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EUROPEAN TRAINING REQUIREMENT

for *Certification of Added Qualification*

FOR TRANSITIONAL CARE OF ADOLESCENTS AND YOUNG ADULTS

European standards of postgraduate medical specialist training

UEMS Council October 2025

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I. INTRODUCTION

1. UEMS Preamble

The UEMS (Union Européenne des Médecins Spécialistes, or European Union of Medical Specialists) is a non-governmental organisation representing national associations of medical specialists at the European level. With its current membership of 40 national associations and operating through 43 Specialist Sections and their European Boards, 17 Multidisciplinary Joint Committees and 4 Thematic Federations the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the professional consensus on the framework for the highest possible level of their training which will pave the way to the improvement of quality of care for the benefit of all European citizens and beyond.

UEMS and its Postgraduate Medical Specialists Training programmes. In 1994, the UEMS adopted its Charter on Postgraduate Training to provide recommendations at the European level for high-quality training. This Charter sets the basis for the European approach in the field of harmonization of Postgraduate Specialist Medical Training, most importantly with the ongoing dissemination of its periodically updated Chapter 6s, specific to each specialty. After the most recent version of the EU Directive on the recognition of Professional Qualifications was introduced in 2011, the UEMS Specialist Sections and other UEMS Bodies have continued working on developing the documents on European Training Requirement(s) (ETRs). They reflect modern medical practice and current scientific findings in each specialty fields, and particular competencies are covered and represented within the UEMS. In 2012, the UEMS Council adopted the document Template Structure for ETR.

The linkage between the quality of medical care and the quality of training of medical professionals. The UEMS's conviction is that the quality of medical care and expertise is directly linked to the quality of training, achieved competencies, and their continuous update and development provided to the medical professionals. No matter where doctors are trained, they should have the same core competencies. The UEMS ETRs reflect many years (or even decades) of experience on the ground of the UEMS Sections/ Multidisciplinary Joint Committees (MJCs) and Boards developing in close collaboration with the relevant European Scientific Societies, training requirements coupled with European Medical Assessments. It is one of the clear aims of the UEMS ETRs to raise standards of training to make sure that European patients find high-quality standards of safe specialist care. While professional activity is regulated by national laws in EU Member States, it is the UEMS' understanding that it has to basically comply with international treaties and UN declarations on Human Rights, as well as the WMA International Code of Medical Ethics.

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UEMS and European legislation facilitate the mobility of medical professionals. The UEMS Council and its Specialist Sections, first created in 1962, have regularly provided advice and expert opinion to the European Commission. This provided the base for the framework that informed the drawing up of the Doctors' Directives in 1975, which made up the mutual recognition of medical diplomas and the free movement of doctors throughout the EU. The revised EU Directive on the recognition of Professional Qualifications (2013/55/EU) allows member states to decide on a standard set of minimum knowledge, skills and competencies that are needed to pursue a given profession through a Common Training Framework (CTF) which represents the third mechanism that could be used to ensure mobility within the EU. This directive states that "professional qualifications obtained under common training frameworks should automatically be recognized by Member States. Professional organizations which are representative at Union level and, under certain circumstances, national professional organizations or competent authorities should be able to submit suggestions for common training principles to the Commission, in order to allow for an assessment with the national coordinators of the possible consequences of such principles for the national education and training systems, as well as for the national rules governing access to regulated professions". The UEMS supported CTFs since they encompass the key elements developed in modern educational and training models, i.e., knowledge, skills, professionalism. In addition, the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare introduced a strong incentive for harmonization of medical training and achieved competencies among EU/EEA Countries through the requirements to assure good and comparable quality of care to increasingly mobile European citizens.
The UEMS ETR documents aim to provide for each specialty the basic training requirements as well as optional elements, and should be regularly updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. The three-part structure of these documents reflects the UEMS approach to have a coherent pragmatic document for each individual specialty, not only for medical specialists but also for decision-makers at the national and European level interested in knowing more about medical specialist training. To foster harmonization of the ETR by adopting more specific guidelines, the CanMEDS competency framework is recommended, which defines the entire set of roles of the professionals that are common across both medicine and surgery. UEMS has an agreement to use an abbreviated version of the competencies within those roles.

