Transition to Adult Healthcare Services Work Group
Recommendations that Have Clinical Applicability

The following recommendations and associated documents/resources/tools have clinical applicability for paediatric and adult healthcare providers in helping youth and their families who will be, or have already been, transitioned to adult services. Recommendations regarding skill/knowledge capacity building, accreditation standards, evaluation, data and required system level changes were also made but are not included on this list.

Recommendation	Description of Supporting Document/ Resource/ Tool	PCMCH Website Link/Document
Recognizing that the attainment of knowledge and self management skills leading to a mastery over a chronic and/or complex physical, developmental and/or mental health conditions is a process that takes time and involves healthcare providers, parents/caregivers and children/youth *AND* Recognizing the roles of children, youth, parents and the healthcare providers change over time and may move back and forth as the medical condition changes *AND* Taking into consideration developmental, cognitive, psycho-social and physical issues as appropriate: A. All healthcare providers begin, *early in adolescence*, the process of facilitating the following: ➢ Knowledge related to their medical condition and the adult healthcare system *AND* ➢ Skills necessary for the management of their condition B. Once transferred to the adult healthcare system, healthcare providers *continue to foster* knowledge acquisition and self management skills within the young adult	The *Shared Management Model of Transition* is a planned systematic approach to a gradual shift in responsibilities from the health care provider and parents to the young person, as developmentally appropriate. Preparation (e.g. attaining knowledge and assuming responsibility for health care needs) must start as early on in the child/family's involvement with the healthcare system as is deemed appropriate, well before the formal transition process commences.	Shared Management Model of Transition

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A combined transition readiness/risk assessment tool be developed and piloted to identify those who would benefit from a more intensive approach during the transition process and, if indicated, to determine a plan of care	The readiness assessment would focus on the condition and the risk assessment would look at other issues (i.e. psycho-social) that may impact the transition and ongoing management. The risk assessment is really getting at who needs more support, for what reasons, and what type of support is needed (e.g. education about medical condition, counselling re: coping with the challenges, etc.).	Detailed listing of the components of the combined readiness/risk assessment
As above	The Good 2 Go Transition Program at the Hospital for Sick Children developed 2 questionnaires ("*Readiness Checklist for Patients", "Readiness Checklist for Parents")* to determine *transition readiness* for patients and for parents.	Readiness Checklist for Patients Readiness Checklist for Parents
As above	Holland Bloorview Kids Rehabilitation Hospital developed "*Developing Skills for Growing Up*: *Getting Started, On My Way and Almost There"*. The 3 checklists are divided into the categories of self-advocacy, social/recreation, independent living skills, school/work and health/ wellness.	Developing Skills for Growing Up
As above	The Transplant Centre at The Hospital for Sick Children developed *"Guidelines for Transition from Paediatric to Adult Care",* a checklist for health care providers to use to make sure all steps are covered regarding preparing youth/families for the transition/transfer to adult care.	Guidelines for Transition from Paediatric to Adult Care
A formal and planned discharge discussion occurs with every patient/family on or near their last appointment in the paediatric setting	Developed by the Good 2 Go Transition Program at SickKids, "*MyHealth Passport"* is a wallet-sized card that lists the individual's medical conditions, past procedures/ treatments, medications, allergies, etc.	MyHealth Passport

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For patients/families assessed through the transition readiness and risk assessments as *needing a more intensive approach to transition*, a joint discharge/transfer meeting/discussion occurs at which the patient, family/caregiver(s) and/or members from paediatric, adult, primary and/or community-based (i.e. CCAC) multi-disciplinary healthcare teams, as appropriate, are present	A listing of possible approaches that could be used when a more intense approach to transition is indicated	When a More Intense Approach to Transition is Indicated
As above	A listing of the possible reasons for transferring at an earlier time or for extending the date of transfer	Possible Reasons for Transferring Before or After the 18th Birthday
Every specialist involved in the provision of care to youth who are transitioning to an adult healthcare provider/setting include *standardized information* on the discharge/transfer summary *for every patient*	A detailed list of suggested items for inclusion in the discharge summary	Discharge Summary Template
All recommendations	An inventory of youth transition tools and resources, including supporting evidence, that were reviewed by members of the expert panel	Inventory of Youth Transition Resources and Tools
All recommendations	A listing of references used in the Transition to Adult Healthcare Services Report	Youth transition references