programs selected for their relevance to young people (and their families) with special health care needs and/or disabilities, as well as others who are seeking information and services designed to help with the transition from school to adult life, higher education, or employment.	HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Department of Human Services Bureau of Health, Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ Fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/cci/newcci/projects/matp/index.htm	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; and family leaders; educators; guidance counselors; school administrators; transition coordinators; state and private agency providers

Resource Guides

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
The Resource Guide to Income and Government Support in Hamilton County, Ohio	<p>This is a 27-page booklet developed by a group of young adults with disabilities, families, and benefits specialists. Gives youth and their families and teachers information to plan for transition. The material is set up as it exits along the road to adulthood. Since most of the information addresses federal resources, such as Social Security, Work Incentives, Section 8, Medicaid and Medicare, a sheet of local phone contacts can be inserted for use in other locales, or the booklet can be revised for other counties or states.</p> <p>Developed by Career Connections/HRTW and the Income and Government Supports work group of the Southwest Ohio Transition Roundtable.</p>	<p>HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors</p>
Resource Guide for Assistive Technology	<p>This is a booklet that lists resources, funding streams, and websites for Assistive Technology. It is localized for SW Ohio, but it can be used as a template for other localities.</p> <p>Developed by Career Connections/HRTW and the Income and Government Supports work group of the Southwest Ohio Transition Roundtable</p>	<p>HRTW-OH Carol Igoe Program Director Career Connections for Students Lighthouse Youth Services, Inc. 1501 Madison Road, PNC Building Second Floor Cincinnati, OH 45206 513-475-5500 x505/ fax 513-221-3665 CIGOE@aol.com www.lys.org</p>	<p>Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; counselors</p>

Project Descriptions/ Overviews

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
<p>Summaries of CHOICES Transition Project and Pilot Projects</p>	<p>What is on the Web Site is available in printed format. Florida Project: Transition Timeline, Partnership Agreements, Identification of Needs forms, Support Plans, assessment forms for use in clinic settings for teens 14 –21, Teen Resource area materials; and a description of transition to adult health care at University of South Florida Medical Center. From Utah Project: Methodology for planning and lists of participants in Weekend Workshops and Health/Vocational Fairs for teens and families; programs for training of CSHCN staff in rural areas about transition issues; and descriptions of participants and processes for an independent transition center and its Advisory Board; agenda and speakers for statewide transition conference. Hawaii Project: descriptions of the Mentorship Project development and activities, advisory board and subcommittee activities; and transition to adult health care at Queen’s Medical Center. From Kentucky Project: Teen resource area and camp programs; participants and activities of WISH Advisory Team, Life Maps; Chicago Shriner’s Hospital (not officially part of CHOICES) information about the summer work program for teens; Cincinnati Shriner’s Burns Hospital; transition newsletters sent to all teens. National CHOICES Office: Agendas and speakers lists and Proceedings for the 3 national CHOICES conferences; and a more complete summary of needs assessment survey data.</p>	<p>HRTW-KY CHOICES Theresa Glore MS Kentucky TEACH Program Coordinator KY Commission for CSHCN 982 Eastern Parkway Louisville, KY 40217 502-595-4459, x 272 / fax 502-595-4673 theresa.glore@mail.state.ky.us</p> <p>Contact People: Florida: Debbie Martin Utah: Kris Ferguson Hawaii: Norine Wong Kentucky: Anja Peersen Chicago: Caroline Anderson Cincinnati: Jack Tager National CHOICES: Kathy Blomquist</p>	<p>All interested in developing transition programs</p>

Project Descriptions/ Overviews

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Maine Adolescent Transition Partnership web page	The Maine Adolescent Transition Partnership's web page has information about the project as well as links to various sites that deal with disability issues. There is also information about the activities conducted with adolescents surrounding Youth Leadership Training and presentations to various groups about their needs.	HRTW-ME Toni G. Wall HRTW-Project Director, CSHCN Department of Human Services Bureau of Health Div. of Community and Family Health 11 State House Station Augusta, ME 04333-0011 207-287-5139 x 5350/ Fax 207-287-5355 toni.g.wall@state.me.us Matpmail@umit.maine.edu www.ume.maine.edu/ci/newcci/projects/matp/index.htm	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders; teachers; students; educators; transition specialists; researchers; policymakers

Videos

<i>Title/Author</i>	<i>Description</i>	<i>How to Find It</i>	<i>Audience</i>
Health Care Self Care Curriculum	Training video for adolescents/young adults on learning health care self care competencies related to the following skills: making a dentist appointment, knowledge of health condition and management, emergency measures, monitoring of health conditions, communication, and health records	HRTW-CA Cecily L. Betz, PhD, RN California Healthy and Ready to Work Project Director USC Department of Nursing USC UAP-Southern California Transition Coalition 1540 Alcazar St. CHP 222 - 33L Los Angeles, CA 90033 323-442-1868 / fax 323-442-1887 cbetz@hsc.usc.edu www.cahrnw.org	Adolescents and young adults with SHCN/disabilities; health care providers
Information is Power	A video for teens focusing on the importance of knowing about your disability.	HRTW-MN Diane Hovey Project Director Project Youth: Family-Centered Community Transition Services PACER Center 8161 Normandale Blvd. Minneapolis, MN 55437-1044 952-838-9000 / fax 952-838-0199 TTY 952-838-0190 toll free 888-248-0822 dhovey@pacer.org www.pacer.org	Adolescents and young adults with disabilities and chronic health conditions and their families; health care providers; family leaders

Healthy & Ready to Work Network

Project Abstracts

Center for Policy and Partnerships

PROJECT ABSTRACT

Project Title: Maximizing Transition Opportunities for Youth SHCN
Project Number: 6H01MC00013
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Institute for Child Health Policy
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Gainesville, FL 32608-5367
Phone: Reiss 888-433-1851/ Hackett 352-207-6808
Fax: 352-392-8822
Web Address: www.mchbhrtw.org
Project Period: 5 Years -- From 7/01/98 to 6/30/03

PROBLEM:

During the 1990s, legislative mandates affecting children with special health care needs (CSHCN) have undergone sweeping reform. While federally mandated services for children and adults with disabilities exist, there are not well integrated, due, in part to a lack of coordination among organization charged to work on behalf this population. While rapid advances in medical science have enabled over 90% of children born with special needs to reach adulthood, YSHCN are much less likely than their non-disabled peers to finish high school, pursue post-secondary education, get jobs, or live independently. As is documented in a 1996 General Accounting Office (GAO) report, only 26 of the 130 federal disability programs focus on employment as an issue, and that only 1% of resources of these programs were spent on this issue. In this era of "outcome based" programs, one may ask "What is the outcome of all these federal programs, health care services, education, rehabilitation? Is the future of children, who happen to be disabled, maximized by the current system of federal supports?"

