

Transition to Adult HealthCare Guideline for Dependent Youth

This guideline identifies tasks that could help when transitioning to adult healthcare. Each age level lists new tasks to do in addition to the items in the previous age. Some youth may be ready to do these tasks earlier, while others may start at a later age. Not all tasks are applicable to everyone.

	At around ages 12-14	At around ages 14-16	At around ages 16-17	At around age 17+
APPLY FOR:	 Social Insurance Number (SIN) Bank Account 	Government issued photo I.D.	Adult Funding* – Persons with Developmental Disabilities (PDD)	 Adult medical and dental insurance* <u>Guardianship and Trusteeship</u>* Day programming through PDD Adult <u>Home Care</u>* – If doing <u>SMC</u>, attend orientation <u>Adult Funding</u>* (i.e. Assured Income for the Severely Handicapped – AISH) Where your care is being transferred Healthcare options between the last pediatric and first adult appointments
LEARN ABOUT:	 Youth's medical condition, allergies, medications, treatments, and prognosis Talking to the healthcare team How your role may change with transition to adult healthcare Support groups and opportunities to connect with other families transitioning to adult healthcare Healthy lifestyle choices for you and your family Public transportation and/or ACCESS Calgary 	 Community resources that support transition to adulthood How medications can react with other medications, street drugs and alcohol Confidentiality, informed consent, and patient rights 	 <u>Differences</u> between pediatric and adult care Changes to <u>health insurance</u> when he/she becomes an adult <u>Guardianship and Trusteeship</u> Adult <u>Home Care</u> (i.e. Vendor Services versus <u>Self-Managed Care (SMC)</u> versus Vendor Services) Day programming options through <u>PDD</u> (Agency versus Family Managed Support) Opportunities for the youth to learn budgeting and <u>money management</u> 	
PREPARE BY:	 Completing the <u>Transition Readiness</u> <u>Checklist for Parents of Dependent Youth</u> each year Creating a <u>MyHealth Passport</u> or <u>Health Journal</u> and updating it each year Finding a <u>family doctor</u> Finding opportunities for the youth to help with meals, grocery shopping and household chores 	 Keeping track of important health information Attending a transition workshop Having an appointment with your family doctor at least once per year Requesting that your family doctor receive all relevant medical reports Requesting a psycho-educational assessment/reassessment for the youth 	 Options to live away from home Updating medical equipment Ensuring the last pediatric clinic visits are scheduled Confirming that your family doctor is receiving all relevant medical reports 	 <u>Booking</u> clinic appointments <u>Preparing</u> for your clinic visits Discussing <u>advance care planning</u> with your healthcare team Obtaining a Medical Transfer Summary

For more details review the **Well on Your Way** website at <u>www.ahs.ca/y2a</u> * Denotes time sensitive task 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 <u>family doctor</u> (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 <u>Confidentiality</u>, informed consent, and patient rights at each visit Community resources that support transition to adulthood <u>Keeping track</u> of health information 	 The differences between pediatric and adult care for your clinic Adult <u>Home Care</u> – <u>Self-Managed Care</u> (SMC) versus Vendor Services <u>Adult Funding</u>* i.e. Assured Income for the Severely Handicapped (AISH) and Persons with Developmental Disabilities (PDD) Updating any medical <u>equipment</u> Programming options through <u>PDD</u> (Agency vs Family Managed Support) <u>Guardianship and Trusteeship</u>* 	 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 – <u>Transition Tracker</u> Provide transition information package 	 Review transition plan and document progress at each visit – <u>Transition Tracker</u> 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 <i>Medical Transfer Summary</i> 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: <u>Transition Readiness Checklist(s)</u> <u>MyHealth Passport</u> or <u>Health Journal</u>	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