Healthcare Provider Guidelines - Transitioning Dependent Youth to Adult Healthcare

Alberta Health Services

This guideline identifies key tasks that healthcare providers can do to help youth and their family prepare for adult healthcare.
Each age level lists new tasks that would be done **in addition to** the items in the previous age.
Note: Not all tasks are applicable to everyone. Unless denoted as a time sensitive task*, use age as a guideline only.

	At around ages 12-14 yrs	At around ages 14-16 yrs	At around ages 16-17 yrs	At around age 17+ yrs
To Discuss:	❑ Inform youth and family about transitioning to adult care at 18 ❑ Transition tools and resources ❑ Lifestyle choices that could impact health and/or medical condition **at each visit** (i.e. diet, exercise, mental health, smoking, sexuality, etc.) ❑ Finding a family doctor (**at each visit** until youth has one)	❑ How medical and developmental condition may affect adult programming/employment options ❑ How medications can react with other medications, street drugs and alcohol ❑ Confidentiality, informed consent, and patient rights **at each visit** ❑ Community resources that support transition to adulthood ❑ Keeping track of health information	❑ The differences between pediatric and adult care for your clinic ❑ Adult Home Care – Self-Managed Care (SMC) versus Vendor Services ❑ Adult Funding* i.e. Assured Income for the Severely Handicapped (AISH) and Persons with Developmental Disabilities (PDD) ❑ Updating any medical equipment ❑ Programming options through PDD (Agency vs Family Managed Support) ❑ Guardianship and Trusteeship*	❑ Where care is being transferred, the process and contact info ❑ Healthcare options between youth's last pediatric and first adult appointments ❑ Advance Care Planning ❑ Medical and dental insurance* coverage after youth turns 18
To Do:	❑ Identify transition patients (12 -18 yrs) ❑ **At each visit** assess transition support required and refer as needed (i.e. translator, allied health, adolescent medicine, community resource. etc.) ❑ Develop a transition plan in collaboration with youth and family ❑ Document the transition plan and track progress – *Transition Tracker* ❑ Provide transition information package	❑ Review transition plan and document progress **at each visit** – *Transition Tracker* ❑ Send medical reports to pediatrician and/or family doctor **from each visit**	❑ Work with family to identify adult provider (if they have a preference) and collaborate with adult service to ensure smooth transfer of care ❑ Ensure final pediatric clinic visits are booked ❑ Send referral and *Medical Transfer Summary* to adult healthcare providers	❑ Complete the *Medical Transfer Summary* and provide a copy to: ❑ Youth and Parent ❑ Pediatrician ❑ Family doctor ❑ Adult specialists ❑ Confirm first adult appointment is attended ❑ Follow up with youth to ask about first adult appointment ❑ Discharge from clinic
Support by:	Informing or reminding youth and family **annually** about the: ❑ *Transition Readiness Checklist(s)* ❑ MyHealth Passport or Health Journal	❑ Referring youth/family to a transition workshop	❑ Giving youth opportunities to participate in medical decision-making **at each visit**	❑ Following up with youth /family to facilitate attachment if appointment wasn't attended

For more details go to www.ahs.ca/y2a

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