



## Transition to Adult Healthcare Services Work Group When a More Intense Approach to Transition is Indicated

Planning proactively for the transfer for all youth and involving current and future team members as indicated will hopefully lessen issues that arise before, during and after the transition, optimize the continuity of care and ultimately, strengthen patient outcomes. The findings of the readiness/risk assessment would be used to determine whether a more intense approach is indicated and, if so, what the plan of care needs to include. The results of the assessment and the plan would be shared with all known and anticipated adult healthcare provider(s) to whom the youth's care is being transferred and to those who will remain involved with the youth's care, i.e. family physicians. Should the assessment show there is a need for more intense involvement from paediatric and/or adult HCPs pre and post transfer, the data obtained from the readiness/risk assessments would be provided to all involved.

The following are intended as examples of possible actions when the assessment shows a more intense approach to transition is needed; the actual approach taken needs to be patient needs driven.

- A joint discharge/transfer meeting at which members from both paediatric and adult healthcare provider teams including family physicians are present in person, by tele-conference and/or video-conference
- Additional supports from one or more team members (i.e. nurse practitioner, social worker, etc.) in the paediatric and/or adult healthcare setting
- Assignment of a key contact person/case manager/patient navigator within the paediatric and/or adult healthcare provider team (including community-based team members)
- Joint clinic visits where designated members from both paediatric and adult healthcare provider teams are present for a period of time (length of time to be determined based on the assessment)

It is important to note the recommendations that were developed were intended to be *generic* rather than site and/or condition specific so they could be adapted to each patient, patient population and the unique characteristics of an organization. It is recognized that consideration may need to be given to the development of recommendations specific to distinct populations with unique transition needs such as, but not limited to:

- Complex care/medically fragile youth
- Youth with very rare conditions for whom no adult providers are available to assume care
- Youth with significant mental health issues

For many of these youth, a life-long approach is needed that goes well beyond the health sector and includes education, housing and social support systems.

Addressing the needs of distinct populations with unique transition needs could be achieved through the establishment of formal linkages/partnerships between Academic Health Science Centres/community hospitals and organizations, potentially through:

- Joint transition clinics for identified populations
- Memoranda of Understanding between paediatric and adult healthcare settings, i.e. medically fragile/complex care clinics for ongoing management
- Inter-hospital/community transition committees
- Cross appointments between paediatric and adult healthcare settings
- Access to consultations with paediatricians for adult patients with rare conditions and for whom no other expertise is available