

TRANSITION AND TRAPEZE

PRACTICE GUIDELINE[®]

DOCUMENT SUMMARY/KEY POINTS

- Transition between SCHN and adult health care providers can be a vulnerable time for young people and their families. All clinicians play a key role in supporting the transition of young people to adult services.
- This document summarises:
 - Transition to adult care principles
 - The Trapeze Service and key relationships

CHANGE SUMMARY

- New document which replaces the Transitional Care Policy and includes new information about Trapeze.

READ ACKNOWLEDGEMENT

- All clinical staff, Clinical Directors and Heads of Departments should read and acknowledge this document.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1 st August 2019	Review Period: 3 years
Team Leader:	Adolescent Complex Care Coordination and Transition Manager	Area/Dept: Trapeze

TABLE OF CONTENTS

Introduction	3
Adolescents and Transition	3
Aim	4
Transitioning a patient	4
1.1 Age of transition	4
1.2 Admissions Policy	4
1.3 Transition Models of Care	4
1.4 Roles during transition	5
Trapeze	5
Referring to Trapeze	6
<i>Powerchart referrals</i>	6
Intake and screening	6
Enrolment in Trapeze	7
<i>Enrolled – Active</i>	7
<i>Declined</i>	7
Trapeze Assessment and Management	7
<i>Assessment</i>	7
<i>HEEADSSS</i>	8
<i>ACI referral</i>	8
<i>Intervention/Follow up</i>	8
<i>Transfer of Care</i>	8
<i>Trapeze discharge process</i>	8
1.5 Resources for transition and self-management	10
References	10

Introduction

Adolescents and Transition

Young people are vulnerable when they move between different parts of the health care system. These transitions threaten patient safety as they can increase the possibility of losing critical clinical information, missing appointments, unplanned admissions and require an increased degree of coordination. In addition, changing healthcare providers can be a stressful experience for the young person and their family.

Transition is defined as the “purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health care systems”.¹ This comprises developmentally-responsive support of a young person’s emerging independence and self-management, preparation and planning around transfer to adult services, integration with primary health care and consideration of their psychosocial, family and cultural context.

Successful transition from paediatric to adult care is an important goal and aims to “maximise lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood.”² Education and optimisation of health care and processes during adolescence can yield a triple dividend with immediate benefits, long term benefits and benefits to the next generation.

The transition process focuses on consultation with and preparation of the young person, with the support of their family, general practitioner, specialty teams and other service providers. To ensure that successful transition occurs, each clinical team should develop a transition model for their service that supports young people and families. Structural supports could include providing adolescent specific clinics and wards, transition clinics, joint paediatric and adult clinics, utilisation of transition principles and checklists, and regular collaboration with adolescent and transition services such as Trapeze, or the Agency for Clinical Innovation Transition Care Network. Other supports include individualised transition plans, provision of education and information about transition to adult care and peer support programs.

The [NSW Youth Health Framework 2017-2024](#) lists a number of key goals to keep young people in NSW healthy, safe and well:

- Goal 1: the health system responds to the needs of young people, including targeted responses for vulnerable young people
- Goal 2: health services are accessible and young people are engaged and respected
- Goal 3: Young people are supported to optimise their health and wellbeing

Transition is identified as an important component of addressing all three strategic goals with its focus on engaging vulnerable, young people with chronic conditions and supporting their self-management and healthcare access. The Trapeze service works collaboratively with the SCHN Adolescent Medicine to address the Youth Health Framework and provide Adolescent and Young Adult (AYA) services across SCHN. They are supported by a comprehensive research program as part of the Academic Department of Adolescent Medicine (ADAM) and

peer support programs such as Chronic Illness Peer Support (ChIPS) and Youth Arts. These services are supported by developmentally appropriate ambulatory spaces with the Centres for Adolescent and Young Adult Health (CAYAH) Randwick on level 7 in Bright Alliance and the CAYAH Westmead precinct due to open in 2020.

Aim

This Practice Guideline provides the framework to plan the transition of young people with a chronic condition into the adult health care system. This includes the timing of transition, the roles of clinical teams and Trapeze and the steps required in transition planning. A range of tools and resources to assist clinical teams in preparing young people for transition is also provided.

