Quality Standards

Moving From Youth to Adult Health Care Services

Suggestions on what to discuss with your health care providers to help you receive high-quality care

Provincial Council for Maternal and Child Health
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Ontario Health

Ontario Health is committed to improving the quality of health care in the province in partnership with patients, health care professionals, and other organizations.

To do that, Ontario Health develops quality standards. These are documents that outline what high-quality care looks like for conditions or processes where there are large differences in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. These quality standards set out important steps to improve care. They are based on current evidence and input from an expert committee that includes patients, health care professionals, and researchers.

This patient guide is for you if you are 15 to 24 years old and transitioning (moving) from youth to adult care services. This guide accompanies the quality standard on transitioning from youth to adult health care services. It outlines the top six areas where providers can take steps to improve care for people moving from youth to adult health care services. The patient guide also includes suggestions on what to discuss with your health care providers, as well as a link to helpful resources.

In each stage of your move to adult health care services, you can include your family or caregivers, if you like.

Below is a summary of the top six areas to improve care for young people moving from youth to adult health care services.

Quality Statement 1: Early Identification and Transition Readiness

What the standard says

Young people who will transition out of child- and youth-oriented services are identified as early as possible and have regular collaborative reviews of transition readiness to support their ongoing preparation needs for transition (and the needs of their parents and/or caregivers).

What this means for you

- Your health care providers should work with you to help you prepare for your transition, or move, to adult care. They should start helping you prepare as early as possible. And they should support you during this whole move.

Quality Statement 2: Information-Sharing and Support

What the standard says

Young people (and their parents and caregivers, where appropriate) are offered developmentally appropriate information and support to meet their needs throughout the transition process. Information-sharing is collaborative, and health care providers actively seek the experience and expertise of the young person (and their parents and caregivers, where appropriate) and incorporate it into the transition planning and shared goal-setting.

What this means for you

- Your health care providers should offer information and support to meet your needs throughout the transition process. This might include information and support on:
  - What will happen during this process and why it is important to begin preparing early
  - Your health and your treatment plan
  - How you can become more comfortable managing your care
  - Any services and supports available to you
  - How services and supports for young people are different from those for adults
  - Where to go for peer support and mentoring, if you want it
  - Where your parents or caregivers can go for support, if they want it
  - Any benefits and financial support you might be able to get and how to apply for them
  - Where to go for more information or resources to support you
- Your care team can talk with you about this information and also write it down for you.
- Your care team should ask you questions about your health condition and experiences. They should learn from you, just like you learn from them, and they should put information from everyone involved into your transition plan (see "Transition Plan" on page 5).

Quality Statement 3: Transition Plan

What the standard says

Young people have an individualized transition plan that is co-created, documented, and shared within their circle of care.

What this means for you

- Your health care providers should involve you in planning your move out of services for young people.
- Your care team (which includes your youth *and* adult providers) should write a transition plan with you. It should describe your care and who will support you when you move to adult services.
- This plan should be easy to read and understand, and it should include:
  - A transfer summary for an adult service or another person who will now be providing your care
  - Details about your first appointment with the adult service or another provider, including how often you might see them
  - How to contact your youth and adult providers, family doctor or nurse practitioner, and home and community support service providers
- Your health care providers should work with you to create a personal folder. You can review and update it over time. The information in this folder will help you understand your care and help you share information with an adult service or another provider (see box on page 6).

Your *circle of care* is the group of health care providers involved in your care. With your consent, they will share information with each other to help them provide you with good care.

Your personal folder

Your health care providers should work with you to create a folder for you. It might help you keep track of your thoughts and figure out what to share with your providers. Here are some examples of things you might want to include:

- [ ] One page that talks about your skills and personality, what's important to you, and how you would like to be supported
- [ ] Your strengths, achievements, goals, and hopes for the future
- [ ] Information about your education, health, community and social support service needs, and any devices you use to help you communicate
- [ ] Other details you want to convey (such as details of past trauma, mental illness, substance use, foster care)
- [ ] Emergency care plans

Quality Statement 4: Coordinated Transition

What the standard says

Young people have a designated most responsible provider for the transition process. This provider works with the young person (and their parents and caregivers, where appropriate) to coordinate their care and provide support throughout the transition process and until the young person (and their parents and caregivers, where appropriate) confirms that the transition is complete.

What this means for you

- Your health care team should involve you in choosing a single provider to be the "designated most responsible provider" for this move. This should be someone you know and trust.
- This person should work with you to coordinate your care.
- They should help arrange appointments and provide support until you feel your transition is complete.

Your *designated most responsible provider* is one person on your health care team who agrees to coordinate your move to adult services. You can help decide who this provider is. If this move takes a long while, over time you might have more than one designated most responsible provider.

Quality Statement 5: Introduction to Adult Services

What the standard says

Young people (and their parents and caregivers, where appropriate) have a meeting with key adult services or other providers before the transfer, to facilitate and maintain continuity of care.

What this means for you

- Before you move from services for young people to services for adults, you should be offered a meeting with key health care providers from the services you are moving to.
- These meetings might happen in a variety of ways:
  - Your youth and adult providers might meet with you together
  - Your designated most responsible provider might go with you to meet a provider from your adult service
  - The meetings might take place in person, or they might be over video or by phone

Quality Statement 6: Transfer Completion

What the standard says

Young people remain connected to the designated most responsible provider for their transition and are supported until health care service transitions are complete and confirmed by the young person (and their parents and caregivers, where appropriate).

What this means for you

- After your last visit to services for young people, your designated most responsible provider should stay in contact with you.
- They should monitor your transition.
- They should provide any support you need while you wait for your first appointment with each adult service or other care provider who is taking a role in your care.
- This support should continue until you have had your first appointment with each adult service or other provider and you have confirmed that your health care service transitions are complete.

Suggestions on what to discuss with your health care providers to help you receive high-quality care

Ask the care team:

- ☐ When will I move from youth to adult health care services?
- ☐ When will I start preparing and planning for this move?
- ☐ Who will work with me to plan this move?
- ☐ How will I be involved in developing my transition plan?
- ☐ Who will provide my future care?
- ☐ Who should I contact if I have questions or concerns about my transition plan?
- ☐ What resources are there in the community that can help me with this move?

Share with the care team:

- ☐ Who you want to include in decisions about your transition plan (like a parent or caregiver)
- ☐ If you don't think the services offered will give you enough support
- ☐ If you have concerns about who will be involved in your future care
- ☐ If you have any worries about this move to adult services
- ☐ Your plans for life as an adult (for example, if you are going away to school or starting a job)
- ☐ Your personal folder
- ☐ Any other questions or concerns you have

Need more information?

We have put together a list of resources that might be helpful for you. You can download it here.

If you have any questions or feedback about this guide, please contact us at QualityStandards@OntarioHealth.ca or 1-877-280-8538 (TTY: 1-800-855-0511).

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