Moving on UP

Transitioning from Child to Adult Healthcare in Tasmania

This is a guide to supporting young people with chronic conditions to transition from paediatric to adult health care in Tasmania.

It is important to start self-management support early. This helps young people to develop the skills and confidence they need to look after themselves and their condition as they mature.

Moving on Up describes five elements needed to support young people to transition successfully.

5 Elements of a successful move to adult healthcare:

1. Person-centred care

A smooth transition is more likely to occur when the young person and their family or carers are included and have a voice in all care decisions.

- Treat young people with dignity, respect and recognise that their care goals may be different from your goals for them.
- Involve young people to be active partners in decisions about their care as much as they are able.
- Discuss the young person's ability to self-manage, especially where this may be limited, so both you and the client have realistic expectations. Include these expectations in the transition plan.
- Give priority support to young people with complex needs.
- Give condition-specific education and information on how the transition process will work for people with their condition.

2. Shared responsibility

Responsibility for care is progressively shifting from family/caregivers (in paediatric care) to the young person themselves (in adult care). It is important that everyone involved understands that full transfer of care will take multiple visits.

PAEDIATRIC CLINICIANS

- Acknowledge the young person's growing autonomy and readiness for transition and encourage families and carers to do the same—allow the young person to 'own' the transition process
- Work early with the child's GP to organise details of the transition collaboratively
- Promote positive self-management behaviour with the young person at every opportunity
- Communicate early and clearly with the adult care teams, the young person and their family
- Learn what options are available in the community to support the young person
- Identify appropriate adult medical specialists and departments for the young person and promote interaction between the young person and the new adult health care team in the lead-up to transition

ADULT CLINICIANS

- Accept the young person into adult care
- Recognise their needs will be different to others

GPS

- Act as the central point for coordinating care.
- Understand the full transition process.
- Be the primary point of contact for the young person's everyday health, growth and development issues.
- Ensure regular follow-up of the young person with the chronic condition.
- Accept the increased responsibility to support the young person to self-manage their chronic condition.

Medicare

- Medicare has Chronic Disease Management items for general practitioners to help them manage the healthcare of people with chronic or terminal conditions.

3. Coordinated care

The paediatric clinician together with the young person should identify a key health professional to provide support throughout the transition process. This may be the GP but could also be a nurse navigator, peer worker, or allied health professional.

- Share information clearly and openly with the young person and their family and ensure that the GP is kept up to date.
- Keep high-quality clinical documentation that is shared across services (timely, appropriate, routine and non–routine).
- Use agreed channels of communication between health professionals, services, and the young person and their family. This could be family meetings, a written health care transition plan, an accessible compilation of the patient's medical information for the young person and all adult health care providers.

Rural and regional care

- For people who live in rural and regional areas, the government can provide financial help for transportation to appointments.
- Telehealth consultations can be used to both a) give the young person access to healthcare consultations, and b) allow professionals from different disciplines to share their knowledge and skills with each other and local support services.

4. Readiness for transfer

Services with young people as clients should maintain a registry to identify those who are ready to start transitioning to adult care. A successful transition can only occur when the young person is ready to move to adult care. The timing for this is different for everyone.

- Regularly assess the young person's readiness to transfer from an early age, beginning in early adolescence. This includes considering their self-management skills, and medical and emotional factors.
- Factor in the young person's major life events, such as exams, starting a new job or beginning university.
- Plan ahead to confirm that the services needed will be available and have capacity to accept the young person into care at the time of transition.

5. Skilled Workforce

A skilled and supported workforce and clinical leadership is essential for an effective transition. Core capabilities of a skilled workforce are:

PATIENT-CENTRED SKILLS

- communication skills, in particular with young people
- assessment of health risk factors
- assessment of self-management capacity (understanding strengths and barriers)
- collaborative care planning
- cultural awareness
- psychosocial assessment and support skills
- working with families and carers

BEHAVIOUR CHANGE EXPERTISE

- motivational interviewing
- collaborative problem solving
- goal setting and goal achievement
- structured problem solving and action planning

GENERAL COMPETENCIES

- working in interdisciplinary teams/interprofessional learning and practice
- awareness of community resources
- allow technologies for communicating with young people (e.g. mobile phones, internet, email and social media).

This guide is a summary of the **Moving on UP** Framework developed by Primary Health Tasmania. The full framework and supporting resources are available at tasmania.healthpathways.org.au

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