Provincial Council for Maternal and Child Health
building a brighter future

Youth Transitions to Adult Health Services: Transition Discharge Planning Tool

The following recommendations will help guide your care of youth who will transition to adult health services at 18 years of age, including which healthcare providers/team members might be involved, and what needs to be done/considered at each stage. This plan, if fully implemented in your care setting, will help you meet Accreditation Canada's transition standards published in Medical Services required organizational practices (ROPs) February 2015 for inclusion in 2016 accreditation surveys. While the plan identifies discrete time periods, each are a guide for activities which will, in fact, be iterative and on a continuum over the 24 months leading up to the patient's 18th birthday and full transition to adult health services.

Before considering the specific needs of patients/families, ***at an organizational level***, it will be helpful to look at the current workflow, policies and procedures, decision support analyses and information management/information technology enablers which could be used, modified, and/or developed, to enable transition planning. For example:

- Is there a policy or procedure in our organization regarding discharging an adolescent from paediatric care to adult services?
- Would it be possible to create a clinic visit called transition discharge consultation, in order to track the number of patients who were provided a formal transition planning discussion?
- How can the information management system (electronic medical record) support the development of the formal transition discharge summary?
- How can the transition discharge summary be provided to the patient and/or family so they can be informed, and so they can inform adult providers who may, for some reason, not have the discharge summary immediately available for the patient visit?
- Is it possible to create, or is there a space within the transition discharge summary, for patients to identify their goals for health and social development?

Who, What, When

Guidance Timeline

Transition Process - Initiation: 24 months before transition discharge (< or = 16 years old)	
Transition team	Although plans begin as soon as a person becomes a paediatric patient, a series of decisions must be considered/made a minimum of 24 months before the person's 18th birthday: • Which program within an organization is responsible for managing the patient's transition? • Who is responsible for transition within a program? • Who, in the regular healthcare team, is the primary transition lead or facilitator for the patient? • If the patient attends other organizations, who can be identified as a lead organization (likely the organization where the most care is received)?

Transition Process - Initiation: 24 months before transition discharge (< or = 16 years old)	

Assess current state and gaps	**Identify:**
	• A primary care provider (not a paediatrician)
	• Primary medical supports (specialists)
	  ○ Community supports; regional and or provincial
	• Other supports needed, for example:
	  ○ Financial
	  ○ Social
	  ○ Educational
	
	Document:
	• Transition assessment in chart
	• Discussion(s) with youth and family related to the transition process
	
	Determine if there are:
	• Organizational transition policies in place to guide transition process(es)
	• Transition clinics for this diagnostic group, or for general youth transition
	• If there is no transition clinic in the organization, schedule a clinic visit to discuss, and initiate, the transition process; Note: every healthcare provider needs to discuss the transition.
	  ○ In addition, the healthcare provider may be supported by a transition clinic
	• Community services, for example, coordinators from Community Care Access Centres and/or other community organizations, who should be involved in the process
	
	• Have a discussion about consent and capacity; start to prepare the youth and family for the difference between family-centred and patient-centred care
	• Begin (and/or continue) to encourage independence/autonomy; at this point, it should be a discussion
	
	Identify gaps and issues between:
	• Patient readiness[1] and family readiness; based on assessment, develop a plan to address the readiness gaps for both
	• Current paediatric services versus available adult services

[1] A readiness for transition tool has been developed and validated by McMaster researchers and the use of this tool, or a similarly validated readiness tool is recommended. The development of a risk assessment tool to help identify those adolescents most at risk of encountering difficulty after transitioning from paediatric services is in development and will also be made available when it is ready on the CanChild website.

