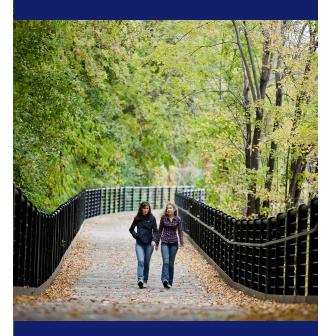
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and Human Services does not discriminate national origin, sex, religion, age or disability ealth • Jeffrey P. Engel, M.D., State Health Director ublichealth.com ere printed ealth and Human Services provision of services per copy. 03/10 lduq si epartment of F nier M. the

Carolina Health And Transition The CHAT Project



...building a bridge from pediatric to adult medical homes for youth with special health care needs.



funded by



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Exceptional Children's Assistance Center and Center for Independent Living

WHO ARE YSHCN?

Youth with special health care needs (YSHCN) are patients in your current or future practice who experience significant health challenges that impact them on a daily basis. These conditions require medical care and sometimes specialized accommodations. The youth have or are at risk for chronic physical, motor, sensory, intellectual or behavioral conditions that persist into adulthood. Nearly a third of adolescents experience at least one or more of these conditions, e.g. ADHD, asthma, diabetes, developmental disability, cancer, autism, diabetes or congenital heart disease, to name a few.



WHAT IS A MEDICAL HOME?

A medical home is not a specific facility or type of provider. It is a concept of person-centered care that was first defined by the American Academy of Pediatrics (AAP) as an approach to providing comprehensive primary care, in partnership with the family and patient to meet medical and non-medical needs. The AAP was joined by the AAFP, ACP, and AOA in the 2007 Joint Principles of the Patient-Centered Medical Home to create medical environments that ensure the provider is in partnership with the patient, caregiver, and staff, in a "medical home" where the patient

- feels recognized and supported;
- finds a centralized base for medical care:
- gets connected to other resources. ٠



WHAT IS HEALTH CARE TRANSITION?

Health care transition is the purposeful, planned movement of adolescents from pediatric to adult health care. It is a not an event. Rather, it is process whereby the responsibility for managing health care shifts from the parent to the young adult. This shift to self-care and self-management occurs over time, ideally beginning at puberty or earlier so that the young person is ready to move into adult care between the ages of 18 and 24.

CHAT – A COLLABORATIVE EFFORT

The State of North Carolina, under the leadership of the NC Division of Public Health, Children & Youth Services Branch, received federal funding from the US DHHS Health Resources and Services Administration (HRSA) to develop a statewide comprehensive system for the transition of care for youth with special health care needs. The goal of the project was to offer training and create a curriculum for three key stakeholder groups:

- youth with special health care needs;
- families of these youth; and
- medical providers who serve them.

There are curricula for youth and their families, as well as a medical practicum for clinicians. These educational elements complement one another to ensure individual youth, families and medical providers are familiar with one another's role in the process. All stakeholders have equal access to each of the training components.

MEDICAL PROVIDER PRACTICUM

The goal of the practicum is to provide physicians and other clinical staff with information on these six areas:

- Health Transition Overview
- Medical Home
- Role of the Provider
- Clinical Toolkit
- Coding and Reimbursement
- Cultural Competence

THE CLINICAL TOOLKIT

Built around the six critical steps outlined in A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs (2002, jointly endorsed by the AAP, AAFP, ACP-ASIM), the CHAT toolkit provides clinical forms that can easily be adapted to any clinic or practice environment.

The toolkit forms include the following:

- Practice Readiness Assessment Tool
- Youth Readiness Assessment Tools
- Parent/Family Readiness Assessment
- Transition Readiness Scoring System
- One-Page Medical Summary
- Transition Information Form
- Transition Action Care Plan



CAROLINA Health & Transition PROGRAM

CHAT Practice Supports & Services

The medical practicum is available online, in hard copy or DVD format, with a downloadable toolkit. In addition, the youth curriculum, family curriculum, patient brochures* and care coordination materials are available at **no cost** to your staff and patients.

*Printed brochures available while supplies last.

Accreditation

The Mountain Area Health Education Center (MAHEC) is accredited by the North Carolina Medical Society to sponsor continuing education for physicians.

Credit

Physicians who wish to implement transition services into their practice may earn CME credits. For details, contact MAHEC directly.

Disclosure Statement

MAHEC adheres to the ACCME Standards regarding industry support to continuing medical education.

FOR MATERIALS and MORE INFORMATION

http://www.fpg.unc.edu/~ncodh/ ChildandAdolescentHealth/index.cfm

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To receive patient brochures (while supply lasts), or to request additional information, please complete and return by fax or mail:

Name:		
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Practice/Clinic:		
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