Importance of making a distinction between Knowledge and Competency in ETR documents. Competency-based education is not oriented towards the period of clinical rotations, but towards the trainee and the trainee's progress in the acquisition of competencies. Having a clear distinction within an ETR's contents between competencies and knowledge helps define both

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how that training should be delivered and how it should be assessed. The UEMS considers that the appropriate use of different methods of assessment of knowledge and acquired skills, emphasizing the workplace-based assessment, is an essential component of quality postgraduate training, focused on high standards of specialist medical practice. To improve the methods of assessment, it is also recommended to use the so-called Entrustable Professional Activities (EPAs) in all specialties for ETRs. In order to recognize common and harmonized standards on the quality assurance in specialist training and specialist practice at a European level, some UEMS Specialist Sections and Boards have, for a long time, organized European examinations (supported and appraised by the UEMS CESMA - Council of European Specialist Medical Assessments).

Overlapping of learning outcomes and competencies. Each of the UEMS ETRs defines a syllabus or knowledge base and describes learning outcomes defined for given competencies. Some of these curricula encompass a whole specialty, others focus on areas within or across specialties, and define the content of the training requirements for specific areas of expertise. Recognizing the potential overlap allows those writing ETRs to draft overlapping or common goals for learning outcomes. Similar measurements do not necessarily equate to the same targets. Rather, across different specialties, the final goal may differ, i.e., there may be clearly defined individual goals for trainees with different expectations.

UEMS ETRs and national curricula. The UEMS strongly encourages the National Medical Competent Authorities (NMCAs) to adopt such requirements and believes that this is the most efficient way of implementing good standards in postgraduate training. We respect and support the vital role of the NMCAs in setting high standards of training and care in their respective Countries and checking through robust quality control mechanisms the qualifications of medical specialists moving across Europe. The UEMS ETRs are developed by professionals for professionals, and this adds unique value to them. UEMS' aim is to indicate the knowledge and competencies that trainees in EU/EEA countries should achieve, as well as the competencies and organization of the training centers. The training environment and results described in UEMS ETRs may be achieved in adapted ways, depending on local traditions, healthcare system, and medical specialist training. Adaptation of UEMS ETRs to local conditions assures the highest quality of specialist training, and each state may include additional requirements, depending on local needs.

Importance of collaboration with other representative European medical bodies. The UEMS always wishes to work with all Colleagues, NMAs, professional and scientific organizations across Europe. In the process of ETRs development, the UEMS recognizes the importance of meaningful collaboration with the other European medical representative bodies, the European Junior

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Doctors (EJD, representing doctors in training), the European Union of General Practitioners (UEMO – Union Européenne des Médecins Omnipraticiens), the Standing Committee of European Doctors (CPME - Comité Permanent des Médecins Européens), the Federation of European Salaried Doctors (FEMS), and the European Association of Senior Hospital Doctors (AEMH - Association Européenne des Médecins Hospitaliers). In addition, UEMS continues to develop closer links with the many European specialist societies. UEMS, in collaboration with its fellow European representative bodies, has constantly been highlighting the importance of coordinated postgraduate specialist medical training programmes, always accepting the differing needs of different specialties. In this way, quality medical care is delivered by highly qualified medical specialists, which is essential to ensuring consumer confidence and protection all over Europe.

Conclusions. UEMS is very proud of all the hard work that has been done until now in developing the UEMS ETRs, and the fact that they are increasingly implemented as national curricula. However, we also recognize the need for constant improvement and are always open to further suggestions. The UEMS insists that the medical profession remains the driver in defining its specialist training and continuous professional development needs. On this basis, we sincerely look forward to working with the key European Union responsible bodies and the national stakeholders in implementing the basic common strategies and requirements outlined with this initiative. We are confident that the priorities detailed in UEMS ETR documents developed for individual specialties (and/or competencies) will become evident in national strategies and programmes, and action plans for postgraduate medical education and training.

