2025-2026

Transition of Care Committee

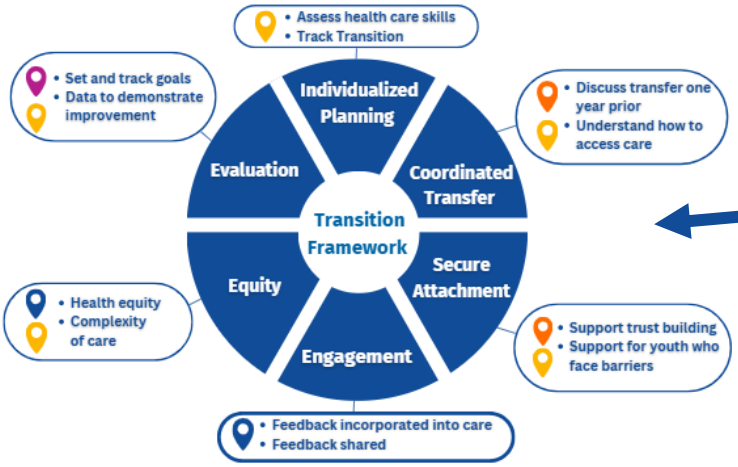
Year in Review

Know a youth or parent who could join our team?

This review outlines the work we do. Feel free to share!

IWK Transition
(902) 266-4054 | IWKTransition@iwk.nshealth.ca
Transition to Adult Health Care | IWK Health

You're in Charge
YoureInCharge@iwk.nshealth.ca | You're in Charge | IWK Health



The **Transition of Care Committee** (TOCC) is **a passionate, collaborative team** of patients, caregivers, health care providers & community partners from across the Maritimes.

Together with our partners, we created the **Transition to Adult Health Care Framework.**

The Transition Framework serves as a guide for a **structured, coordinated, individualized and consistent approach** to the transition to adult care that is **evidence-informed and grounded in patient, family & provider experience**.

Our goal is to **integrate the Transition Framework into practice across IWK Health's Children's Health Program** and with our health care partners across the Maritimes to improve health outcomes for youth during the transition from pediatric to adult health care.

We connect locally and nationally to advocate for improved transitions of care.

Looking to improve your transition to adult care practice?

The **Transition Community of Practice** provides education on the Transition Framework, opportunities for collaboration with colleagues across the Maritimes, and a focus on implementation of your transition practice goals.

Contact IWKTransition@iwk.nshealth.ca to be added to our distribution list of over 100 Transition Champions Maritime-wide!

What does TOCC do as a '*Transition Innovation*'?

Here is what TOCC members shared as part of a CIHR funded research project: *Implementation and sustainability of transition in care (TiC) innovations for youth (I-STiCK).*

Transition of Care Committee Highlights
2025-2026

Our goal is to create a space where people feel valued and where a diversity of experiences from across the Maritimes helps us to make transition better for everyone.

Transition of Care Committee members hail from across the Maritimes!

This year, TOCC members shared their expertise in many places:

- ✓ You're in Charge
- ✓ Let's Talk: Teens Building Health Care Skills
- ✓ Maritime Child Health Summit
- ✓ Complex Transfer Working Group
- ✓ Transition Office Hours
- ✓ Brigadoon March Break Camp
- ✓ Affirming Care Conference
- ✓ OPOR Consultations
- ✓ Youth Learning Series
- ✓ National Transition Quality Indicators Study
- ✓ CIHR Transition Resource Hub Grant
- ✓ CHC 'Shared Accountability' Roundtable

100% of TOCC members Agreed or Strongly Agreed

- I feel valued as a member of the team
- I think our work makes a difference to patients
- Participating on TOCC is a good use of my time

'Each meeting has clear micro-goals related to the overall purpose and mission of the committee, making it easier to track incremental progress'

'Diversity of viewpoints, focused meetings that actually accomplish goals'

OCTOBER
TOCC Purpose & Plan
- Outlined how TOCC connects to IWK Health Strategic Plan
- Prioritized initiatives to implement the Transition to Adult Care Framework for the coming year(s)
- Community of Practice with Jordan's Principle

NOVEMBER
Maritime Child Health Summit
- MCH looks to support evidence based care for children in the Maritimes
- TOCC partners presented on how TOCC has helped to standardize transition care in NB and shared their expertise on family experience & patient engagement

DECEMBER
Multiple Provider Transfer List
- Gathered feedback on a form patients can use to keep track of their new health care providers
- Your HealthNS added the IWK transition webpage to their app

JANUARY
Rebranding You're in Charge
- Suggestions shared with IWK Communications to update YIC logo and tag line
- New content added to YIC from TOCC recommendations