<table>
<tr><th colspan="2">Transition Process - Initiation: 24 months before transition discharge (< or = 16 years old)</th></tr>
<tr><td>Design individualized state</td><td>
At every point of contact with the youth and family, assess readiness using readiness tools:

Patient
Parent
Link youth and family to resources
Other factors to consider include developmental status and status/trajectory of the chronic disease

Develop a “service mirror”:
<table>
<tr><th colspan="2">Paediatric</th><th colspan="2">Adult</th></tr>
<tr><td>X</td><td>Primary care MD</td><td>√</td><td>Primary care MD</td></tr>
<tr><td>√</td><td>Respirologist</td><td>X</td><td>Respirologist</td></tr>
<tr><td>√</td><td>Endocrinologist</td><td>X</td><td>Endocrinologist</td></tr>
<tr><td>√</td><td>Mental health clinician</td><td>√</td><td>Mental health clinician</td></tr>
<tr><td>√</td><td>Paediatrician</td><td>X</td><td>Paediatrician</td></tr>
</table>
</td></tr>
<tr><td>Implement</td><td>

Help patient complete “MyHealth Passport”, an online tool developed at SickKids to document key health information on a form that can be printed and folded into a wallet sized document; it could be used to help the youth learn how to make a 3-sentence summary of their health condition
If multiple care organizations are involved, collaborate to determine the lead organization for transition preparation; most likely will be the organization providing the most service
If patient does not have a family doctor, support patient and/or family in finding one
Health update sent to (new) family doctor

</td></tr>
<tr><td>Monitor</td><td></td></tr>
<tr><td>Evaluate</td><td></td></tr>
</table>

Transition Process: 12 months before transition discharge (< or = 17 years old)	
Transition team	
Assess	
Design	**Develop a "transition to adult health services document" that includes:** • An overview of the specific transition process, issues, and mitigation strategies • A summary of social, educational, developmental status and supports • A comprehensive discharge summary with standard elements provided by all disciplines currently involved in care • Input from all specialists currently involved • Who will provide case management (may be primary care provider/service or may be community organization) • Discharge summary sent to all adult providers and copy given to patient and/ or family (if patient gives permission to share with family); exceptions only for components that are sensitive and/or have been identified as confidential • Standard formatting is recommended to improve clarity of communication for reader

Implement	• Start sending referrals for adult services that includes summary with recommended elements
	• Document activity and confirm plans for adult services:
	  ○ Name of provider / service
	  ○ Contact information for provider/service
	  ○ Location address
	  ○ Transportation to get to provider/service

Monitor	
Evaluate	

Transition Process: 3 months before transition discharge (< 18 years old)	
Transition team	
Assess	
Design	

Implement	• Primary case manager to conduct transition visit/appointment and include adult healthcare providers as appropriate and possible; if in-person attendance is not possible and yet a "warm" handover preferred, consider video or tele conference options for providers who cannot attend
	• Ensure written documentation of transition visit is in chart and given to patient and/or family
	• Ensure patient and/or family knows contact information for coordinator
	• Give written and verbal information to patient and/or family, confirming all adult providers and services arranged:
	  ○ Name of provider/ key contact person
	  ○ Date and time of appointment
	  ○ Location of provider
	  ○ Phone number
	• Based on availability and care complexity, link clinicians between paediatric and adult teams, for example, nurse to nurse, social work to social work, physician to physician - by specialty, or ensure primary care adult doctor has contact information for paediatric specialist(s)
	Document and confirm to patient and/or family where to seek care, if required, before first contact with adult healthcare provider

Monitor	
Evaluate	

Transition Process: After Handover Complete	
Transition team	• To ensure a smooth transition, let the patient and family know that the paediatric providers can be contacted if problems arise prior to establishing the relationship and/or first visit with the adult healthcare provider
Assess	
Design	
Implement	
Monitor	• Contact patient within three months after discharge to confirm first visit to adult provider(s) has taken place; based on the phone call, consider whether further action is required
Evaluate	• Further provincial evaluation activity will be considered - within the context of PCMCH's strategic work review and strategic planning

Links to Transition Resources

About Kids Health https://www.aboutkidshealth.ca/transitionadultcare

CanChild https://www.canchild.ca/en/search?utf8=%E2%9C%93&q=transition&commit=Search

Health Quality Ontario Teamwork Primer

The Hospital for Sick Children https://www.sickkids.ca/en/patients-visitors/transition-adult-care/

Provincial Council for Maternal and Child Health www.pcmch.on.ca/transition

Feedback

Please let us know if you use this guidance and how useful you found it. If you are willing to provide helpful feedback to further improve the tool, please send it to info@pcmch.on.ca