2. Certification of Added Qualification for Transitional care for adolescents and young adults

Rationale

Adolescents (ages 10–19) and young adults (ages 20–24) make up approximately 25% of the population in the European Union. Due to advancements in pediatric and neonatal care, an increasing number of adolescents and young adults (AYAs) are living with chronic, complex, or rare conditions that require long-term management. Many carry the burden of chronic illness, emerging autonomy, and identity development while navigating care systems that may not be responsive to their needs. Transitions are common from pediatric to adult medical care and Child and Adolescent Mental Health Services (CAMHS) to adult psychiatry. This is especially relevant for individuals with developmental and psychiatric comorbidities. In these cases, diagnoses made in CAMHS can help identify ongoing developmental disorders that lead to functional impairments and increase the risk of emerging psychiatric issues, which require careful transitional care. The

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success of pediatric care has resulted in a growing demand for coordinated, developmentally appropriate adult healthcare for young people. However, over 60% of these individuals disengage from care within two years of transitioning to adult services.

In this document, "adolescents and young adults" will be abbreviated as "AYAs," and the term "youth" will refer to individuals aged 15 to 24, by the World Health Organization's (WHO) standards.

Transition is not just a single event or an administrative handover; it is a sensitive developmental phase and clinical process that involves medical, psychosocial, educational, legal, and behavioral changes. While transfer means the actual transfer and referral of a patient and their healthcare information to a new setting, typically occurring at a defined point in time, transition should be seen as a process spanning several years and three stages: 1) preparation in pediatric services beginning by the age of around 12 years; 2) planned transfer of care and necessary information, potentially including a joint appointment with pediatric and adult healthcare providers at least when healthcare needs are complex; and 3) patient-centered adjustment of adult-oriented services to the developmental needs of young adults. Transition refers to a purposeful, planned process that addresses the medical, psychosocial, and educational/vocational needs of AYAs as they move from child-centered to adult-oriented healthcare systems. Effective transition encompasses, but is not limited to, transfer. If not appropriately managed, transition can lead to disruptions in care, loss to follow-up, disengagement from care, and increased healthcare utilization in later years. This can result in delayed diagnoses, complications from unmanaged conditions, worsening mental health, and emotional distress. The risk is particularly significant for individuals with chronic conditions, where maintaining continuity and adherence to treatment is crucial for lifelong management. Therefore, it is essential to minimize dropout rates during transition.
Despite the clear evidence and growing awareness of this issue, transition readiness is rarely assessed systematically, and the age of transfer can vary between 15 and 21 years across Europe. While research suggests that healthcare transition should be based on an individual's maturity and readiness rather than fixed age limits, this patient-centered approach is seldom implemented in practice. Additionally, although validated assessment tools are available, transition readiness is not routinely or systematically evaluated. Inconsistent policies, differing definitions of maturity, and legal discrepancies regarding consent, confidentiality, and capacity further complicate transition practices[1].

[1] World Health Organization and Unicef. Child and Adolescent Health In The WHO European Region – Fact Sheet. Available at: https://www.unicef.org/eca/media/38451/file/Providing%20services%20to%20adolescents.pdf

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Most European countries signed the UN Convention on the Rights of the Child. This convention acknowledges that minors' rights to decision-making should be based on their evolving maturity rather than their age alone. All clinical, legal, and policy decisions must be guided by the principle of acting in the child's or adolescent's best interest[2]. However, young adults, while legally autonomous, remain economically, socially, and psychologically vulnerable. From a public health perspective, prioritizing their care leads to long-term benefits, as adult health outcomes are closely linked to health behaviors and continuity of care during adolescence.

To address these issues, every healthcare provider working with AYAs must be skilled in transitional care. This involves understanding both typical and atypical biological, psychological, sexual, cognitive, and social development that occurs beyond the legal age of majority. Providers should assess patients' capacity for autonomous decision-making using tools endorsed by the World Health Organization (WHO)[3], navigate the ethical and legal frameworks that vary across different age groups, and support self-management and future planning. This is particularly important when identity, adherence, and health literacy evolve.

Many healthcare providers, especially those in adult care, report feeling unconfident in delivering transitional care, despite recognizing the importance of youth-centered communication and shared decision-making. They often lack the structured training and resources to implement these practices effectively. However, managing transition can not rest solely with pediatric or child and adolescent psychiatry teams for optimal outcomes. Adult specialists must be prepared to receive and continue care for young adults transitioning to their services, identify and address gaps in care for those who never experienced structured pediatric care, adjust consultations and interventions to meet the evolving needs of young adults, collaborate with pediatric providers, primary care, child and adolescent psychiatrists, and community services. Transitional care providers should be trained to prioritize the well-being of youth as a clinical outcome. This includes addressing nutrition, sleep, stress, and social connection, and promoting resilience through trauma-informed, empowerment-based care.

