Grantee/Project Title	Health Care Transition Program Description -- FY16
Caroline County	Caroline County provides transition for youth through transition training events, Regional Transition Youth Conference, information shairng, respite camp, regional consortiums.
Calvert County	Calvert County provides community and provider outreach for health care transition in the community; and medical home services; transition case management through referrals, telephone calls, home vistis, and letters. Promoting health care transition through health fairs, presentations, and community meettings. And promotion of the CYSHCN reource locator. This county local department collaborates with local and civic group organizations.
Univerity of Maryland: The Access to Special Kids (ASK) Program	Using the Medical Home model, ASK provides care coordination for families of children and youth with complex healthcare needs. Support for families, assist care providers in serving families, serve as a bridge between families, primary care providers and specialists, identify and link to community resources, primary point of contact for families and providers at U of MD Children's Hospital, optimize integration into school and specialized day care.
CNMC - Complex Care and Parent Navigator Program	At Children's National, our Parent Navigator Program helps to reduce family stress by connecting parents or caregivers to resources, assisting with navigating care, finding educational tools for parents and children, and providing emotional support so that managing a child's healthcare journey is a little easier. The navigators also bring a unique perspective and understanding to a child's healthcare team since they too are parents of children with special needs.
The Coordinating Center- The Coordinating Center's Transition Connection Initiative	This project seeks to implement Transition Connection Initiative (TCI), a pilot initiative to improve health care transitions for CYSHCN and their families. TCI will focus on a subset of youth served through the Rare and Expensive Case Management (REM) program with cerebral palsy/diplegia/quadriplegia, congenital anomalies of the nervous system and hereditary degenerative nervous system disorders living in Baltimore County and Baltimore City. This Program focuses on resource mapping, and physician analysis to conduct outreach and provide interventions.
JHU Dept of Pediatrics: Developing an Innovative Interdisciplinary Transition Curriculum	This Project will develop a curriculum that will be a state and national model by incorporating the new Six Core Elements of health Care Transition into the JHU's interdisciplinary curriculum. The JHU faculty will add the Six Core Elements as a new core competency and develop a set of didactic and clinic-based training methods that can be incorporated and evaluated for current and future trainees.
JHU Division of Peds and Adolescents: J-Train: The John Hopkins Transition Independence Network	This Project seeks to customize an evidence-based best practice model for HCT for use in John Hopkins Medical System (JHM) based on the Six Core Elements of health Care Transition. Incorporate HCT into JHM's Health Information Technology (HIT) system to facilitate adoption of transition into routine clinical care. Initiate system-wide implementation of the HCT model with EMR supports across the Johns Hopkins Medical System.
JHU, Dept. of Pediatric Hematology: Improving Hematology Services for Children with Hereditary Hemoglobinopathies and Bleeding Disorders and their Families	This project provides comprehensive services to children with SCD and bleeding disorders. Improve services, based on previous needs assessments; and improve access to and quality of these comprehensive services in Maryland. This program assess the effectiveness of current efforts in transition of youths with SCD and bleeding disorders to adult care and assess the effectiveness of interventions, based on these assessments. This proposal seeks to improve the quality of screening for stroke risk in CYSHCN with SCD and Improve transition and increase access to dental care for patients with bleeding disorders.

