



NAPNAP Position Statement on Supporting the Transition from Pediatric to Adult-Focused Health Care

National Association of Pediatric Nurse Practitioners, Adolescent Health
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Transition from a pediatric to an adult model of care is a key milestone for all adolescents and young adults (AYAs) across health care, educational, and community systems. The National Association of Pediatric Nurse Practitioners (NAPNAP) supports pediatric-focused advanced practice registered nurses (APRNs) to advance evidence-based care and nationally recommended best practices for the effective transition to adult care of all AYAs, with and without special

health care needs (SHCNs). Successful, sustainable, equitable, and patient-centered health care transition (HCT) requires pediatric-focused APRNs to play a critical leadership role in primary and specialty clinical practice, system wide quality improvement (QI) efforts, research, advocating for funding support, and collaboration with interprofessional partners and parents/caregivers.

BACKGROUND AND SIGNIFICANCE

Health care transition is the process of moving from a pediatric to an adult model of health care, with or without transfer to a new clinician, with initiation of HCT planning at 12–14 years and transfer and integration spanning 18–25 years (White & Cooley, 2018/2023). The HCT process includes guiding parents/caregivers from a more primary role to a coaching and supporting role, thus allowing AYAs to reach greater autonomy and self-management (Ellison et al., 2022). The pediatric-focused APRN is central to the collaboration between the patient/family and our interprofessional partners which include, but are not limited to, adult clinicians, social workers, nurses, educational, vocational, and community agencies. (Song et al., 2025; Vittorio et al., 2023; Wyngaert et al., 2023). The success of HCT requires engagement and active participation of the interdisciplinary health care team, the family, and the AYA, all collaborating in mutually respectful relationships.

The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians Transitions Clinical Report emphasized HCT as a

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TABLE. Six Core Elements of Health Care Transition

Element	Description
1. Policy/guide	Develop, discuss, and share transition and care policy/guide
2. Tracking/monitoring	Track progress (EHR, flow sheet, registry)
3. Readiness	Assess self-care skills and offer education on identified needs
4. Planning	Develop HCT plan with medical summary
5. Transfer of care	Transfer to adult-centered care and to an adult practice
6. Transition completion	Confirm transfer completion and elicit consumer feedback

Note. EHR, electronic health record. HCT, health care transition. Source: [White et al. \(2020\)](#).

standard of care for all AYAs with and without SHCNs that incorporates three phases: (1) planning, (2) transfer, and (3) integration into adult care ([White & Cooley, 2018/2023](#)). The clinical report affirms the Six Core Elements of Health Care Transition (see [Table](#)), a structured process that can be applied to different transition models and used across clinical settings ([White et al., 2020](#)). Customizable, comprehensive resources for AYAs, families, clinicians, and organizations are available through Got Transition ([Got-Transition.org, 2025](#)).

A structured HCT process has demonstrated improved outcomes in patient experience, population health, and utilization/cost of care ([Gabriel et al., 2017](#); [Schmidt et al., 2020](#)) as well as clinician experience ([Lie et al., 2025](#)). The 2023-2024 National Survey of Children's Health found that only 21.7 % of youth with SHCNs and 19.1 % of all youth received clinician support for HCT planning to adult care ([Data Resource Center for Child and Adolescent Health, 2023-4](#)). Improving processes in clinical practice should consider developmental changes from early adolescence through emerging young adulthood to better align transition preparation and readiness to the evolving motivation and goals of AYAs ([Betz et al., 2023](#); [Cleverley et al., 2020](#); [Lestishock et al., 2025](#)).

In contrast to reported improvements with a structured HCT process, research has demonstrated negative consequences without implementation of coordinated HCT processes. These include worsening of chronic conditions ([Donvito et al., 2025](#)), decreased medication adherence ([Antonino et al., 2024](#); [Campagna et al., 2020](#)), increased emergency room and hospital utilization ([Aurora et al., 2025](#)), consumer dissatisfaction ([Toledo-Chavarri et al., 2025](#)), and discontinuity of care ([Moons et al., 2021](#)). These occur in the context of ongoing, significant challenges and uncertainties in the national health care environment. Although there has been an increase in published HCT interventions and research, measuring HCT patient-centered outcomes across institutions remains complex and challenging.