PURPOSE:

Significant improvements in transition service systems are needed to increase the chances that youth with special health care needs (YSHCN) will be "Healthy and Ready to Work." YSHCN need greater access to health insurance, a medical home and integrated, comprehensive, and community-based, youth-oriented systems. The Center is to facilitate implementation of improvements by assisting federal and state, agencies; programs; projects; and consumers work collaboratively to identify, collect, analyze and use information and data needed to design, implement, monitor and evaluate programs and policies that promote independence and employment of YSHCN and child SSI beneficiaries. The overarching purpose of the Center is to maximize transition opportunities for youth SHCN.

GOALS:

- ?? Coordinate and support activities related to the HRTW/Transition component of DSCSHN's 10-year action plan for full implementation of comprehensive care systems for all children and youth with special health care needs;
- ?? Support interaction among the National Centers supported by MCHB/DSCSHN on issues related to MCHB's "Healthy & Ready to Work" (HRTW) initiative;
- ?? Support activities to MCHB's "Healthy and Ready to Work" (HRTW) Network;
- ?? Provide a forum for interaction between MCHB and other organizations regarding policy initiatives related to YSHCN and children receiving SSI;
- ?? Enhance telecommunication activities between MCHB and others concerned with transition and employment of YSHCN and children receiving SSI and;
- ?? Expand capacity to collect, analyze, and use the data to promote independence and employment of YSHCN and children receiving SSI, as appropriate.

METHODOLOGY:

The Center is to maximize transition opportunities for YSHCN and promoting development of appropriate system of care for CSHCN by 1) supporting and facilitating the HRTW Network, the Federal HRTW Interagency Workgroup and other designated working groups; 2) implementing Tri-Regional Meetings on CSHCN in Managed Care; 3) developing electronic discussion groups (listservs) and WWW sites and disseminating information through these computer-based telecommunications media; 4) supporting participation of families and YSHCN in leadership training and policy development activities; 5) gathering information and data through surveys and analysis of Block Grant Applications; 6) developing policy papers and other documents; 7) publishing a Director of CSHCN Programs annually; and 8) carrying out other activities as directed by DSCSHN.

EXPERIENCE TO DATE:

During Year 2, the Center has addressed the project goals by: facilitating the Transition Workgroup in its efforts to support DSCSHN in development of a 10-year plan for CSHCN; convening two meetings of the HRTW Network; developing and disseminating four policy papers related to HRTW/Transition; implementing electronic information systems including Web sites and ListServes; coordinating two Tri-Regional workshops for States to discuss and develop plans for meeting the needs of CSHCN in Managed Care environment; conducting a survey to document states provision of rehabilitation services to SSI beneficiaries and YSCHN transition services; producing the "Measuring Success" informational video and developing and disseminating numerous information updates, informational videos, and other products.

EVALUATION:

Evaluation strategies include review of MCH Block Grant Applications, including review of data on CSHCN-related Performance Measures; follow-up surveys and interviews; and tracking of participation on e-mail lists and use of the HRTW Web sites. Through this systematic collection of information about activities of the Center, we will gain an understanding of the degree to which this project: 1) carried out planned activities in an efficient manner; 2) met the training, TA, information and support needs of CSHCN Program leaders; and 3) enhanced the capacity of those participating in ILSCP activities to address their legislated CSHCN Program roles and responsibilities, as measured by the MCH Program Performance measures.

KEY WORDS:

Access to health care, Adolescents, Transition, Adolescents with Special Health Care Needs (ASHCN), Youth with Special Health Care Needs (YSCHCN), Employment Incentives, Coordination of Health Care, Disabilities, Independence, Self-sufficiency, Self-determination, Service Coordination, Special Health Care Needs, Transition services, Interorganizational, Work Incentives, System Collaboration, Interagency Collaboration, Rehabilitation, Family-Centered.

HRTW California PROJECT ABSTRACT

Project Title: California Healthy and Ready to Work
Project Number: 1 MCJ 06HRW9-01-0
Project Director: Cecily L. Betz, RN, PhD, FAAN
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Phone: 323-442-1868
Fax: 323-442-1887
Web Address: <http://www.cahrtw.org>
Project Period: From 10/1/97 to 9/30/01

PROBLEM:

The prevalence of chronic illness amongst this nation's youth is a foremost public health concern. According to recent prevalence reports, it is estimated that 18% of children have special health care needs (CSHCN); this percentage increases to 21% in the adolescent age group (McManus, 1999). Since 1960, the numbers of C/ASHCN has risen 100% (Blum & Gerber, 1992). There is need for coordinated service system change to address these concerns (Woods, Haberman & Packard, 1993). The systemic changes to address the long-term needs of C/ASHCN are needed in the educational, social service, rehabilitation, and health care systems and require the coordination of effort between these service systems.

GOALS AND OBJECTIVES:

The goals of the project are:

- Goal 1:** To increase understanding of the holistic needs of ASHCN as they transition to adulthood having aspirations for physical and mental well being, and living independent, productive and successful lives.
- Goal 2:** To promote and enhance community-based collaborations and partnerships with public and private entities within service delivery systems.
- Goal 3:** To establish linkages and provide input to local school-to-work systems pertaining to the needs, strengths and special problems of ASHCN in making successful transitions to adult health care, career and employment opportunities, and independent living and to implement and replicate in other communities in the state.
- Goal 4:** To assure that ASHCN will lead healthy and productive lives and maximize their financial independence.