MARCH
Complex Transition Guide
- Reviewed draft of the Transition Resource for patients and families with complex medical needs
- Presented at Youth Learning Series on Food Security
- Community of Practice on Transition & OPOR

APRIL
I-STiCK Research
- Over the next few years we will be part of a study looking at implementing and sustaining transition innovations
- Focused on how TOCC is a transition innovation
- Let's Talk: Teens Building Health Care Skills webinar

MAY
Youth Learning Series
- TOCC members presented at Youth Learning Series on Complex Transitions of Care alongside Primary Care, Jordan's Principle, PEI Children with Complex Needs Program and Inclusion Nova Scotia
- You're in Charge

JUNE
TRIC Surgery & MSSU Health Care Use Research Projects
- Supporting a new Translating Research into Care (TRIC) grant for surgical care
- Brainstorming key messages and recommendations from the MSSU post-transfer health care use findings

We're Recruiting!

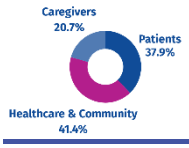
Interested in joining the Transition of Care Committee? Do you know a patient or caregiver who could add a new perspective to our team? Check out the IWK website.

Thank you!

Our work is supported by **incredible youth, caregivers, healthcare providers & partners** who volunteer their time & expertise to TOCC and by **countless health care providers & partners** who work hard to improve health outcomes for youth as they transition to adult care.

Looking for more information on the transition to adult health care?
Please reach out to IWKTransition@iwk.nshealth.ca or check out the IWK website

System Leadership, Partnership and Adovcacy



*With over **60% patients & caregivers**, TOCC is grounded in lived experience from across the Maritimes and **poised to partner across health and community-based systems** to be a strong voice for improved outcomes for youth during the transition to adult care*

Highlights

Transition of Care Committee (TOCC) Membership

- **4 new TOCC members** recruited
- The Patient-Public Engagement Evaluation Tool (PPEET) results demonstrate the positive work being done by the committee. These results also shape any changes needed to the committee structure.
- Committee members receive regular progress updates on our goals & how their feedback influences change.

You're in Charge

- Partnerships with Brigadoon and the Muscular Dystrophy Association supported **33 youth & 9 families to engage in You're in Charge Programming**, learning how to set & achieve health goals.

'Weaving Wellness', Complex Care Transitions & OPOR @ CoP

- Collaborated with Jordan's Principle Unama'ki, Inclusion NS, PEI Children with Complex Needs Program, TOCC members and OPOR/Tantalus on **5 Transition Community of Practice sessions.**

Nourishing Youth @ Youth Learning Series

- Partnered with a Youth from Pictou County's Karma Closet, Nourish, Feed NS & the IWK Diabetes Care Team to increase awareness & interventions to support food security for youth.

Working with youth? Join our mailing list @IWKTransition@iwk.nshealth.ca for webinars on youth health.

Maritime Child Health Summit

- TOCC members shared their expertise on the patient & family engagement panel & as part of a Fireside Chat on 'care closer to home' outlining the impact of TOCC and the Transition Framework on diabetes care in a NB clinic and our work was highlighted as examples throughout the summit.

Children's Healthcare Canada "Shared Accountability for Transition"

- Our NSH Episodic & Acute Care Network colleague and Transition Coordinator attended a planning session with CHC to look at how pediatric, adult (& primary care) have a joint responsibility for secure attachment to adult care.
- TOCC members continue to be active members of the CHC Transition Hub sharing & learning from transition champions across the country.

Impact

PPEET Results Include:

- The awareness of the Transition Framework is starting to spread. More people are getting involved in implementing the framework in their own ways.
- Extremely helpful to help my work as a Transition champion on my team to advocate this with the Ped & Adult team and specialists.
- Broad representation, Excellent leadership. Everyone has a voice.

Workshop Participant Responses:

- This was an excellent session 10/10! The panel of speakers was well chosen from patient /now IWK staff to family experience.
- Emphasizes the importance of successful transition of complex care pts...Will look beyond the last day at IWK & extend planning.
- I will start screening for food insecurity.

Our Youth Learning Series & Transition Community of Practice distribution lists total over 370 health & community partners.

National CHC Transition Hub

- CHC to work with partners (e.g. HealthCareCAN, Healthcare Excellence & Accreditation Canada) to strengthen transitions through policy recommendations & share emerging adult programs

Next Steps

- TOCC members are interested in engaging leaders with the capacity to make change within the broader system and increasing the use of our transition resources by clinicians and families.
- Re-energize the Youth Learning Series Planning Team with broader representation from the IWK.
- Promote You're in Charge through IWK Pediatric Grand Rounds (October 28, 2026), introducing peer facilitators to the IWK Primary Health Team & sharing resources with families in the Goldbloom Pavillion.