Transitional care is essential for all clinicians who work with AYAs; it is not just a niche area of expertise. The engagement of AYAs improves when services are culturally safe and inclusive, and

[2] United Nations. Convention on the Rights of the Child, 1989. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

[3] World Health Organization. Assessing and supporting adolescents' capacity for autonomous decision-making in health care settings: a tool for health-care providers, 2021. Available at: https://iris.who.int/bitstream/handle/10665/350193/9789240039582-eng.pdf

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when shared decision-making is prioritized. Recent frameworks recommend using structured self-assessment tools, encouraging open dialogue, and providing health literacy support, mainly focusing on digital platforms. These elements are essential for promoting AYAs' self-management and well-being during transition. When transition is appropriately structured and tailored to the developmental needs of young people, it leads to better engagement, adherence to treatment, and long-term health outcomes. By providing healthcare providers with specific knowledge, skills, and tools related to transitional care, we can create systems that support young people as they transition into adulthood, rather than hinder them.

Purpose and scope: why certification matters

The transition from pediatric to adult care requires more than just disease-specific expertise; it necessitates a deep understanding of autonomy, health literacy, and support for psychosocial resilience. Even in cases where transition programmes are available, many AYAs enter adult services without adequate preparation. This inconsistency in access to such programmes highlights the need for healthcare providers to possess universal competencies in transitional care. As proposed in this document, the Certification of Added Qualification (CAQ) in Transitional care for AYAs aims to standardize the competencies related to transition across various pediatric and adult specialties. This certification equips clinicians with the necessary tools to ensure continuity of care, facilitate safe and patient-centered handovers, and support young people during one of the most sensitive phases of their healthcare journey. The certification promotes youth-friendly care regardless of the following factors:

- ✓ whether the patient is newly transferred or experiencing a relapse in young adulthood.
- ✓ whether the diagnosis was made in pediatric or adult care settings.
- ✓ whether a formal transition clinic is available.
- ✓ whether the provider works in primary, secondary, or tertiary care.

This transitional care ETR offers flexibility; it can be pursued as a Continuing Professional Development (CPD) module, as an elective within a residency or fellowship programme, or as a stand-alone qualification recognized under national or UEMS frameworks.

The ETR proposes a structured framework for a CAQ in Transitional care, applicable across pediatric and adult specialties, including child and adolescent psychiatrists. Its goals include:

- ✓ Standardizing transition-related competencies and equipping specialists with the necessary knowledge, skills, and attitudes in transitional care.
- ✓ Supporting healthcare professionals in managing care for AYAs with or without chronic conditions.
- ✓ Enhancing multidisciplinary collaboration between pediatric and adult services.

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- ✓ Promoting safe handovers and ensuring continuous follow-up.
- ✓ Reducing loss to follow-up, improving self-management skills, and empowering young individuals by supporting their autonomy, personal growth, participation in education or work, social inclusion, and a meaningful life aligned with their values and aspirations.
- ✓ Supporting health care professionals/trainees in leading or contributing to transition initiatives, and promoting research and quality improvement in transitional care.

Global context and policy alignment

The WHO, in its 2015 and 2023 frameworks, along with other major international professional bodies, highlights the essential role of trained providers in delivering adolescent- and youth-friendly healthcare that responds to the specific developmental and systemic needs of AYAs. In the "Global Accelerated Action for the Health of Adolescents" (AA-HA!) report published in 2023[4], the WHO reinforces the importance of health professionals addressing this critical life stage with competence, respect, and structure. The report emphasizes the need for all health providers to be trained in adolescent-responsive care, including developing competencies for transitioning from pediatric to adult services.

In 2022, the European Academy of Paediatrics and the UEMS approved the "Training Objectives for UEMS Specialists About the Care of Adolescents and Young Adults." This updated European ETR for the CAQ in transitional care builds on that foundation.
The framework aligns with key international standards, promoting clinical governance and harmonizing European transitional care. Structured training and certification that recognize the unique healthcare needs of young adults can significantly reduce care discontinuity and fragmentation. Additionally, these measures support sustainable workforce development, improve long-term health outcomes and well-being, address health inequities during the transition to adulthood, enhance patient engagement, and empower young people in their healthcare journeys.