METHODOLOGY:

The project consist of the following components: outreach training, training infrastructure, conference, technical assistance and consultation, collaborative interagency model, mentoring program, integrated career paths in school-to-work programs, transition teams, advocacy training model and system for identification of eligible adolescents.

COORDINATION:

Project activities are coordinated with a number of agencies at the community level. Our project partner is Southern California Transition Coalition (SCTC). This coalition has been in existence since 1991. Together with SCTC Coalition, we have partnerships with the agencies and local offices representing California Children Services (Title V), private, public and nonprofit health agencies, Department of Rehabilitation, Department of Education (14 local school districts, East San Gabriel Valley Regional Occupational Program), 2 regional centers (developmental disabilities), Department of Mental Health, Workforce Investment Act agency (LA Works), Employment Development Department, Center for Independent Living, Consumer/Parent coalition, Social Security Administration, and juvenile justice.

EVALUATION:

Systemic evaluation will be conducted in a variety of forms to insure effectiveness in meeting project goals and objectives. Data gathered from evaluation efforts is evaluated formatively and summatively to monitor effectiveness and outcomes. Methods include compilation of data regarding program activities such as date, amount, recipients, geographic region; self-report on usefulness and relevancy of technical assistance, team participation; pre and post test measures of training and services, adolescent and family outcomes.

EXPERIENCE TO DATE:

During the past year, *CA HRTW* has provided transition training to 4,169 youth, parents, young adults, service providers and professionals. Over 60% of participants represent ethnically diverse populations. Three hundred and sixty four technical assistance contacts have been provided to assist in the provision of services and program development. Currently *CA HRTW* is working with 4 community-based organizations that provide services to A/CSHCN in developing outreach transition services. *CA HRTW* has replicated the interagency team at Children's Hospital Los Angeles and has provided transition services to 26 adolescents and young adults with SHCN.

KEY WORDS:

Adolescents with Special Health Care Needs
Youth in Transition
Adolescents with Disabilities
Interagency Collaboration

HRTW Iowa PROJECT ABSTRACT

Project Title: Adolescent Transition: Healthy and Ready to Work
Project Number: CFDA#93.110D
Project Director: Jeffrey Lobas, M.D.
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E-Mail: Jack-Hillyard@uiowa.edu
Web Address: www.medicine.uiowa.edu/hrtw
Project Period: From 10/01/97 to 9/30/01

PROBLEM:

In Iowa, a profound need exists to address transition issues and services at the state and local level through the development of collaborative, coordinated, and comprehensive system that will enable youth with special health care needs to leave school healthy and ready to work.

GOALS AND OBJECTIVES:

Form community-based collaboratives of consumers and family members, medical providers, social service agencies, school personnel and businesses to increase the understanding of policy-makers and business leaders about adolescents with special health care needs and/or disabilities making successful transitions to adulthood and employment.

- I.1. Have in place and functional a minimum of eight regional collaboratives.
- II.1. Plan and conduct a statewide conference for the Area Education Agency Health Resources teams.
- II.2. Plan and produce a multi-purpose Iowa video related to students with special health care needs.
- II.3. Update "A Survey of Special Health Care Procedures Required by Students in Iowa for more current information.
- II.4. Provide three physician workshops.
- II.5. Establish private sector business capacity such that at least four local businesses will hire youth with disabilities with on-the-job personal supports provided.
- II.6. Conduct interactive training for pediatricians.
- II.7. Define information and capacity needs and address those needs through interactive website training as determined by physician-led planning group.
- III.1. Offer High School High Tech.

III.2. Provide health management sessions at the Futures Conference.

III.3. Produce The Independence Checklist.

METHODOLOGY:

During each year of the project, two local communities will be selected and work will focus on developing a broad-based, regional collaborative to address issues and services related to successful transition for young people with special health care needs. Training and resource materials will be developed and provided to educators, employers, AEA Transition Coordinators, medical providers, consumers, and other interested persons.

COORDINATION:

The project is intended to decrease fragmentation of transition services. Early in the project, it was determined that the best way to decrease fragmentation was to bring all concerned together to collaboratively address solutions. Federal, state, and local partnerships are an integral part of this project.

EVALUATION:

This project will employ the CIPP model in order to provide a more comprehensive evaluation of all aspects of project activities.

EXPERIENCE TO DATE:

Community collaboratives to address transition issues have formed in several communities throughout the state. Collaborating partners include consumers, families, service providers, policy-makers, medical providers and businesses. Particular emphasis has been placed on making sure that business and medical providers are represented in the collaborative process. Collaboration is a key component of this project and great care has been taken to form partnerships at both the state and local level. State-level partnerships will facilitate the coordinated plans of service developed by local collaboratives. Training, based on expressed needs, has been provided to physicians, consumers, family members, and educators.

Various resources specific to this project have been developed and tested including a Healthy and Ready to Work video, a checklist, and a curriculum, and a project website.

KEY WORDS:

Adolescents, adolescents with disabilities, youth with special health care needs, chronic illnesses and disabilities, community development, community integrated service system, community participation, family professional collaboration, interagency cooperation, interdisciplinary teams, medical home, public policy, youth in transition, training, Title V Programs, school-to-work.

HRTW Kentucky PROJECT ABSTRACT

Project Title: KY TEACH Project (Kentucky Youth Transitioning to Employment And Comprehensive Healthcare)
Project Number: AT-99-04
Project Director: Beverly Hampton, Executive Staff Advisor
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Web Address: <http://cfc-chs.chr.state.ky.us/chs/CwSHCN/index.htm>
Project Period: 4 years -- From 7/1/99 to 5/31/03
Budget Period: 6/1/00 – 5/31/01

PROBLEM:

Success of transition from pediatric to adult health care, from school to work, and from home to community depends upon the relationships among the adolescents, families, supports, and service providers. The KY Teach Project expands the coordination of services developed throughout the last decade through CHOICES and the WISH Healthy and Ready to Work (HRTW) Project collaboration among the Kentucky Commission for Children with Special Health Care Needs (CSHCN), Shriners' Hospitals for Children (SHC), and Vocational Rehabilitation (VR) in Kentucky to include schools, independent living centers, managed care organizations, family advocacy groups, community health care providers, and the Medical Home Project of the American Academy of Pediatrics.