The PPMD: Enhancing Medical Home and Youth Transition to Adult Health Care through Family/Professional Partnerships	Promote optimal health for CYSHCN and facilitate their access to an effective health delivery system by providing information, education, technical assistance and peer support to Maryland families of CYSHCN and professionals and assuring that CYSHCN and their families have access to medical homes, successful transition to adult health care, work, and independence, and community based services.
Univerity of Maryland - ***The Access to Special Kids (ASK) Program***	The ASK Program provies a medical home model approach to provide care coordination for families of children and youth with complex healthcare needs. Support for families, assist care providers in serving families, serve as a bridge between families, primary care providers and specialists, identify and link to community resources, primary point of contact for families and providers at University of Maryland Children's Hospital, optimize integration into school and specialized day care; serves as a Single Point of Entry to University of Maryland Medical Center and Children's Hospital Pediatric Specialists; Uses a Team Approach in assisting families with their child's medical condition.
Children National Medical Center - ***Complex Care and Parent Navigator Program***	Children National Medical Center understand's that families who have children with chronic medical conditions and special healthcare needs require extra support. At Children's National, our Parent Navigator Program helps to reduce family stress by connecting parents or caregivers to resources, assisting with navigating care, finding educational tools for parents and children, and providing emotional support so that managing a child's healthcare journey is a little easier. The navigators also bring a unique perspective and understanding to a child's healthcare team since they too are parents of children with special needs.
The Coordinating Center- ***The Coordinating Center's Transition Connection Initiative***	This project seeks to implement Transition Connection Initiative (TCI), a pilot initiative to improve health care transitions for CYSHCN and their families. TCI will focus on a subset of youth served through the Rare and Expensive Case Management (REM) program with cerebral palsy/diplegia/quadriplegia, congenital anomalies of the nervous system and hereditary degenerative nervous system disorders living in Baltimore County and Baltimore City. This Program focuses on resource mapping, and physician analysis to conduct outreach and provide interventions.
John Hopkins University Department of Pediatrics: Developing an Innovative Interdisciplinary Transition Curriculum for Maryland	This Project will develop a curriculum that will be a state and national model by incorporating the new Six Core Elements of health Care Transition into the JHU's interdisciplinary curriculum. The JHU faculty will add the Six Core Elements as a new core competency and develop a set of didactic and clinic-based training methods that can be incorporated and evaluated for current and future trainees.
John Hopkins University Division of Pediatrics and Adolescents: J-Train: The John Hopkins Transition Independence Network	The J-Train Project seeks to customize an evidence-based best practice model for HCT for use in John Hopkins Medical System (JHM) based on the Six Core Elements of health Care Transition. Incorporate HCT into JHM's Health Information Technology (HIT) system to facilitate adoption of transition into routine clinical care. Initiate system-wide implementation of the HCT model with EMR supports across the Johns Hopkins Medical System.
John Hopkins University, Department of Pediatric Hematology: Project Title: ***Improving Hematology Services for Children with Hereditary Hemoglobinopathies and Bleeding Disorders and their Families***	This project provides comprehensive services to children with sickle cell disease (SCD) and bleeding disorders in the State of Maryland; Improve services, based on previous needs assessments; and improve access to and quality of these comprehensive services in Maryland. This program assess the effectiveness of current efforts in transition of youths with SCD and bleeding disorders to adult care and assess the effectiveness of interventions, based on these assessments. This proposal seeks to improve the quality of screening for stroke risk in CYSHCN with SCD and Improve transition and increase access to dental care for patients with bleeding disorders.
PPMD: Mini Grants Calvert County Health Department - ***Crossroads Program***	The purpose of the "Crossroads" Project is to facilitate a smooth, organized, and coordinated transition for adolescents with chronic health conditions from child to the adult health care system. The goals of the project are to: Optimize health, Proactive transition to adult healthcare, Successful coordinated integration into the adult healthcare system.
PPMD: Mini Grants Kennedy Krieger Children's Hospital - ***Health Care Transition for Youth with Special Needs Program***	The efforts under this proposal will create a systematic, orderly and family centered evaluation of current healthcare needs for youth and young adults approaching transition age at the CARD by creating a portable healthcare document that will aid in coordination of services between pediatric and adult health care providers. This will ensure high case- by –case personalization of care & healthcare management of the young adult with autism and thus improved quality of life for the individual with autism.

yes

PPMD: Mini Grants **The Johns Hopkins Hospital -** ***Electronic Transition Readiness Assessment (ETRA) to improve the quality of transition for youth with specail health care needs in Primary Care Program***	This program will target YSHCN ages 16-25 who lives in the East Baltimore and receive care in the Adolescent Medicine Section of the Harriet Lane Clinic (HLC) at Johns Hopkins Children's Center. The Harriet Lane Clinic (HCL) has over 18,000 visits per year and serves as the medical home to approximately 8500 children from birth to 25 years old. This project will implement a quality improvement project using the Plan, Do, Study, Act (PDSA) approach=h. The goal is to: (1) Improve the quality of the transition experience of YSHCN and their families age 16015 and their families who live in the East Baltimore area; and (2) implement an ETRA in an academic primary care practice serving adolescents and young adults.
PPMD: Mini Grants **Maryland Chapter of the American Academy of Pediatrics -** ***Educational Event on Transition Program***	This program is to coordinate an educational event that provides CME credit for pediatricians and other primary care providers, many of whom are members of the Maryland Chapter of the American Academy of Pediatrics with a focus on transition, describing the need for deliberate and organized transition for youth with special healthcare needs, and describing strategies for the successful implementation of the "Got Transition?" tools in primary care practices.
PPMD: Mini Grants **Pathfinders for Autism -** ***Primary Care Physicians and Transitioning Youth with Special Health Care Needs- Expanding, Enhancing , and Educating Maryland's Community Program***	The intent of this program is to work at a grassroots level – conducting surveys of parents and CYSHCN (specifically ASD), posting inquiries on social media outlets, reaching out to our 15,000 plus subscriber database, and working with other autism groups in the State, to increase providers and services database to include more PCPs and general practitioners.
PPMD: Mini Grants **Oscar Taube, MD, Medical Director: Pediatric Outpatient Department, Sinai Community Care (SCC) -** ***Transitioning from Pediatric to the Adulat Medical Home for Patients in Sinai Community Care, Sinai Hospital of Baltimore Program***	The Sinai Community Care (SCC) porgram will enhance SCC's transition from the Pediatric to the Adult Medical Home by engaging a Transition Coordinator and introducing an Adolescent Leadership Council. A coordinator, overseeing the transition process, will enable successful transition to adult care. SCC Pediatrics has made some preliminary steps toward successful transition; with the services of a coordinator and an Adolescent Leadership Council, we will build on this initial progress.