A competency-based approach to transition

This ETR is based on the principles of Competency-based medical education (CBME) and aligns with the World Federation for Medical Education (WFME) Global Standards for Postgraduate Medical Education (2023). It emphasizes outcome-based training, accountability, and learner-centered progression. The ETR reflects the evolving nature of medical practice by integrating

[4] World Health Organization. Global Accelerated Action for the Health of Adolescents (AA-HA!) - Second edition. 2023 Available at: https://www.who.int/publications/i/item/9789240081765 (chapter 5, section 3.1)

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Entrustable Professional Activities (EPAs) that relate to the CanMEDS roles. These EPAs serve as workplace-based, observable measures of real-life readiness, rather than relying on time-based learning.

Trainees will participate in supervised clinical encounters, structured didactic teaching, and reflective practice. Competency will be assessed through direct observation, workplace-based assessments (such as mini-clinical evaluation exercises (mini-CEX) and case-based discussions), and the achievement of EPA milestones. Key training outcomes include being entrusted with core EPAs independently, demonstrating skills in care planning, ethical decision-making, and interprofessional collaboration, and gaining a holistic understanding of the transition process as a continuum of care.

Completing the CAQ will improve continuity of care for AYAs across various specialties. It will also enhance health literacy and autonomy among young patients, increase patient and family satisfaction, and promote health equity by reducing care fragmentation and disengagement from the healthcare system. Ultimately, transitional care should not be viewed as an optional skill but as an essential aspect of safe and ethical medical practice. The CAQ in Transitional care aims to ensure that every specialist working with AYAs is equipped to contribute confidently and competently to this critical stage of life.

3. Aims of the Certification of Added Qualification (CAQ) for Transitional care for adolescents and young adults

This CAQ equips clinicians with the skills to effectively lead, deliver, and coordinate high-quality, developmentally appropriate care for AYAs transitioning from pediatric to adult healthcare systems. The CAQ prepares clinicians for leadership roles in transitional care across clinical, educational, and policy areas.

As part of clinical and developmental competence, trainees will integrate biological, developmental, psychological, social, cognitive, and ethical aspects into individualized care for AYAs. They will provide inclusive, developmentally sensitive care for AYAs with and without chronic or complex conditions. Additionally, trainees will demonstrate expertise in managing common conditions within this population, including internal diseases, mental health, reproductive and developmental issues, or physical impairments.

As part of structured and competency-based care, trainees will utilize validated tools (e.g., transition readiness assessments), EPAs, and knowledge of the unique needs of AYAs to guide and evaluate the transition process. They will create care plans tailored to the AYAs' maturity,

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legal status, and psychosocial context, ensuring safe and continuous care across the pediatric-adult interface.

As part of interdisciplinary collaboration and communication, trainees will work alongside specialists from various fields and primary care providers. They will engage families, caregivers, and community partners in coordinated care and facilitate shared care planning through effective team communication.

Regarding leadership, advocacy, and system improvement, trainees will advocate for youth-friendly and equitable care models within healthcare institutions. They will identify gaps in transition services, support policy or pathway development, and lead or contribute to local, regional, or national transitional care initiatives. Furthermore, they will promote research and quality improvement in delivering transitional care.

This CAQ aims to harmonize transitional care standards across Europe and empower clinicians to lead change that reduces fragmentation and improves long-term outcomes for young people navigating adult healthcare systems.

4. Procedure of ETR Development/Revision

Development Process

This ETR was initiated and drafted by the Multidisciplinary Joint Committee (MJC) on Adolescent Medicine and Health under the European Union of Medical Specialists (UEMS). The development process involved a structured, collaborative, and multidisciplinary approach that drew on the expertise and experience of:

- ✓ UEMS Specialist Sections and Boards relevant to AYAs' care;
- ✓ Youth representatives and patient advocacy organizations;
- ✓ Faculty members from international academic and professional networks, including the European Training in Effective Adolescent Care and Health Team (EuTEACH), the European Academy of Paediatrics (EAP), the International Association for Adolescent Health (IAAH), the European Union for School and University Health and Medicine (EUSUHM), and the European Union of General Practitioners (UEMO).