GOALS AND OBJECTIVES:

- Goal 1:** Increase the number of children, adolescents, and young adults with special healthcare needs in Kentucky who have medical homes and coordinated healthcare.
- 1.1** Enhance the capacity of pediatric and adult health care providers to provide medical homes through education about special healthcare needs and use of funding and service delivery systems.
 - 1.2** Strengthen collaboration between medical homes and specialty care providers at tertiary centers and community levels.
 - 1.3** Enhance the abilities of parents and young people to access and use medical homes, specialty care providers and healthcare funding mechanisms.
- Goal 2:** Increase the number of young people with special health care needs in Kentucky who are prepared for employment with health insurance benefits.
- 2.1** Enhance the capacity and willingness of the service delivery system to prepare young people with special healthcare needs for employment.
 - 2.2** Enhance the skills of young people to find and keep jobs.

METHODOLOGY:

Methods include: 1) Needs assessments and planning including focus groups and surveys; strategic planning by the Advisory Team about statewide activities and evaluation methods; meetings of

Commission, SHC, VR, staff of other agencies, and parents and young people to plan, set targets for and participate in programs; and project staff as they work with national organizations and the HRTW Network; 2) Implementation including teamwork of staff, parents, and young people in developing the collaborations and monitoring the changes in practices and transition outcomes; training of agency staff and community providers, families and young people; direct service programs with selected youth; 3) Dissemination of processes and products developed through web sites, newsletters, and presentations at local, regional, and national professional and parent meetings; and 4) Evaluation and monitoring of outcomes for young people and systems and costs of the project.

COORDINATION:

KY Teach is located in the Title V CSHCN agency in Kentucky, which is developing formal and informal relationships with a variety of state, regional, and local health, education, and social service organizations.

EVALUATION:

Levels include: 1) systems changes within Kentucky and how agencies collaborate among themselves and coordinate transition services; 2) evaluation of the specific programs put in place in the Commission clinics and SHC in terms of participation, evaluation, and outcomes perceived by staff, young people and their families; 3) evaluation of the effects of systems and specific programs on changes on transition outcomes of young people, especially those graduating from the Commission and SHC; and 4) description of the benefits and costs of the project. Evaluation is coordinated with the HRTW Network data collection and evaluation protocols. The project is collecting specific data to show trends in use of adult health care providers, SSI status, education level, living accommodations, work and health insurance status for all young people who graduate from the Commission and SHC throughout the four years of the project.

EXPERIENCE TO DATE:

The multidisciplinary Advisory Team has met twice to discuss barriers to transition, recommend activities, and begin planning the Medical Home training program. Multiple meetings with managed care, educational, vocational, family advocacy, and independent living agencies are resulting in collaborative ventures. Focus groups and surveys of parents and providers show that barriers to care include transportation and convenient hours. Survey of CSHCN graduates show that 77% have a primary care provider, 36% have no health insurance; 38% have Medicaid, 12% have health insurance through work, 25% are on SSI, 49% work, 60% of those not working want to but need transportation, education, or health insurance, 23% are not high school graduates and not in school. Activities include workshops for teens and their families on preparing for work, emphasis on summer camps and independence-building experiences, teaching and data collection through use of Life Maps with all clients of Commission and SHC, and making clinics more active in resource dissemination. Case management, referral and collaboration, and quality assurance initiatives support transition activities and outcome measurement.

ANNOTATION:

Young people with special healthcare needs are much less likely than their peers to finish high school, to pursue post-secondary education, to get jobs with health insurance benefits, and to live independently. The purpose of the KY Teach project is to 1) create system changes that promote smooth transitions from school to work and from pediatric to adult healthcare in Kentucky; 2) increase the number of children, adolescents, and young adults with special healthcare needs in Kentucky who have medical homes and coordinated healthcare; 3) increase the number of young people with special healthcare needs in Kentucky who are prepared for employment with health insurance benefits; and 4) work with children, families, and young people to teach them the skills needed to maneuver through the various systems of healthcare and employment in Kentucky. This project builds upon the long history of collaboration among providers developed through the CHOICES and WISH Projects that enhanced coordinated services among the Kentucky Commission for Children with Special Health Care Needs, Shriners Hospitals for Children, Vocational Rehabilitation, managed care organizations, education and independent living agencies, family advocacy organizations, and others.

KEY WORDS:

Access to Health Care
Adolescent Health Programs
Adolescents with Disabilities
Advocacy
Children with Special Health Needs
Family Professional Collaboration
Health Insurance
Local Health Agencies
Medical Home
Parent Education Programs
Physical Disabilities

Pediatricians
Preventive Health Care
Professional Education in CSHCN
Systems change
Third Party Payers
Title V Programs
Training
Uninsured
Vocational Training
Youth in Transition

HRTW Louisiana PROJECT ABSTRACT

Project Title: Louisiana: Healthy and Ready to Work
Project Number: MCJ-22HRW6
Project Director: Jane M. Everson, Ph.D.
Phone: 504-942-8245
Organization
Name: LSU Health Sciences Center, Human Development Center
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E-Mail: Jeverson@hdc.lsumc.edu
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Web Address: www.hdc.lsumc.edu
Project Period: 4 Years – From 10/01/1997 to 09/29/2001
Budget Period: From 09/30/1999 to 09/29/2000

PROBLEM:

Using a focus group process, problems were explored in detail during Year One, resulting in the identification of 20 specific, transition-related needs. Each project year, two Work Teams prioritize needs from these 20 to address. In Year Four, we are addressing six needs.