Research, Innovation & Applied Science

*TOCC is committed to an **implementation science approach** to model a **Learning Health System**. For us, this means building our research evidence in **partnership with patients & families** to improve care & then **using our findings to implement changes in our work**, evaluating the difference it makes & spreading what we learn.*

Highlights

Translating Research into Care: *Implementing and evaluating a framework to support the transition from pediatric to adult care*

- We continue to work with GI, Cardiology & Hematology to implement their Transition Framework Goals. Though OPOR was a significant focus, teams tried to make transition a priority when possible.
- Gathering feedback surveys from patients & caregivers is a challenge; however, we are hearing this from other projects too.

Are you a patient with IBD, a congenital heart condition, sickle cell anemia or a caregiver? *We would love to connect!*

Maritime SPOR Support Unit: *Sticking the Landing: Transfer Age & Predictors of Secure Attachment to Primary and Specialist Care for youth with chronic conditions*

- This research looks at health care use for 3 years pre & post transfer for 4 conditions. Among the findings so far (to be finalized):
  - **Only 62% 'securely attached' to adult care within 3 years.**
  - The older you are at transfer, the more likely you are to be securely attached to a specialist or family physician.
  - Those living in areas with more recent immigrants or visible minorities are less likely to land with a specialist.
- One team noted how their NSH partners help with patient follow-up as well as the need to improve their connections to primary care.
- Research team members presented at CAHSPR (Canadian Health Policy) & ISPAD (International Diabetes) Conferences.

Canadian Institutes of Health Research: *Quality Indicator Domains for Transition to Adult Care: A Canadian Online Modified Delphi Study*

- Identified **11 transition quality indicator domains** to help measure transition across the country. Publication in *Pediatrics* coming soon!

Canadian Institutes of Health Research: *Implementation & sustainability of transition in care (TiC) innovations for youth (I-STiCK).*

- In this new study, TOCC is being researched alongside transition programs in Ontario & Alberta to better understand how to implement & sustain transition innovations.

Translating Research into Care: Transition in the Department of Pediatric Surgery: a needs assessment and pathway development

- TOCC provided insights on patient friendly language & engagement.

Impact

- Care teams built stronger connections between pediatric & adult care providers, created patient resources & **improved communication & coordination**-- key enablers of transition.
- **Team members report increased confidence transferring patients** & a better understanding of adult care, enhancing anticipatory guidance & transition support.
- We now have local transition health care utilization data. TOCC recommends improving system navigation supports, routine data tracking & billing for parallel care.
- Patient partners have said they feel 'seen' in the data, that it reflected their experience:

*When I think about the "**landing**" & "**secure attachment**" language, it brings me back to **how disorienting it can feel** when you age out.*

*It connects to the idea of "**secure attachment**" … like there's **some kind of ongoing thread of care** that follows you even as things change.*

Publication Alert: *MacIntyre G et al., Knowledge Translation Interventions for Youth Health Care Transitions: Protocol for a Realist Review. JMIR Res Protoc 2026;15:e99731.* doi: 10.2196/99731

Next Steps

- Complete the implementation phase of TRIC research on the Transition Framework, analyze the findings. Use those findings to inform implementation of the Transition Framework across IWK Children's Health & beyond.
- Present the Health Care Utilization data to all 4 care teams & at Pediatric Grand Rounds in Fall 2026 to inform key messages & recommendations from the data for families, healthcare providers & leaders.
- Identify barriers and facilitators to implementing the prioritized quality indicator domains.

Responsible Stewardship

*As **youth with complex medical needs** are at the **greatest risk** in transition and **require the most resources**, we have prioritized this patient population outlining three goals to **'Build the Bridge' to Adult Care** for youth with complex care needs*

Highlights

Goal One: Access to Primary Care

- A **partnership with the Need a Family Practice Registry** has provided a path to primary care for unattached pediatric patients from Complex Care Clinic and Complex Respiratory Clinic.
- Health Homes have received information on potential requirements for patients with complex care needs (e.g. accessibility needs, care guidelines, equipment sizing, triggering environments).

Goal Two: Transition Navigation Supports for Youth with Complex Medical Needs

- A **resource guide for families** and one for health care providers has been drafted and feedback has been provided by various partners.
- A companion document for health care providers has been shared to provide a checklist for transfer planning and a companion form for families to keep track of the contact information of their new providers has also been drafted.
- An SBAR was drafted (not submitted) to propose Transition Navigation Support in partnership with NSH; however, currently there is no funding option to pursue this goal.
- NSH has started to map the supports available across the province which may help navigate to appropriate care in the future.

Goal Three: Model of Care for Youth with Complex Medical Needs

- We have outlined the needs of this patient population and shared this documentation with Nova Scotia Health Acute Care Network.
- An Intensivist with an outpatient practice in General Internal Medicine has shared her desire to **support adult patients with Intellectual and Developmental Disabilities** in her practice and has connected with IWK's Complex Care Clinic for possible partnership.