The ETR is evidence-informed and aligned with global standards. It is based on several core reference frameworks, including:

- ✓ The UEMS-endorsed 2022 Training Objectives for Adolescent Care Specialists;

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- ✓ The WHO Core Competencies in Adolescent Health and Development (2015), including its educational toolkit for pre- and post-graduate medical training;
- ✓ The WHO Global Accelerated Action for the Health of Adolescents (AA-HA!) framework (2023);
- ✓ The International Association for Adolescent Health (IAAH) Education Committee Policy Statement on Education and Training of Healthcare Providers (2022);
- ✓ Peer-reviewed literature and consensus guidelines covering transitional care, ethics, patient engagement, and multidisciplinary practice;
- ✓ Feedback and iterative consultation with UEMS delegates, external experts on Adolescent and School Medicine, Medical education, and training institutions.

This comprehensive process ensures that the ETR addresses current clinical needs, incorporates educational innovations, and reflects policy developments in transitional care for AYAs.

Revision Process

The ETR will undergo a systematic and transparent review in line with UEMS guidelines to remain current and relevant.

1. *Regular review cycle* - the ETR will be reviewed and updated every five years. However, updates may occur sooner if there are significant changes in European training structures, adolescent health policy, or advancements in transitional care.
2. *Revision responsibility* - revisions will be coordinated by the MJC on Adolescent Medicine and Health, in collaboration with the ETR Review Committee of the UEMS Council.
3. *Consultation and consensus* - updates will involve consultation with national authorities, UEMS Specialist Sections and Boards, academic institutions, professional societies, and youth/patient representatives (AYAs and caregivers) to ensure inclusive and representative decision-making.
4. *Alignment with standards* - all updates will ensure continued alignment with CanMEDS roles and frameworks, World Federation for Medical Education (WFME) standards, national and European accreditation criteria for postgraduate medical education, and evolving models of EPAs and assessment tools.
5. *Overlap and integration* - the review will also assess overlaps with related specialties and ensure coordinated integration of shared competencies in adolescent and transitional care.

This organized development and revision process ensures that the ETR remains a dynamic, relevant, and high-quality training framework for clinicians working with AYAs in transition throughout Europe.

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II. TRAINING REQUIREMENTS FOR TRAINEES

a. Definition of trainee in the Added Qualification for Transitional care for adolescents and young adults

A trainee seeking a CAQ in Transitional care for AYAs is a licensed medical specialist who has already completed core postgraduate specialty training. This trainee now engages in structured, competency-based training in transitional care.

The trainee is expected to develop expertise in managing the medical, psychological, developmental, and social needs of AYAs aged 10–24 years. The focus is ensuring safe, patient-centered, and effective transitions from pediatric to adult health care.

The training can be undertaken in various ways, including:

1. As a part of CPD;
2. As a defined module within residency or fellowship training;
3. As a stand-alone module leading to a recognized CAQ under national or UEMS-recognized guidelines.

b. Content of training and learning outcomes

Definition of Transitional care:

In healthcare, "transition" refers to the purposeful, planned process of preparing and supporting AYAs as they move from child- or youth-oriented healthcare services to adult-oriented services. For AYAs with chronic or complex health conditions, structured transitional care and competency-based interventions are essential to prevent gaps in care and to avoid declines in health outcomes[5]. For any AYAs transitioning into adult-oriented services, regardless of chronic illness status, including those who may have developmental, psychosocial, or situational health needs, this transition involves adolescent-friendly care to ensure continuity of care. In both cases, this patient-centered approach considers biological, developmental, cognitive, psychological, and social factors and emphasizes equity. It aims to promote health across different systems during a crucial developmental period. Transitional care during AYAs' years integrates medical, emotional, legal, and vocational aspects, acknowledging that healthcare

[5] Campbell F, et al. Transition of care for adolescents from paediatric services to adult health services. Cochrane Database Syst Rev. 2016;4(4):CD009794.

