# Transition Checklist for Pediatric Health Care Providers

**Introduction**

The Society of Pediatric Nurses is committed to supporting the role of the pediatric nurse in the facilitation of transitioning adolescents and emerging adults (AEA) from pediatric to adult care, especially those with disabilities and/or special health care needs. The SPN Position Statement, released in December of 2016, provides a framework for pediatric nurses to provide comprehensive health care transition services based upon a family-centered, adolescent-focused and interdisciplinary framework of care. As defined in the SPN Position Statement, Health Care Transition (HCT) refers to the comprehensive services based upon an interdisciplinary framework of care that addresses the biopsychosocial needs of early adolescents (11-15 years of age), late adolescents (16-18 years of age), and emerging adults (18-25 years of age).

**Suggested Use**

The purpose of this document is to provide a useful tool for pediatric nurses to facilitate the transition of AEA into adult care settings. The checklist also will describe the transition of role responsibilities from the parents/caregivers to the adolescent. SPN encourages users to adapt the checklist to meet the needs of individual institutions and the AEA they serve. This document is not intended to be integrated with an electronic medical record (EMR), but instead should be adapted for use as a communication tool amongst the health care team.

**Practice Setting Expectations**

These guidelines can be applied in the following practice settings:

1. In the primary care setting or outpatient clinic, wherein ongoing care is provided, the nursing coordinator or care manager should provide planning and oversight.
2. In private practice settings, nurses should facilitate the development and implementation of the transition plan.
3. In the inpatient setting, nurses should be expected to be aware of current health care transition planning efforts, and assist with informing those who are coordinating care.

## Extended HCT Preparation

Many ongoing preparatory processes need to be continually addressed beginning in early adolescence [i.e. 12 years of age], continuing up to the transfer of care. These initial steps, described below, provide the basis for what will become an ongoing provision of care.

- ❏ Initiate the discussion pertaining to the process of health care transition planning, including what it involves and its rationale.
    - ❏ Identify significant benchmarks of the process.
    - ❏ Describe the role of the Health Care Transition Coordinator, nurses and interdisciplinary providers involved in the care.

- ❏ Explain focus on promotion of independence through achievement of self-management knowledge and skills.
- ❏ Explain importance of becoming a health-literate consumer.
- ❏ Define the changes in role responsibilities between parents/caregivers and the adolescent for managing care.

❏ Initiate discussion of the adolescent's interests, needs, and preferences for future planning that is integrated into the HCT plan.
❏ Involve parents/caregivers in discussions of shifting role responsibilities.
❏ Provide a timeline outlining the extended HCT preparation process.
- ❏ Identify milestones associated with middle school, high school and postsecondary settings and/or workforce participation.
  - ❏ Adjust as needed for particular needs of AEA groups and their conditions.
- ❏ Identify the legal regulations related to age of majority.

## Ongoing Processes

The following processes should be initiated in early adolescence and continuously monitored throughout the adolescent's care until the transfer of care is complete. The adolescent should be provided with educational resources based on their preferences, learning style, and comfort level with technology.

❏ Provide community coordination and referrals, as appropriate for the AEA.
- ❏ Encourage involvement in recreational activities and/or adaptive sports for physical and social skill building.
- ❏ Refer to therapy services (PT, OT, Nutrition) if not already addressed
- ❏ Encourage development of age-appropriate peer relationships (e.g. peer support groups, social networks).
- ❏ Refer to mental health services as needed.
- ❏ Facilitate access to appropriate supplies and durable medical equipment, with shifting responsibility from the caregiver to the AEA as appropriate.

❏ Encourage participation in Individualized Education Plan (IEP) and 504 plans, as appropriate.
❏ Review and update the AEA's future plans based on changes in interests, needs, and preferences, and integrate into the HCT plan.
- ❏ Review appropriateness of parents'/caregivers' involvement in discussions acknowledging shifting responsibilities as developmentally appropriate.
- ❏ Review the adolescent's developing interests, needs, and preferences in terms of revising their future goals.

❏ Monitor readiness of transition to adulthood and transfer from pediatric to adult services.
- ❏ Administer HCT Readiness Assessment to assess status of self-management competencies, at least yearly, and as needed per individual.
  - ❏ Select HCT readiness assessment.
  - ❏ Review time frame for administration.
  - ❏ Identify process of review and feedback.

        - ❏ Identify measureable outcomes and timeframe for goal setting.
    - ❏ Use assessment tools to provide a basis for individualizing the instruction needed.
- ❏ Provide ongoing assessment, instruction, review and evaluation of self-management knowledge and skills.
    - ❏ Encourage development of health-related personal care skills (e.g. hygiene, condition-specific health maintenance skills).
    - ❏ Promote ongoing development of health and media literacy.
    - ❏ Develop an emergency preparedness plan in collaboration with the AEA.
    - ❏ Encourage ongoing efforts to pursue advanced health-related and condition-specific knowledge and skills.
    - ❏ Provide developmentally-appropriate anticipatory guidance pertaining to sexual development, safe sex practices, and reproductive decisions.
    - ❏ Provide risk prevention education (e.g. use of illicit substances, personal safety measures).
- ❏ Provide guidance related to rights and protections as it pertains to health care services across developmental milestones.
    - ❏ Inform families, children, AEA of Pediatric Bill of Rights.