Transitioning a patient

1.1 Age of transition

Preparation for transition should generally commence from age 12 years followed by active transition planning from age 16 years. From age 12, all teams have a role in supporting age appropriate individuation and self-management, for example encouraging medication management. Transition planning should be flexible in timing and appropriate to the young person's developmental capacity, starting with the recognition of the important and continuing role of their GP and then encouragement of the young person's increasing self-management, balanced with support from their family/carer. Consideration needs to be given to promotion of health literacy as well as assessment of the young person's changing psychosocial needs.

1.2 Admissions Policy

The admissions policy establishes clear guidelines for appropriate age of admission and outpatient clinic care. This is relevant when planning successful transitions involving young people to adult services. Please refer to the [Age for admission / treatment: principles regarding inpatient, outpatient, outreach clinic care and clinical research](#) Policy for detailed information around these principles.

1.3 Transition Models of Care

There are three general types of transition:

1. Simple/direct transition of care
2. Complex with multidisciplinary paediatric clinics and scattered adult services
3. Challenging with no adult equivalent services available.

Underpinning these types of transition are seven [key principles](#) developed by the Agency for Clinical Innovation (ACI) and Trapeze:

- i. A systematic and formal transition process
- ii. Early preparation
- iii. Identification of a transition coordinator/facilitator
- iv. Good communication
- v. Individual transition plan
- vi. Empower, encourage and enable young people to self-manage
- vii. Follow up and evaluation

The principles detail how transition will be undertaken for all young people transitioning their healthcare, including the role of individual team members in transition preparation, the age at which transition will begin and be completed, and the resources to be used to support the process. To facilitate effective transition, treating teams should develop a local transition model for their service, potentially including adolescent specific clinics for patients aged over 12 years and/or at entry to high school.

1.4 Roles during transition

- Treating Clinician/Team: encourage self-management where appropriate, provide timely referral to adult services and continue to provide health care until such time as transfer of care is complete. They may see the young person individually, and will provide an individualised transition plan taking into account other factors in the young person's life (e.g. the end of school, age of the young person, and procedures or changes to treatment that may need to be undertaken prior to leaving SCHN).
- General Practitioner (GP): is key in the ongoing coordination of care. This role becomes increasingly important once the young person has left the children's hospital as they provide care coordination and access to specialist and allied health services.
- Trapeze and the ACI Transition Care Network: appropriately assist with transition planning for complex and challenging transitions. They provide a comprehensive medical/psychosocial assessment to guide ongoing transition needs which may involve self-management support, linkage with community support services, support at first adult appointments, guidance around Centrelink and preparation for transition. The Trapeze clinicians work collaboratively with the SCHN clinical teams who remain responsible for the young person's care.

Trapeze

Trapeze is a multidisciplinary transition and care coordination service for the SCHN, supporting young people with chronic conditions as they transition from paediatric to adult health care services. The team assess, facilitate, monitor and coordinate a young person's care during transition and helps the young person live their healthiest lives.

Trapeze works in close collaboration with the ACI Transition Care Network. While Trapeze focus on facilitating transition from the SCHN, the ACI care coordinators help find appropriate

health services, provide support to attend clinics and ensure young people stay engaged in adult health services.

Trapeze aims to:

- Understand, support and advocate for the needs of the young person during transition to adult services
- Identify emerging adolescent healthcare needs and support the clinical teams and young person to manage these
- Empower the young person to better manage their chronic health condition as they transition to adult services
- Strengthen the young person's links with their GP and community
- Collaborate with paediatric and adult healthcare teams to provide smooth transition from SCHN
- Support and assist the young person to navigate the health system to improve their engagement with health services
- Keep the transitioning young person well so they can live their healthiest life

Referring to Trapeze

Where additional support is required to facilitate transition and care coordination leading to transition, a SCHN staff member, other healthcare provider, teacher, parent or carer may refer the young person to Trapeze.

Eligibility criteria:

- Aged between 14-25 years, and
- With a chronic condition, and
- Known to the Sydney Children's Hospital Network (Westmead or Randwick Campus)

Powerchart referrals

Referrals can be completed on SCHN Powerchart. To refer:

Enter patient file – Ad Hoc – Trapeze Service – Trapeze Referral – Chart.

Intake and screening

All referrals are viewed to determine priority and the transition support needs. A set of 10 questions have been designed to help identify needs and the appropriate support pathway. Considerations for triaging referrals include: age, Aboriginal or Torres Strait Islander identification, non-English speaking background, refugee or asylum seeker, out of home care, proximity to hospital (e.g. rural location), upcoming appointments at the hospital and complexity of the young person's condition and situation.