You can build great things, but you need to meet regularly as pediatric and adult care providers ~ Dr Hergenroeder

Impact

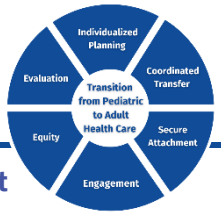
- **4 unattached patients** with complex medical needs were **triaged to** an experienced **primary care** provider or a health home.
- 3 patients have completed **Complex Care plans** in collaboration with the Halifax Infirmary ED to **support emergency care post transfer.**
- More routine meetings with care teams are helping to ensure a more coordinated transfer and transition for patients with very complex needs.
- Caregivers & health care providers giving feedback on the transition resource guides have expressed their appreciation for the guide & are eager to have a user-friendly version to share.
- A pediatric sized equipment kit has been added to the Halifax Infirmary Emergency Department to ensure the right sized equipment is available for youth with complex medical needs resulting in better patent experience in the ED.
- Youth Learning Series/Community of Practice on Complex Transitions had **75 people registered from across health and social programs in the Maritimes.**

Next Steps

- Connect unattached Complex Care Clinic patients with the Need a Family Practice Registry.
- Provide information to Health Home & Service Leads caring for patients with complex needs to strengthen care.
- Consider opportunities to expand pediatric equipment 'kits' to other adult care areas in the province.
- Finalize Complex Transition Guides ensuring patients, caregivers & health care providers are aware of the resources available.
- Support coordination of transfer timing within the Children's Health Program.
- Support tracking of Complex Care patients in adult care to better plan for their health care needs in the future.

Achieving as a High Reliability Organization

*This year TOCC shifted our purpose to specifically work towards **integrating the Transition to Adult Care Framework into practice** in the Children's Health Program (CHP) to provide **safe, high-quality transition care** consistently across CHP & throughout the Maritimes.*



Highlights

Individualized Planning

- Successful Fall & Spring sessions of '**You're in Charge**' & the **"Let's Talk: Teens Building their Healthcare Skills'** webinar.
- TOCC provided suggestions for new You're in Charge branding & content to increase engagement & enhance skill building for youth.
- Adjustments made to **OPOR** to enhance access to transition related documentation including the Readiness Checklist and the ability to add "Transition to Adult Care" to the 'problem list' to **better coordinate and track transition in the future.**

Coordinated Transfer

- Transfer Letter Auto-text available on OPOR.

Secure Attachment

- TRIC grant has helped pediatric and adult teams to connect and build a more trusting relationship, improved transfer communication and the NSH Bleeding Disorder clinic nurse has joined too!

Engagement

- Presented the TOCC engagement model at an **IWK Town Hall**.
- Participated in IWK Patient & Family Experience Office's engagement strategy development.
- **Transition "Office Hours"** in October and April.

Equity

- Readiness Checklist and Three Sentence Health Summary available in 5 languages on the IWK website.
- TOCC members presented at the Affirming Care Conference.
- Stronger ties to Inclusion NS and Jordan's Principle Unama'ki, including opportunities to connect with the Tripartite Forum's Jordan's Principle Sub-Committee.
- Recommendations on improving access to NS Pharmacare for young adults shared with Department of Health & Wellness.

Evaluation

- TOCC has identified key initiatives to support the implementation of the six components of the Transition Framework and created a **system to track progress** on these initiatives.

Impact

Spread the Word!

Families can register for YIC on the IWK website.

Let's Talk Webinar: October 2nd

You're in Charge: Nov 9th & 23rd

- IWK staff & physicians have clear guidance on how OPOR can enhance & document transition practice within the IWK OPOR Clinical Learning Site.
- OPOR will allow for greater sharing of transition information and, *when optimized*, may provide greater opportunities to prompt transition practice, collaboration & reporting.
- Care teams adding 'sticky notes' to the ambulatory care organizer in OPOR to prompt use of the Readiness Checklist

Partnerships & consultations with over 40 clinicians, care teams & community organizations with a focus on both individual & system level interventions to support transition.

- **YourHealthNS app** now links to IWK transition website.
- 10 Transition Reward Jars shared with care teams to prompt & motivate transition practice reflecting the **COM-B model of behaviour change**.

Next Steps

- Official endorsement of the Transition Framework by the IWK & corresponding implementation plan.
- Improved tracking of transition consultation requests & care teams implementing the Transition Framework.
- Optimization of OPOR to standardize transition documentation & find opportunities to better track & measure transition practice & secure attachment to adult care.
- Collaboration with NSH to flag 'new referrals' to adult care as 'transitioning patients' to improve triage information & increase continuity of care.