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navigation, self-management, adherence, and outcomes are influenced by developmental stages rather than chronological age.

c. Competencies required of the trainee

In transitional care, competencies address the complexity of supporting AYAs during sensitive life stages. This requires adapting care to their developmental, psychosocial, legal, and healthcare contexts. Competencies include cognitive, procedural, interpersonal, and reflective domains, and they are best organized according to the internationally recognized CanMEDS Framework. Training should prepare trainers to promote "graduated autonomy" — the gradual transfer of decision-making responsibility to the young person, customized to their developmental stage, cognitive capacity, and readiness.

CanMEDS-based competency roles in transitional care
Upon completion of the training, the trainee will be expected to demonstrate the following competencies:

CanMEDS Role	Competency description	Examples in Transitional Care
Medical Expert	Demonstrates clinical expertise and applies decision-making tailored to the development and chronic conditions of AYAs.	Provides evidence-based, developmentally age- and maturity-appropriate care tailored to AYAs with acute, chronic, or complex health needs; integrates disease-specific knowledge in the context of youth development; uses validated psychosocial and readiness screening tools (e.g., HEADSSS, SSHADESS, TRAQ, Transition-Q); identifies and manages gaps in care that may arise after transfer or during re-engagement with healthcare services; understands the principles and structure of the WHO International Classification of Functioning, Disability, and Health (ICF) checklist, including its application in assessing functional status, disability, and environmental factors relevant to transitional care; be able to use tools such as the WHODAS 2.0 or other validated instruments (e.g., SDQ, GAF) to assess functioning when appropriate.
Communicator	Communicates effectively while establishing youth-centered, developmentally appropriate, trauma-informed, and confidential	Explains consent and autonomy to AYAs; balances parental involvement with patient privacy; builds trust in youth who have experienced trauma and applies trauma-informed principles to engage AYAs in shared decision-making; adapts communication strategies to

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	communication with AYAs and families; respects diversity in communication.	the language preferences, sensory abilities, and functional communication needs of AYAs, including use of interpreters, sign language, alternative and augmentative communication (AAC) methods, and proxy communication where appropriate, to ensure equitable participation in care.
Collaborator	Collaborates effectively with professionals from various fields and sectors to facilitate transition planning and ensure coordinated care.	Communicates with colleagues and coordinates joint consultations between pediatricians, adult care providers, social workers, and education professionals (involving mental health services if necessary) as part of transitional care planning. Leads multidisciplinary team meetings and supports transitions within complex care pathways; works in partnership with a multidisciplinary team, ensuring that functional impairments and contextual barriers are addressed.
Leader/ Manager	Identifies obstacles to effective transitions, such as gaps between pediatric and adult services, and advocates for institutional support for transition models.	Leads initiatives to improve the quality of care and helps incorporate transitional care into service models and the implementation of transition clinics; enhances or develops institutional policies that support structured transition pathways and improves the documentation of transition plans; manages and adapts resources in fragmented or under-resourced services.
Health Advocate	Promotes equitable, inclusive, age-appropriate, and culturally sensitive care for all AYAs, especially for vulnerable populations.	Advocates for migrant youth in transition and adapts care for LGBTQ+ adolescents, youth with disabilities, and those in out-of-home care; identifies and addresses social determinants of health and transition challenges that stem from poverty, discrimination, or stigma.
Scholar	Committed to critical appraisal, teaching, and research to improve transitional care.	Engages in quality improvement audits; presents cases at journal clubs; evaluates transition models and initiatives; participates in academic activities promoting best practices in structured care transitions.
Professional	Demonstrates ethical integrity in all professional interactions, respects autonomy, and is committed to lifelong learning.	Maintains confidentiality under challenging cases; demonstrates self-awareness of biases and limitations in expertise; uses a portfolio and feedback to foster growth; engages in ongoing professional development.

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These competencies ensure trainees can provide interdisciplinary, developmentally responsive, ethically grounded, and practically effective care to AYAs across pediatric and adult European healthcare systems.

i. Theoretical knowledge

The knowledge on transition care includes medical information and understanding of developmental, psychosocial, legal, and systems-level factors necessary for effectively managing the transition from pediatric to adult care.

