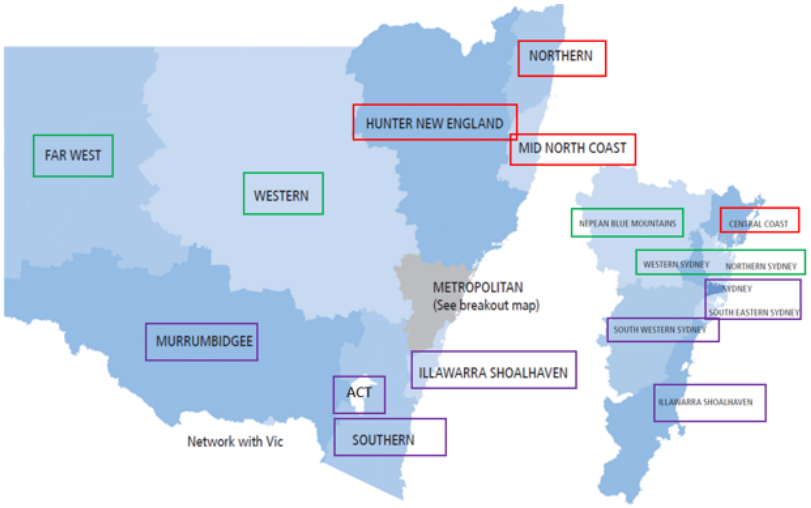
NSW Health

ACI Transition Care Service

The NSW Agency for Clinical Innovation (ACI) Transition Care Service is a state-wide care coordination service. It is responsible for supporting young people (aged between 14-25 years) with chronic illness/disability as they move from children's health services to adult health services. The Service has a Manager, three Transition Care Coordinators and three (part-time) Transition Support Workers.

Aims of the service

- Improve the continuity of care as young people move from paediatric to adult health services.
- Provide a patient-centred approach to transition.
- Provide support and resources to help young people, their families and carers and health workers plan and prepare for transition.



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ACI Transition Care Coordinators can help by:

- Finding appropriate adult health services.
- Supporting young people when they first move to adult health services including attending first appointments if needed.
- Following through and providing feedback once young people have moved to adult health services.

Our referral criteria is:

- The young person resides in NSW or ACT, is aged between 14 and 25 years, with a chronic illness/disability (excluding a primary diagnosis of mental illness or eating disorders), that requires complex case coordination to transition to adult specialist health services.

1 Early preparation for transition

Health care clinicians and teams should start talking to young people about transition from around age of 14 years. Transition readiness checklists and transition factsheets are available to assist - please visit our webpage and make referrals to ACI Transition Care or Trapeze for SCHN patients.

2 Appropriate pathways developed into new adult health services

Paediatric clinicians should start thinking about appropriate clinicians to refer to in adult health services. Referrals are often required a year or so in advance depending on the waiting times for new clinicians/services/clinics. Consider transition requirements for medications. Ensure a clinical summary and handover is prepared.

3 Appointments made and attended

ACI Transition Care Coordinators can support this process to ensure referrals are received and appointments made. The ACI Transition Care Coordinators may attend first appointments as needed and assist with follow ups as appropriate.



4 Successful transition to new health care team

ACI Transition Care Service will check in with young people to see how appointments and follow ups are progressing. We are able to support young people until the age of 25 years if required. We usually discharge young people from our service once they are engaged and comfortable with their new clinicians.

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https://www.aci.health.nsw.gov.au/networks/transition-care/about/transition-care-service

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