QUALITY STANDARD PLACEMAT FOR

Transitions From Youth to Adult Health Care Services

This document is a resource for health care providers and summarizes content from the *Transitions From Youth to Adult Health Care Services* quality standard.

Preparing for Transition

Quality Statement (QS)* 1: Early Identification and Transition Readiness

- Identify young people who will transition out of child- and youth-oriented services as early as possible. Keep track of when they will transition
- Regularly review the young person's ongoing preparation needs for transition (and needs of their caregivers). Start these reviews as early as possible, and update them regularly (i.e., at least once a year); *see Resources for examples of assessment tools*

*The quality statements are provided in full on page 2.

QS 2: Information-Sharing and Support

- Offer developmentally appropriate information and support to meet the young person's needs throughout the transition process. If appropriate, also offer tailored information and support to meet the needs of caregivers; *see* resources for young people and their caregivers
- The young person (and their caregivers, where appropriate) has expertise to offer. Ensure a collaborative flow of information between all members of the team, so that everyone has the information and support they need and want to facilitate a successful transition

Transition Documentation and Coordination

QS 3: Transition Plan

- Prepare a documented, individualized transition plan for young people who will transition out of youth-oriented services; *see Resources for examples of transition plans*
- Co-create the transition plan with the young person (and their caregivers, where appropriate) and the health care teams involved in the person's care
- Prepare a transfer package that includes the information listed on pages 21–22 of the quality standard
- Give the young person (and their caregivers, where appropriate) a written copy (printed or ideally digital) of their transition plan before they transfer out of youth-oriented services

QS 4: Coordinated Transition

- Early in the transition process, work with the young person (and their caregivers, where appropriate) to identify a designated most responsible provider who will coordinate their care and provide support throughout the transition process
- The designated most responsible provider might be a nurse, social worker, youth worker, primary care provider, transition navigator, case manager, etc. This provider may change over time
- Coordinate care and provide support throughout the transition process until the young person (and their caregivers, where appropriate) considers the transition is complete: act as the main link between the young person and other providers; arrange appointments; act as a support person and advocate; guide the young person to other services and sources of support; provide support to the young person's caregivers, where appropriate; and ensure there are no gaps in the transition process

Transition Completion

QS 5: Introduction to Adult Services

- Participate in collaborative transition meetings with key adult services/providers to facilitate continuity of care
- These meetings may be one meeting (with key providers together with the young person) or multiple meetings that pair providers from youth-oriented and adult services; may include the designated most responsible provider and/or a primary care provider; may be in person or virtual; and may be informal. The young person and their youth-oriented service providers can decide whether a meeting is needed

QS 6: Transfer Completion

If you are the designated most responsible provider for the transition:

- Monitor the young person's transition to each adult service or other provider by regularly checking in (e.g., by phone, secure text messages, email) with them (and with their caregivers, where appropriate) until they have had their first appointment
- Offer support, as needed, while the young person waits to be seen by each adult service or other provider
- If the young person has medical needs, direct them (and their caregivers, where appropriate) to the most appropriate person or place with medical expertise to address their needs
- Confirm that the young person has attended their first appointment with each adult service or other provider and that they (and their caregivers, where appropriate) agree their health care service transitions are complete

Note: This resource can be used to support health care providers in the provision of care. It does not override the responsibility of health care providers to make decisions with patients, after considering each patient's unique circumstances. Grouping/directionality of statements may not be applicable for every patient, and clinical judgment should be used.

Transitions From Youth to Adult Health Care Services QUALITY STATEMENTS

Quality Statement 1: Early Identification and Transition Readiness
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).

Quality Statement 2: Information-Sharing and Support
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.

Quality Statement 3: Transition Plan
Young people have an individualized transition plan that is co-created, documented, and shared within their circle of care

Quality Statement 4: Coordinated Transition
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.

Quality Statement 5: Introduction to Adult Services
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.

Quality Statement 6: Transfer Completion
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).

Resources

- Transitions From Youth to Adult Health Care Services Quality Standard, Guide for Young People, and Guide for Caregivers
  bit.ly/3ltei70

Examples of validated transition readiness assessment tools:

- Transition Readiness Assessment Questionnaire (TRAQ)
  bit.ly/3ytfRol
- Transition Questionnaire (TRANSITION-Q) in conjunction with MyTransitionApp
  bit.ly/3uzTWUo, bit.ly/3uD6rOC
- Am I ON TRAC? for Adult Care Questionnaire for youth and for parents
  bit.ly/3Rq6Xcr, bit.ly/3OZar4h

Examples of resources for information-sharing and support:

- Moving From Youth to Adult Health Care Services: Resources for Young People and Their Caregivers
  bit.ly/3c7QklX

Examples of transition planning resources for various clinical populations:

- Alberta Health Services Transition Tracker (all clinical populations)
  bit.ly/3IsodGY
- Youth Transitions to Adult Health Services: Transition Discharge Planning Tool (all clinical populations)
  bit.ly/3uEOm2O
- Complex Care for Kids Ontario: Youth Transition to Adult Care Toolkit—Healthcare Provider Checklist
  bit.ly/3Pg5nYX
- mindyourmind Service Transition Plan: Moving to Adult Mental Health and Addiction Services
  bit.ly/3v1IMl7
- SHARE Transition Plan: Talking About Transition With Young People With Developmental Disabilities and Their Families
  bit.ly/3NUjphL

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