GOALS AND OBJECTIVES:

We have two goals: (1) to build the self-determination skills of adolescents; and (2) to maximize the coordination of state and local educational services, health and medical services, and rehabilitation services. We have four objectives: (1) provide technical assistance to a minimum of two sites who are interested in implementing self-determination curricula; (2) hold an annual Youth Leadership Forum (YLF) for a minimum of 12 Student Delegates; (3) develop a minimum of 20 new "Fact Sheets" in Year Four and continue dissemination of those "Fact Sheets" developed in Years Two- Four in Year Five; and (4) continue the activities undertaken by the project's two Work Teams.

METHODOLOGY:

Objective #1: In the final months of Year Three and the initial months of Year Four, a series of six workshops on self-determination was held across the state; a total of 57 professionals, family members, and consumers attended. Planning and marketing are underway for repetition of these workshops in Year Five; however, only three workshops will be held due to decreased need. During Year Four, four LEAs were accepted for technical assistance in choosing and using commercially available self-determination curricula. One site dropped out of the technical assistance process midway; the remaining three LEAs are receiving technical assistance

(i.e., on-site and telephone from project staff and telephone from the authors of the various curricula). Six applications have been received and are currently being reviewed for Year Five activities; as stated in the initial grant proposal and subsequent continuation proposals, a minimum of two sites will be accepted.

Objective#2: The Year Four LYF will be held July 22-26, 2000. A total of 38 youth from across the state have submitted applications to attend; a minimum of 12 will be selected. The most significant accomplishment associated with this objective has been the Governor's Office on Disability Affairs' commitment to continue the YLF following cessation of grant funding.

Objectives #3 and #4: Because the activities of the two Work Teams and the products are interrelated, updates on these objectives have been combined in this section.

Health and Medical Work Team. The final version of a health and medical resource guide for teenagers and their families was recently completed by this team and is being reviewed and edited by project leadership. It will be disseminated statewide in the final quarter of Year Four. In addition, the highly-evaluated, "Ready Resources for Residents", a pocket guide to locally-available disability resources, is being updated and will also be disseminated to medical residents in the final quarter of Year Four. Lastly, the Work Team and project staff prioritized 25 new "Fact Sheets" for Year Four; 20 are currently being written and are on schedule for dissemination in the first quarter of Year Five. All "Fact Sheets" developed in Years Two - Four will continue to be disseminated by mail, by fax, at conferences and workshops in Year Five. In Year Four, they have also been made available on HDC's webpage. (A total of 76 "Fact Sheets" have been developed by the project; of these, 24 were developed or will be developed in Year Four.) The YLF Work Team. In Year Four, the "YLF Facilitator's Guide" the "YLF Student Delegate Workbook", and the "Resource Guide" are being minimally revised based upon evaluation data from the project's Year Three YLF. An alumni newsletter, "The FAN" has been created and was disseminated in Year Four to all Year Three Student Delegates and volunteers. "The FAN" will continue to be developed and disseminated in Year Five.

COORDINATION:

The Management Team has been re-titled the Sustainability Team, to reflect the project's commitment to continuation of project activities. The team meets quarterly (instead of monthly), but continues to provide project oversight. Work Team chairs (project staff) continue to submit activity-tracking data to the Project Coordinator for review by the Project Director and the Sustainability Team. No changes are proposed for Year Five.

EVALUATION:

Formative and summative evaluation activities detailed in the original grant application and in subsequent continuation proposals continue to be operational in Year Four, with minimal changes, and are proposed for continuation and completion in Year Five.

EXPERIENCE TO DATE:

To date, the project has accomplished all proposed activities and timelines. More adolescents than proposed are expected to attend the Year Four YLF. All evaluation data indicate positive progress in student outcomes and program capacity. Mechanisms for addressing identified problems are in process. No significant changes in project goals, objectives, or activities are proposed or anticipated in Year Five.

KEY WORDS:

Adolescents with disabilities; self-determination; transition; youth leadership; youth in transition

HRTW Maine PROJECT ABSTRACT

Project Title: Maine Adolescent Transition Partnership
Project Number: H01MC0005
Project Director: Toni G. Wall
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Web Address: http://www.ume.maine.edu/~cci/project_summaries/matp.html
Project Period: 4 Years – From 10/01/1997 to 09/30/2001
Budget Period: From 10/01/2000 to 09/30/2001

PROBLEM:

The MATP (Maine Adolescent Transition Partnership) project is designed to enhance the successful transition to adulthood, productivity, and financial independence for the diverse population of adolescents with special health care needs through the development, implementation, evaluation and expansion of a collaborative, accessible, comprehensive, culturally competent, model program.

GOALS:

- Goal #1:** To advance successful transition, productivity and financial independence for adolescents with special health care needs, create an integrated model partnership, herein named the MATP (Maine Adolescent Transition Partnership) by joining the MAT Steering Committee and the Participatory Action Team created in the planning year of the *Health and Ready to Work* initiative with existing efforts in the State of Maine (including the Maine COT system, the School to Work Partnerships, LEARNS Maine Cite, and representatives from adolescents, parents, health care providers, employers, and other system representatives such as social service providers, school personnel, higher education faculty, policy makers and community members).
- Goal #2:** To advance successful transition, productivity and financial independence for adolescents with special health care needs and building on the findings of the planning year, the PAT as part of the newly formed MATP, will conduct a statewide system development effort using the force field analysis planning tool piloted in the planning year, to develop an articulated set of adolescent-centered procedures through which adolescents are identified, plan for their transition, and obtain support and services necessary for successful transition.
- Goal #3:** To insure that the MATP promotes the successful transition, productivity and financial independence of adolescents with special health care needs, educate and train providers and community members involved in adolescent transition about the special needs of this group and in the use of the newly codified student-centered procedures.
- Goal # 4:** To advance successful transition, productivity and financial independence for adolescents with special health care needs, provide technical assistance to providers, schools, employers etc. who are involved in the transition of adolescents with special health care needs.