For the young person who requires transition support, they may be assessed by a Trapeze clinician at either campus of SCHN:

- At a Trapeze multidisciplinary clinic
- At an additional appointment before or after one of their already scheduled appointments (e.g. hospital or school clinic)
- At an outpatient appointment with their usual treating teams
- In hospital, while admitted
- By telephone

Enrolment in Trapeze

After the intake process is undertaken, the young person is either enrolled as an active patient or declined.

Enrolled – Active

These are young persons who have been identified to have multiple transition needs. They have given verbal consent to be part of the service and for Trapeze to communicate with other health professionals involved in their care. They are enrolled in the service and allocated a clinician who will make further contact to complete a more comprehensive initial assessment.

Declined

These young persons have indicated they do not want/need any Trapeze assistance or have needs that cannot be supported by Trapeze. They are not enrolled in the service, however are still welcome to contact the service at any time until they are 25 years old.

Trapeze Assessment and Management

Assessment

A comprehensive biopsychosocial initial assessment is undertaken to determine the needs of the young person.

The following areas are discussed:

- Chronic conditions and clinicians/clinics involved
- GP and community involvement
- Capacity and stage of individuation and self-management
- Individual transition plan and transfer of care planning e.g. completion of procedures or treatments while still at SCHN, simple or complex transfer, availability of adult care locally
- Psychosocial /cultural context e.g. financial entitlements, future plans, family and peer support
- Young person's ability for advocacy or problem-solving

From the initial assessment the clinician and the young person and family determine goals and tasks to be allocated and completed.

HEEADSSS

Where appropriate the young person will be asked to complete the HEEADSSS (Home environment, Education/employment, Eating, peer related Activities, Drugs, Sexuality, Suicide/depression, and Safety) psychosocial survey, currently available on the TickiT™ platform, on an electronic tablet or mobile phone. Results of the survey must be reviewed by the Trapeze clinician with the young person during the appointment to help with transition planning.

ACI referral

When the young person has ongoing needs they are referred to the ACI Transition Care Network by a Trapeze staff member. The Trapeze clinician will work in conjunction with the ACI Transition Care Co-ordinator to ensure a smooth transition from paediatric to adult services and remain in contact with treating teams to ensure clear delineation of roles and responsibilities. Trapeze focus on facilitating transition at SCHN, including the preparation for leaving children's services and ACI Care Coordinators help find appropriate adult health services, provide support to attend clinics and ensure young people stay engaged in adult health services.

Intervention/Follow up

Intervention occurs in the areas of self-management, GP engagement, specialty care engagement, care planning, assisting teams to identify referral pathways and appropriate adult services and addressing psychosocial needs. Trapeze does not assist with NDIS coordination or primary case management. Follow up continues until the young person is transitioned and engaged in adult services. The duration of follow up is individualised.

Transfer of Care

The clinician will be in contact with the health care professionals involved in the care of the young person to determine their transfer of care plans. They will ensure referrals are completed and received and first appointments are made.