Groups that require additional HCT support include those with medical complexity, mental or behavioral health conditions, developmental, and/or intellectual disabilities, low health literacy, and social complexity, as well as the emerging young adult population ([Bonnie et al., 2015](#); [Toulany et al., 2022](#); [White & Cooley, 2018/2013](#)). [Bailey et al.,](#)

[2024](#) found associations between social determinants of health and HCT outcomes, noting that inequities in race, ethnicity, gender, insurance status, and income can impact HCT outcomes. AYAs experience incrementally worsening health care access and private and public insurance coverage gaps with increasing age ([Bonnie et al., 2015](#); [Ilango et al., 2025](#); [McManus et al., 2024](#)).

National recommendations promote improving the adult primary care workforce and the care of AYAs with medical complexity to reduce system-level barriers that impact HCT, including lack of communication and coordination between pediatric and adult care, as well as primary and subspecialty adult clinicians ([White & Cooley, 2018/2023](#); [Ziemann et al., 2023](#)). Adult clinicians have reported knowledge gaps and limited experience with pediatric onset chronic conditions and inadequate system supports to appropriately integrate and accept AYAs into adult practices ([Warrillow et al., 2025](#); [White & Cooley, 2018/2023](#); [Ziemann et al., 2023](#)). Recommendations include initial transfer to the adult primary care clinician for coordination of subspecialty care for AYAs with chronic conditions, sometimes requiring coordinated efforts among multiple providers in a medical home model ([White & Cooley, 2018/2023](#)).

Pediatric-focused APRNs are uniquely poised to effectively lead HCT considering that health promotion, interprofessional collaboration, advocacy, patient/family-centered care and education, and population health are central to APRN practice ([American Association of Nurse Practitioners, 2025](#); [The National Organization of Nurse Practitioner Faculties, 2022](#)).

NAPNAP RECOMMENDATIONS

Clinical Practice

1. Integrate evidence-based practice (EBP) guidelines for successful HCT that encompass planning, transfer, and integration into adult health care services.
2. Provide all AYAs with an individualized, developmentally sensitive HCT process beginning as early as 12 years old and continuing throughout adolescence.
3. Incorporate time alone with the teen and pediatric-focused APRN into health care visits beginning in early adolescence.
4. Engage AYAs in ongoing goal setting to align with acquisition of self and health care management skills

that includes an understanding of personal medical history and navigation of health care systems.

5. Encourage use of the patient portal/electronic health record to facilitate self-care, independence, and communication with the health care team.
6. Approach and treat AYAs beginning at age 18 as adults, when developmentally appropriate, with requisite legal rights and responsibilities.
7. Collaborate with adult clinicians to facilitate HCT processes and provide ongoing consultation as APRN content experts in childhood illnesses/conditions.

Family Support

1. Engage parents/caregivers as essential partners in the HCT process while maintaining respect for minor consent/confidentiality within the confines of state confidentiality laws (Guttmacher Institute, 2025; National Center for Youth Law, 2025).
2. Support parents/guardians of AYAs with intellectual disability/impairment through appropriate medicolegal resources and referrals for future care planning.
3. Provide education and guidance for shared decision-making and legal documentation/consent for young adults and their families to maximize their fullest level of independence.
4. Assist families to access services to support social and community aspects of HCT.

Advocacy

1. Develop and lead strategic HCT approaches and programs that can be adapted to any setting or specialty to prevent gaps in health care.
2. Participate in interdisciplinary collaborations to maximize opportunities for funding from public or private entities to enhance HCT services.
3. Develop educational resources, conduct research, and lead EBP/QI initiatives to identify gaps and foster equitable HCT services for AYAs and their families.
4. Partner with APRN colleagues and health care system stakeholders to create the necessary infrastructure, including EHR utilization to document, communicate, and streamline HCT processes.
5. Advocate for focused collaboration and representation in community and professional organizations at the local, state, and national levels to improve HCT.

The mission of NAPNAP is to optimize the health and well-being of all infants, children, adolescents, and young adults and empower our community of pediatric experts. NAPNAP recognizes that a timely, collaborative, comprehensive transition from pediatric to adult-focused health care is necessary to optimize the long-term health of all AYAs and that pediatric-focused APRNs are uniquely positioned to lead clinical, research, and EBP/QI initiatives in this area.

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