Goal # 5: MATP activity will continue to increase the capacity of the state of Maine, and other states as well, to identify needs and promote the successful transition, productivity and financial independence of adolescents with special health care needs through the conduct regular and ongoing knowledge generation, collaborative planning and service revision.

Goal #6: To inform service and support provision nationally to improve the transition of adolescents with special health care needs, disseminate the MATP nationally.

METHODOLOGY:

The project began with a development year, in which all target groups described above specified needs and model services and procedures so that all collaborators could offer consistent, seamless supports to adolescents in transition. In Year Two, the model, its scope of work and its procedures, were implemented in one region. Based on the evaluation findings, the scope of work and procedures were revised and expanded to two additional regions in Year Three. In the final year, the project will be implemented. throughout the state.

COORDINATION:

A hallmark of the project is collaboration, which has served to bring together a wide variety of state agencies to form the "Partnership. Partners include but are not limited to Bureau of Health (Title V), labor (including VR and Workforce Development), education (School to Work, Vocational and Adult Ed and Special Services), social security staff from regional offices, health care (including hospitals, school nurses and specialty clinics), independent living centers, families and parent organizations, and youth.

EVALUATION:

Evaluation of the project is multi-level, summative and formative. We have evaluated the articulation of the project with the national performance indicators and regularly examine the processes and outcomes of the project in the State of Maine.

EXPERIENCE TO DATE:

This project year, we expanded our pilot year successes into two new regions of the state, strengthening partnerships and working closely with youth to foster their leadership and realization of their transition goals. Based on the pilot year successes and lessons learned, three focused areas of project activity, a. education, b. information dissemination, and c. partnership development and technical assistance, have been implemented and evaluated.

KEY WORDS:

Adolescents, special health care, coordination, collaboration, community-based support

HRTW Massachusetts PROJECT ABSTRACT

Project Title: Massachusetts Initiative for Youth with Disabilities
Project Number: H01MC00006 (formerly MCJ-25HRW1)
Principal Investigator: Deborah Allen, ScD
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Web Address: www.state.ma.us/dph/shcn/miyd.htm
Project Period: 4 Years – From 10/1/97 to 9/29/01
Budget Period: 9/30/00 to 9/29/01

PROBLEM:

While Massachusetts has many resources that promote successful transition, young people with disabilities still face major barriers to autonomy and independence. These include: overlapping and uncoordinated approaches to transition across service systems; discontinuity between schools and adult disability services; poor preparation of individual teens for adult life; lack of incentives or supports for early transition planning; lack of communication among health care providers, schools and community supports; lack of models for medical transition; and lack of capacity in the adult health care system to provide care that promotes autonomy. State data indicate that in 1994-95, the drop-out rate for students with special needs was twice the state average. Once out of school, 70% of individuals with disabilities are unemployed.

GOALS AND OBJECTIVES:

The Massachusetts Initiative for Youth with Disabilities (MIYD) addresses gaps in the resources and supports available to Massachusetts youth with special health care needs as they approach adulthood. The overall goal of MIYD is to assure that every young person with special health care needs in Massachusetts has the opportunity to live a full, autonomous, productive life. Related goals are: to expand the aspirations and expectations of youth with special health care needs and their families; to promote a culture of inclusion throughout communities and public and private organizations across the state; and to create capacity within education, health, employment and other service systems to address needs of youth with disabilities. An additional goal for the DSHN is to improve its internal capacity to address the needs faced by young people with disabilities and their families as they lay the groundwork for adult autonomy and independence. MIYD offers an opportunity to develop a new awareness and new strategies that redefine family-centered care as a precursor to full, productive adulthood, rather than a static, isolated goal.

Key MIYD objectives are: (1) to build skills, knowledge and confidence of youth related to self-management of health care; (2) to identify and encourage clinical practices and policies which promote self-management; (3) to encourage health care system strategies, such as partnerships between pediatric and adult providers, which support transition; (4) to create opportunities for health skills building among adolescents with disabilities; (5) to strengthen and build community efforts related to inclusion and effective transition; and (6) to expand and enhance data collection and analysis related to transition needs and services.

METHODOLOGY:

MIYD is a collaborative effort of DPH and parents, community groups, service providers, and other state agencies. These parties have formed the Mass Partnership for Transition (MPT), a statewide coordinating council that also serves as an advisory committee to MIYD. MIYD projects include: support for model social inclusion projects in rural Franklin County; efforts to develop models and strategies for medical transition at Children's Hospital and the Springfield MA Shriners Hospital; a health-focused mentoring program for youth with disabilities; design and dissemination of a physician handbook and a poster for MD offices to educate providers and youth about transition and the role of medical providers in transition planning; and creation of the role of Parent Transition specialist through a contract with the Federation for Children with Special Needs, the state Parent Training and Information center.

COORDINATION:

MIYD is a project of the Title V CSHCN agency at the state Department of Public Health. MIYD projects are carried out through contracts with Children's Hospital in Boston; an independent living center in western Mass; Partners for Youth with Disabilities, which serves youth statewide; and the Federation for Children with Special Needs, the state Parent Training and Information organization. Collaboration with other state agencies and community organizations also occurs through the MPT.

EVALUATION:

Evaluation in early stages of the project focused on process objectives. With implementation, we are increasingly focused on outcomes. Methods include surveys of teens in the mentorship and clinical programs to assess satisfaction, skills and knowledge acquired; focus groups and/or surveys of parents of youth involved in clinic, school and community programs; provider surveys and focus groups; and case studies of clinic transition models. Evaluation is the responsibility of the PI and the project coordinator. All MIYD contracts require accurate and timely reporting to permit monitoring of progress toward project goals and objectives.

EXPERIENCE TO DATE:

Achievements have included: formation of MPT; establishment of transition partnerships with Children's and Shriners hospitals; an analysis of current policies, practices and attitudes of staff at four specialty clinics at Children's Hospital (spina bifida, cystic fibrosis, HIV and sickle cell) to identify barriers to clinical transition and develop tools and strategies to facilitate transition to adult-oriented medical care; implementation of the "Making Healthy Connections" mentoring program to enable youth with special health care needs to learn about their health and their options for health promotion and fitness, build communication skills, and develop strategies for self-management of health care through interaction with peers and mentors; implementation of two inclusive school-based recreation programs; development and hiring of parent Transition Specialists to consult to MIYD other projects and provide training and technical assistance to parents and professionals on all aspects of transition; and creation of a physician handbook and teen-oriented poster on transition.

