PLANNING FOR PEDIATRIC PRACTICES

BY THE ENDOCRINE SOCIETY

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RECOMMENDED APPROACH TO PLANNING FOR PEDIATRIC PRACTICES

1. Have a consistent, practice-wide policy or a planned approach for transitioning patients.
   - Develop a written plan or approach to health care transition. Some examples of transition policies can be found on the "Got Transition" website.
   - Share the transition policy with patients and families ("health care transition is a positive part of preparation for a successful and healthy adult life;" "we care about you and want to be sure you are prepared as you mature and go into your adult life.").
2. Have a youth registry to identify who is ready to start the transition process as well as to track progress and outcomes.
3. Transition Preparation/Readiness Assessment
   - Identify a skill set for independent self-care (suggested language for patients: "we want to be sure you are prepared to transition/we want to help prepare you for transition").
4. Transition Planning
   - Introduce health care transition planning for transgender youth—including planning both for increasing self-management and for ultimate transfer to adult care. This should be initiated at or around age 16 years, or when hormone regimens have reached the expected adult doses. Patients and families should participate in ongoing self-management education throughout the teenage years.
   - Discuss expectations of gender affirming hormone therapy and timing of gender affirming surgeries (if desired).
   - Individualize transition skills education according to the needs of the patient.
   - Develop a clear transition action plan with shared goals.
   - Help parents with transition roles and assignments within the action plan.
   - Work with the patient to develop and review portable medical summary and emergency care plan.
5. Transition and Transfer of Care
   - Plan for the transfer to adult care, according to the practice policy. Ultimately, the transition process culminates in the transfer from a pediatric health care model to an adult health care model.
   - Work with the patient and family to clearly identify appropriate adult providers who are competent in providing trans-affirmative care.
   - Exchange information with the receiving adult care provider.
   - Send transition package of necessary medical records.
6. Transition Completion
   - Continue to provide medical advice and support to the young adult patient until the transition is complete.
   - Put measures in place in the pediatric practice to "close the loop" and ensure that transitioning patient is established in adult care.

Adapted from GOT TRANSITION® Six Core Elements of Health Care Transition—www.gottransition.org.

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