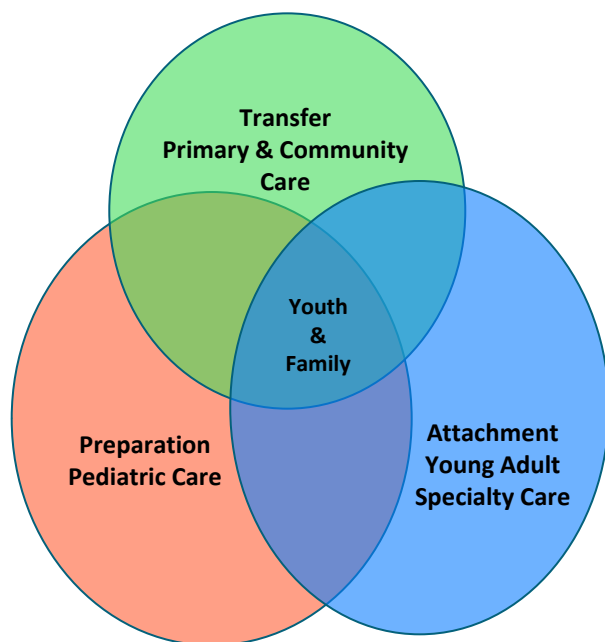


# ON TRAC

## Transition Clinical Practice Guideline



**Patient-Centred: Youth with chronic health conditions and/or disabilities (CHC/Ds)** require developmentally-appropriate, holistic transition care. Transition care should begin during early adolescence (age 12) with increasing personal responsibility (as they are able), through to transfer at 18 years of age, until they are securely integrated into the adult system (by 24 years of age). Through annual assessments, care should be responsive to individual differences of development, cognitive and physical abilities, cultural and family dynamics, and trajectory of the youth's condition.

**Youth & Family Engagement:** Youth and family engagement and interaction are central to the success of all transitions. For youth with CHC/Ds with intellectual disabilities, a family member or guardian should be identified. Youth and/or family/guardians should be active participants engaged through annual **readiness assessments (Youth Quiz or Family Checklist)**, counselling and education.

**Documentation:** The transfer from pediatric to adult care is a time of increased clinical risk which requires particular attention to the transfer of relevant documentation. This includes using standardized clinical transition tools: the **Transition Clinical Pathway(s)** and a **Medical Transfer Summary**, supported by appropriate reports and assessments, sent to the **Adult Specialist(s), Family Practitioner** (physician and/or nurse practitioner) and the **Youth** at the time of transfer.

**Attachment to Community & Adult Services:** All youth with CHC/Ds should be attached to a **Family Practitioner by 14 years of age**, and have **identified Adult Specialist(s) and services** within one year prior to leaving pediatric care (**16-17 years of age**). A first visit to the Adult Specialist should be within 6 months of transfer. Transfer to adult care requires functioning referral networks and follow-up communication between pediatric and adult providers.

**Knowledge Translation:** New learning requires education, online resources and skill-building support **for all stakeholders - youth, families, and health care providers**. Content areas include condition-specific care requirements, medical information, emergency planning, long-term care requirements, changes to benefits and funding, psychosocial and emotional supports, privacy and consent, sexual health, educational/vocational planning, living arrangements, and accessing adult services.

**Roles & Care Coordination:** Successful transition requires an understanding of the **roles and responsibilities** amongst all stakeholders in the process. The youth, family, family practitioner, specialized pediatric and adult care physicians, and allied health providers are the core stakeholders in transition. For youth with more complex needs, government and community-based care providers are also integral to the process. A **most responsible practitioner** should be identified for each patient throughout the process. **Specialized care coordination** and **navigation** may be necessary for more complex, individual patient situations.

**Research & Evaluation:** Ongoing research and evaluation should include **patient identification** (clinic lists or registries), youth and family **assessments, process and tool testing, feedback** and **satisfaction** of all stakeholders, and youth **health outcomes** and **quality of life measures** as part of **quality improvement** and **accreditation standards** for transition.