KEY WORDS:

Adolescents with disabilities; children with special health needs; chronic illnesses and disabilities; youth in transition; state systems development initiative

HRTW Minnesota PROJECT ABSTRACT

Project Title: Ready 2 Work: Family Centered Community Transition Services (FACCTS)
Phase II Implementation
Project Number: MCJ27HRW5
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Web Address: www.pacer.org
Project Period: 4 years – From 10-1-97 to 9-30-01

PROBLEM:

Employment is the main concern for youth with chronic illness and disabilities, according to the first large survey of Minnesota youth with disabilities planning transition to work.

The survey also indicated that health providers play a limited role in facilitating and supporting transition. Less than 50 percent of teens surveyed received information on how to make their own medical decisions. In all, teens said they felt they were ill prepared to plan their future.

The need for providing transition services on a community level that truly address the priorities and concerns of youth is apparent. In addition, better coordination with health providers and employers, is essential. It is time for communities to come together to provide comprehensive transition services that focus on the needs of youth and promote a successful and healthy transition to work and more self-sufficiency.

GOALS AND OBJECTIVES:

1. To provide training, information and ongoing support for youth with disabilities, so they are better prepared for a healthy transition to more self-sufficiency.
2. To provide training and information for parents of youth with disabilities about preparation for transition to adulthood.
3. To collaborate and provide information for community health providers to provide transition services that are culturally sensitive for youth with disabilities.
4. To collaborate and provide information to community employers to promote employment opportunities for youth with disabilities.
5. To collaborate with state and local agencies to develop comprehensive community based transition services that are family-centered and culturally competent and support youth with disabilities to transition to adulthood and more self-sufficiency.

METHODOLOGY:

This project focuses on youth between 12 and 22 years of age and their families in the urban center of St. Paul, Minnesota, as well as, state and local agency personnel, community health professionals, and employers. Multicultural specialists focus on the unique needs of minority communities, including the Southeast Asian and Hispanic communities.

Trainings and information were presented to youth and their families at local schools. Project staff provided information on community resources, planning transition IEPs, SSI, rehabilitation services and self-advocacy. A Pediatric Nurse Practitioner under subcontract with the St. Paul Public Schools provided one on one information and support for teens to learn about managing their own health care needs. An "employment network" was established on the PACER Center web page and provides teens, parents and employers with information about employment and success stories of youth with disabilities working in the community. A newsletter, *Looking Ahead*, has been developed, translated into Spanish and Hmong and sent to parents of children in special education in St. Paul.

COORDINATION:

Coordination with the various State and local agencies varies according the project goals and includes: 1) coordination with St. Paul Public School in Youth leadership activities, transition health services, and community collaboration; 2) coordination with health clinics at the University of Minnesota and Gillette Children's Hospital through resident/physician transition training; 3) coordination with MN State Education to insure the inclusion of transition and health issues in the transition guidelines; 4) coordination with community employers to promote employment opportunities for youth with disabilities, and; 5) coordination with Minnesota Children with Special Health Needs in developing and maintaining a focus and current health and transition issues for youth.

EVALUATION:

All activities of the project are carefully evaluated. All training sessions are evaluated individually by participants. Youth involved in the pilot project with the Pediatric Nurse Practitioner received a pre and post assessment to track any change in health behaviors and outcomes.

EXPERIENCE TO DATE:

Many of the activities of the past seven months have built on or been a continuation of the past years experiences. Three new youth groups have been established this year. Six new youth have received individual health and transition support from a Pediatric Nurse Practitioner. Resident /Physician transition training continues on a monthly basis as well as training for other health and education professionals (412 this year). Families (6561 this year) continue to receive information, training, and support. Of these families, 54 Southeast Asian parents met with their county developmental Disability staff to advocate for their own issues and to clarify questions and concerns.

KEY WORDS:

Adolescents with Disabilities, Advocacy, Chronic Illness and Disabilities, Community Participation, Cultural Competence, Eligibility Determination, Employers, Families, Family Center Health Education, Family Professional Collaboration, Hispanics, Information Sources, Interagency Cooperation, Medicaid, Mental Health Services, Parent Education, Parent Professional Communication, Professional Education in Chronic Illness and Disabilities, Public Policy, Rehabilitation, School Health Services, Schools, Service Coordination, Sexuality Education, Southeast Asians, State Systems development, Stress, Supplemental Security Income, Third Party Payers, Title V Programs, Training, Vocational Training, Youth in Transition

HRTW Ohio PROJECT ABSTRACT

Project Title: Healthy & Ready To Work, Career Connections for Students
Project Number: MCJ - 39HRW5 - 03
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Project Period: 4 Years -- From: 1997 to 2001

PROBLEM:

In Hamilton County, Ohio, the transition of adolescents with special health care needs and/or disabilities to the adult world is not well coordinated. This is an urban county, which contains the city of Cincinnati. Although many of the adolescents are involved in multiple public service systems, they do not have a comprehensive plan for transition that takes into consideration all their needs. The Cincinnati schools are facing typical urban problems of funding and student dropout. They are attempting to comply with the requirements of IDEA, but need further guidance in planning and implementation. Many adolescents leave school prematurely, further cutting themselves off from supportive services. There is evidence that youth who lack a parental advocate for their transition have very limited success.

PROJECT:

Four methodologies are used to develop transition services at the system level and at the level of individual students and their families: (1) development and presentation of a comprehensive life skills curriculum for transition for professionals, families and youth; (2) development of information and referral systems and products for transition resources; (3) transition coordination for youth with long term conditions Hamilton County and Cincinnati who are at high risk of drop out and unemployment; (4) support and facilitation of a transition network (Roundtable) in Southwest Ohio of a wide range of stockholders, and facilitation of interagency cooperation at the state level to improve the system of transition services.