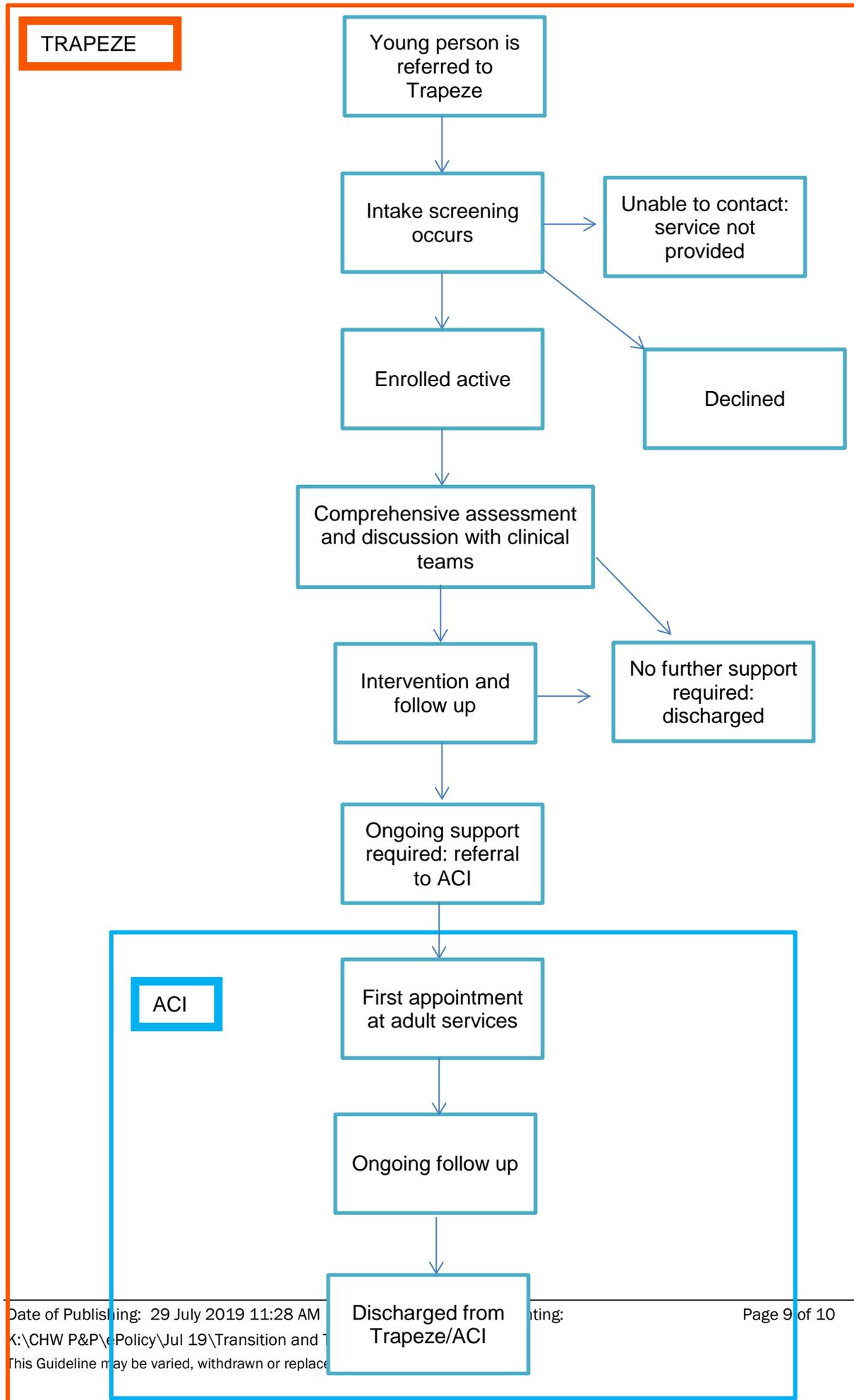
Trapeze discharge process

Trapeze will consider discharge when the young person is actively engaged in adult health care services. All young people are welcome to contact Trapeze following discharge if they require additional support until 25 years.

Possible indicators of engagement in adult health care include:

- 1 year after leaving SCHN services
- Regularly attending adult health care
- When the young person is older than 20 years of age
- When the young person or parent/carer is confident in their adult health care and able/empowered to coordinate for themselves
- There has been no active support from Trapeze in 1 year

At the point of considering discharge, a Trapeze clinician will conduct a discharge screening questionnaire to ensure the young adult is engaged in appropriate health care services and achieved adult transition to their capacity.



1.5 Resources for transition and self-management

Providing the young person with some [prompts](#) may help them identify what needs they have to help them transition. In addition, the [transition readiness checklist](#) may help the young person prepare for transition. The [individual transition care plan](#) can help the young person and their carer document key contacts and goals of transition. More factsheets and resources can be found on the [Trapeze factsheet webpage](#) or on the [Trapeze website](#).

References

1. Blum, R. W., Garell, D., Hodgman, C. H., Jorissen, T. W., Okinow, N. A., Orr, D. P., & Slap, G. B. (1993). Transition from child-centered to adult health-care systems for adolescents with chronic conditions: a position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health, 14*(7), 570-576.
2. American Academy of paediatrics, American Academy of Family Physicians & American College of Physicians – American Society of Internal Medicine (2002). 'A Consensus Statement of Health Care Transitions for Young People with Special Health Care Needs', *Paediatrics, 110*(6) pp1304-1306, http://pediatrics.aappublications.org/content/110/Supplement_3/1304.short

Copyright notice and disclaimer:

The use of this document outside Sydney Children's Hospitals Network (SCHN), or its reproduction in whole or in part, is subject to acknowledgement that it is the property of SCHN. SCHN has done everything practicable to make this document accurate, up-to-date and in accordance with accepted legislation and standards at the date of publication. SCHN is not responsible for consequences arising from the use of this document outside SCHN. A current version of this document is only available electronically from the Hospitals. If this document is printed, it is only valid to the date of printing.