# Sample Transition Policy

## A clinic transition policy is key to integrating youth transition services into your practice.

A basic clinic policy statement formalizes and adds consistency to clinic processes and workflow for youth transition services. The policy should articulate how the practice defines youth transition and transition age, the changes that occur at the age of majority, and the required age of transfer to adult care. When disseminated it can serve to engage adolescents and families with the transition process. Please feel free to modify and use this sample policy below for your practice. It's been adapted from evidence-based tools at gottransition.org:

"[**Pediatric Practice Name**] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with adolescents, beginning at ages **12 to 14**, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the adolescent **without the parent present** in order to **assist them in setting health priorities** and **supporting them in becoming more independent** with their own health care.

***At age 18, adolescents legally become adults**. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult's consent will we be able to discuss any personal health information with family members. **If the adolescent has a condition that prevents him/her from making health care decisions**, we encourage parents/caregivers to **consider options for supported decision-making**.

We will collaborate with adolescents and families regarding the age for transferring to an adult provider and recommend that this transfer occur **before age 22**. We will assist with this transfer process, **including helping to identify an adult provider, sending medical records, and communicating with the adult provider** about the unique needs of our patients. For adolescents with disabilities or chronic diseases, we will also link families to programs that can assist with planning for other transition issues, such as **adult insurance, education, jobs, independent living, legal issues/decision making,** and so on."

*Laws are always changing. For the latest information about minors and consent for treatment visit https://www.laaap.org/

# Additional Resources

- **GotTransition.org:** A program of the National Alliance to Advance Adolescent Health that provides youth health transition resources for providers, families, and policymakers.
- **SmoothMovesYHT.org:** A website intended for adolescents with activities and tools to help them build the skills they need to be independent.
- American Academy of Pediatrics Clinical Report. **Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home.** White PH, Cooley WC; Transitions Clinical Report Authoring Group; AAP; AAFP; ACP. Pediatrics. 2018;142(5) – Feb 1, 2019.

### Who We Are

The Louisiana Department of Health, Office of Public Health, Bureau of Family Health's Children's Special Health Services program works to ensure that children and youth with special health care needs in Louisiana have access to health care services. These services are designed to minimize their disabilities and maximize their ability to enjoy independent and self-sufficient lives.
Visit us at **partnersforfamilyhealth.org/cshs**

LOUISIANA DEPARTMENT OF HEALTH

PARTNERS FOR FAMILY HEALTH LOUISIANA