EXPERIENCE IN FY 2000:

Twenty -three trainings were delivered to youth with special health needs in their school environment, with six sessions of a Teen Discussion group held at the programs offices. Seventy-seven parents participated in training activities. There were fourteen training session for professionals working in the field, collaboratively produced by 10 agencies. New training segments were developed and already established segments refined on the basis of input from trainees. The information and referral services distributed 7,300 copies of six different transition information brochures. Transition coordination services were provided to 107 new students. Of these, 68 participated in a health care screening, 39 received transition services and 26 received intensive transition coordination. Community planning and coordination services conducted by Career Connections included continued leadership of the Southwest Ohio Transition Roundtable, including participation with the County Board of MR/DD in developing a strategic plan. In collaboration with Cincinnati Public Schools, local rehabilitation agencies, the Bureau of Vocational Rehabilitation and County MR/DD Board a new program for orthopediacally and multiply handicapped students was developed and delivered. The program participated with the Parent

Information Center and the local Legal Aid Society in redesign effort of Cincinnati Public High Schools to better retain special education students and accommodate their transition needs.

KEY WORDS:

Adolescents with Disabilities; Children with Special Health Care Needs; Chronic Illnesses and Disabilities; Families; Health Professionals; Youth In Transition, Urban Youth.

HRTW Oregon PROJECT ABSTRACT

Project Title: Community Solutions Project: Building capacities to support the transition of youth with special health needs from diverse cultures to independence and employment.

Project Number: CFDA # 93.110

Project Director: Laurie E. Powers, Ph.D., PI

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Project Period: 4 Years -- From 10/1/97 to 9/31/01

Budget Period: From 10/1/99 to 9/31/00

PROBLEM:

In the 5 years following high school, youth with special health care needs lag behind their peers in the general population in terms of rates of employment, wages earned, access to post-secondary education, and residential independence (Blackorby & Wagner, 1996). Specifically, youth who experience health conditions, multiple disabilities, orthopedic impairments, and mental retardation continue to demonstrate poor transition outcomes, particularly minority youth.

Findings from a needs assessment with African American, Native American and Hispanic youth suggest a number of barriers that must be address to promote youth transition success. These barriers include (a) cultural insensitivity, (b) lack of awareness by professionals and employers of the obstacles imposed by health problems and accommodations that can be provided to assist youth, (c) isolation of youth and families from transition and health care supports, and (d) poor coordination between discrete school programs that support youth with diverse conditions, and between schools, community organizations and disability or health-focused programs. If we are to improve the transition outcomes of culturally diverse youth, it is essential that family-centered, culturally-responsive, community-driven strategies be developed to reduce these barriers.

GOALS AND OBJECTIVES:

The purpose of the Community Solutions Project is to build the capacities of schools, health providers and community organizations in the Portland Area to promote the health and transition success of minority teenagers with special health needs through a 4 year model demonstration and systems development initiative. Community Solutions is accomplishing 4 major goals:

Transition-Focused Family Support. A transition-focused family-support program has been established for teenagers and families in the African American, Hispanic and Native American communities. Transition Support Liaisons provide outreach to youth and their families, and assist them to conduct person-centered transition planning, to identify and access supports and to negotiate transition barriers. Liaisons are based in the school district and in organizations that provide health/disability, employment and cultural supports to youth and their families.

Leadership Development. We have established a leadership development program that facilitates mentorship and intra-generational peer support for youth and educational and advocacy activities to promote cultural responsiveness and health awareness among educators, employers, health professionals, and community organizations.

Interdisciplinary Professional Development. We are establishing a training focus in culture and transition supports within the OHSU Maternal and Child Health Training Program. Maternal and Child Health trainees and OHSU medical school and nursing students participate in instructional and practicum experiences focused on enhancing their cultural responsiveness and their transition support skill. Curricula are being developed to support trainee participation in instructional and practicum activities.

Systems Development. An inter-organizational Policy Team meets quarterly to consider the system barriers to transition success that are being identified through the Project and to develop specific objectives and strategies to address the barriers. The Policy Team includes representatives of key State health, education and employment agencies, youth and family Project participants and representatives from community organizations.

METHODOLOGY:

Community Solutions is committed to work with youth with SHCN, their families and leaders from communities with ethnic and cultural richness in every step of the process. Methods include a review of extant data, surveys, focus groups, self-assessments of transition-focused cultural competence by organizations poised to address the employment needs of youth with SHCN, and inter-organizational strategic planning.

COORDINATION:

The Center on Self-Determination at Oregon Health Sciences University, a program of the Child Development and Rehabilitation Center (CDRC), is collaborating with schools and community programs in Portland, Oregon to address the needs of minority youth in transition from high school to adult life. CDRC is the Title V. agency in Oregon and it's leaders, Dr. Jerry Sells and Charles Carter, are actively involved in the project.

EVALUATION:

The central outcome of the Project is the development of comprehensive approaches to address the identified employment and health needs of youth with SHCN within and across the target communities. Formative and summative strategies address administrative and methodological monitoring for: 1) Fidelity to the plan; 2) Social Validity of activities and products; and 3) Efficacy of the activities. The Community Solutions Project is being systematically evaluated to determine its impact on adolescent, family, employer, and health provider participants as well as its impact on systems development. The findings, strategies and products from the Project will be comprehensively disseminated to promote the design and delivery of transition supports to culturally diverse youth with health conditions and disabilities across the nation.

KEY WORDS:

SCSHN, Adolescent, Transition, Employment, Culture

ANNOTATION:

The Community Solutions Project aims to build the capacities of schools, health providers and community organizations in the Portland Area to promote the health and transition success of minority teenagers with special health needs. The project is a 4-year model demonstration and systems development initiative that includes transition-focused support and advocacy for youth and families, youth leadership, an inter-agency policy task force, and interdisciplinary training for health professionals in transition and cultural competence.