## Middle School Processes

Provision of services based upon continuous assessment of needs during this period include the following:

- ❏ Determine health-related and academic/outpatient/community accommodations.
- ❏ Inform families about available accommodations, including risk prevention, in schools and community settings.
- ❏ Discuss whether IEP and 504 plans address academic/special health care needs, or safety-related accommodations.
- ❏ Coordinate with other providers to facilitate the implementation of accommodations (OT, SLP, PT).
- ❏ Provide referrals to social worker or other providers if additional advocacy efforts are needed.

## Processes in High School and Beyond

Provision of services based upon continuous assessment of needs during this period include the following:

- ❏ Recommend health-related and academic/outpatient/community accommodations during high school years:
    - ❏ Encourage self-advocacy.
    - ❏ Encourage the AEA to actively provide input into accommodation recommendations, such as risk prevention, with social clubs, extracurricular

activities, job training, and provide information about secondary settings and/or workforce participation.
- ❏ Inform about accommodations as it relates to drivers' education.
- ❏ Reassess whether IEP and 504 plans address necessary special health care or safety-related accommodations; monitor academic accommodations' pace with the progression through school, as well as college preparatory activities such as ACT/SAT test taking.
    - ❏ Coordinate with other providers to facilitate implementation of accommodations.
    - ❏ Provide referrals to social worker or other providers if additional advocacy efforts are needed.
- ❏ Encourage AEA and/or parents/caregivers to identify opportunities for ongoing self-care skill building in the school setting.
- ❏ Anticipate and discuss legal ramifications associated with age of majority (conservatorship, power of attorney, emancipation), and initiate referral to the appropriate resource (e.g. social worker).
- ❏ Explore with parent and AEA need for advocacy services (IEP, SSI, conservatorship), as warranted, and refer as appropriate (e.g. social worker).
- ❏ Recommend AEA obtain photo identification and voter registration, according to state regulations.
- ❏ Anticipate the need for information, and refer to knowledgeable local resources as appropriate:
    - ❏ health insurance enrollment programs
    - ❏ supplemental security income (SSI)
    - ❏ Independent Living Centers for community living and other support services

- ❏ Discuss career/vocational planning resources as appropriate:
    - ❏ Explore opportunities for learning such as college, adult alternative or online school programs, including identification of academic/health-related accommodations (e.g. through Disabled Student Services) and financial support (e.g. FAFSA grants/scholarships) as appropriate.
    - ❏ Explore postsecondary options for job training, such as: Department of Rehabilitation/Vocational Education, FEMA, AmeriCorps, Apprenticeships, Workforce Investment Act (WIA) program, Job Corps.
- ❏ Encourage exploration of volunteer activities as precursor for job training and career development.
- ❏ Discuss future options for community living in adulthood:
    - ❏ Explore options for living in the community (independent, supportive) and strategies for risk prevention.
    - ❏ Consider options for community mobility and refer to appropriate programs as necessary (mobility training, driver's training, public transportation use, vehicle modifications).

- ❏ Refer as needed to instructional programs for life skills (e.g. money management, household maintenance, etc.).
- ❏ Review anticipated changes with community-based, adult oriented social networks and organizations (outside of customary pediatric and child health systems of care).

## Transfer of Care Period

According to the SPN Position Statement, the implementation of the AEA's transfer of care should occur during the later adolescent period [i.e. between ages 18 and 21 years], and should begin when the emerging adult exhibits signs of readiness. Approximately 1-2 years prior to transfer of care, determine the following:

- ❏ Review the number/type of adult providers needed.
- ❏ Evaluate appropriateness of health insurance plan for eligibility and any changing needs.
- ❏ Encourage parents to obtain conservatorship if necessary.
- ❏ Inquire if durable medical equipment is in good working condition.
- ❏ Obtain signature for release of medical records from AEA or parent/guardian (if there is a conservatorship) for transfer.
- ❏ Facilitate transfer of medical records, and if not done electronically, copies can be provided to AEA or parent/guardian and adult providers/organizations.
    - ❏ Compose medical summary and distribute to adolescent and parent/guardian and includes:
        - ❏ Medical history
        - ❏ Treatment plan
        - ❏ Recent laboratory and diagnostic findings
        - ❏ Medications
        - ❏ Recent hospitalizations
        - ❏ Recent ED visits
    - ❏ Compose transition summary to encompass the self-management competencies progress and resource referrals including:
        - ❏ Progress towards competencies achieved
        - ❏ Career/vocational resources
        - ❏ Volunteer opportunities
        - ❏ Community living resources
        - ❏ Conservatorship obtained if necessary
- ❏ Schedule an orientation visit if possible with the adult providers/organizations.

## Contributors

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