Overview: Transitioning Youth to an Adult Health Care Clinician

1 TRANSITION AND CARE POLICY/GUIDE

- Develop a transition and care policy/guide with input from youth and parents/caregivers that describes the practice's approach to transition, an adult approach to care in terms of privacy and consent, and age of transfer to an adult clinician.
- Educate all staff about the practice's approach to transition and distinct roles of the youth, parent/caregiver, and pediatric and adult health care team in the transition process, taking into account cultural preferences.
- Display transition and care policy/guide somewhere accessible in practice space, discuss and share with youth and parent/caregiver, beginning at age 12 to 14, and regularly review as part of ongoing care.

2 TRACKING AND MONITORING

- Establish criteria and process for identifying transition-aged youth.
- Develop process to track receipt of the Six Core Elements, integrating with electronic medical records (EMR) when possible.

3 TRANSITION READINESS

- Conduct regular transition readiness assessments, beginning at age 14 to 16, to identify and discuss with youth and parent/caregiver their needs for self-care and how to use health care services.
- Offer education and resources on needed skills identified through the transition readiness assessment.

4 TRANSITION PLANNING

- Develop and regularly update the plan of care, including readiness assessment findings, youth's goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents.
- Prepare youth and parent/caregiver for an adult approach to care, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information.
- Determine need for decision-making supports for youth and make referrals to legal resources.
- Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult care. If both primary and subspecialty care are involved, discuss optimal timing for each.
- Assist youth in identifying an adult clinician(s) and provide linkages to insurance resources, self-care management information, and community support services.
- Obtain consent from youth/parent/caregiver for release of medical information.
- Take cultural preferences into account throughout transition planning.

5 TRANSFER OF CARE

- Complete transfer package, including final transition readiness assessment, plan of care with transition goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional clinical records.
- Confirm date of first adult clinician appointment.
- Prepare letter with transfer package, send to adult clinician, and confirm adult clinician's receipt of transfer package.
- Communicate with selected adult clinician about pending transfer of care.
- Confirm the pediatric clinician's responsibility for care until youth/young adult is seen by an adult clinician.
- Transfer youth/young adult when their condition is as stable as possible.

6 TRANSFER COMPLETION

- Contact youth/young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm attendance at first adult appointment.
- Elicit anonymous feedback from youth/young adult and their parent/caregiver on their experience with the transition process.
- Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed.
- Build ongoing and collaborative partnerships with adult primary and specialty care clinicians.

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