Trainees must develop proficiency in the following theoretical domains:

No.	Domain	Detailed content outline and Learning Outcomes
1.	*Adolescents and young adults' health in Europe*	✓ Describe the epidemiology, demographics, morbidity/mortality trends in AYAs in the country of practice and regional variances. ✓ Identify vulnerable subgroups and their implications for care and policy.
2.	*Normal development from early adolescence to young adulthood (10–24 years)*	✓ Describe physical, psychosocial, cognitive, emotional, and sexual development ✓ Understand the development of autonomy, brain maturation, and identity formation. ✓ Assess how development impacts chronic disease management and healthcare transitions
3.	*Chronic health conditions and transitional care models*	✓ Understand the challenges AYAs face with chronic or rare conditions, including immunization plans and pharmacological aspects of therapies. ✓ Evaluate structured models (e.g., Got Transition, NICE QS140, disease-specific pathways). ✓ Apply validated transition readiness tools (e.g., TRAQ) to guide planning and follow-up. ✓ Conduct psychosocial assessment using HEADSSS, SSHADESS, or similar strength-based psychosocial assessments to explore health, home, education/employment, activities, safety, and support systems. ✓ Assess and discuss the strengths, aspirations, and personal goals of AYAs to foster motivation, self-efficacy, and resilience. ✓ Discuss adherence, reproductive health, long-term planning, and barriers to transfer while maintaining a balanced, strengths-based approach. ✓ Assess functioning using ICF-based tools (e.g., ICF Checklist, WHODAS 2.0) to identify activity limitations, impairments, and understand the

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		impact of chronic diseases, neurodevelopmental, cognitive, and mental health conditions on daily life, evaluate activity limitations, and contextual barriers to health. ✓ Recognize how functioning outcomes can guide multidisciplinary transition planning, ensuring that personal capabilities and resources are incorporated into each personalized transition plan, academic/professional development, and autonomy. ✓ Foster an atmosphere of empowerment, resilience, and shared decision-making throughout the transition process.
4.	*Legal and ethical aspects of healthcare*	✓ Interpret national and EU frameworks related to consent, assent, autonomy, confidentiality, and safeguarding. ✓ Apply shared decision-making and manage ethical dilemmas. ✓ Follow human rights-based care standards.
5.	*Social determinants of health*	✓ Analyze the impact of social, economic, and environmental factors on health. ✓ Identify risk and protective factors. ✓ Develop strategies to reduce inequity and support resilience.
6.	*Communication and health literacy*	✓ Apply age- and developmentally appropriate communication techniques, including motivational interviewing, coaching strategies, and digital health in consultations in compliance with confidentiality boundaries, and patient-centered care. ✓ Promote self-management and enhance health literacy.
7.	*eHealth, digital technologies, and telemedicine*	✓ Use and navigate electronic health records and patient portals effectively to support continuity, coordination, and quality of care. ✓ Apply telemedicine appropriately, demonstrating the ability to assess its suitability for individual AYAs, clinical situations, and follow-up needs, while recognizing its limitations. ✓ Critically evaluate digital engagement tools for their clinical relevance, accessibility, and data security in the AYA population. ✓ Recognize and address the social media impact on AYAs' health, well-being, and health-seeking behavior ✓ Integrate discussions of safe and responsible online behavior into clinical encounters
8.	*Interprofessional collaboration and education*	✓ Understand the roles of multidisciplinary team members (e.g., transition coordinators, psychologists, nurses). ✓ Participate in shared care planning and handover processes.
9.	*Leadership and physician wellness*	✓ Foster respectful, inclusive team dynamics and mentoring of peers. ✓ Demonstrate accountability in care coordination, communication, and follow-through.

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		✓ Identify signs of burnout and apply strategies to foster resilience and reflective practice.
10.	*Quality improvement, patient safety, and resource stewardship*	✓ Identify risks of poor transition (e.g., dropout, adverse events). ✓ Incorporate patient perspectives into quality improvement.
11.	*Mental, cognitive, and behavioral health*	✓ Identify and manage mental health disorders, learning disabilities, neurodiversity, substance use, and self-harm. ✓ Address behaviors, school performance, academic achievements, and coping mechanisms compassionately.
12.	*Safety, violence, and risk reduction*	✓ Recognize signs of abuse, violence, or neglect. ✓ Understand risk-taking in youth with chronic conditions and implications for safe care transition.
13.	*Special populations and equity considerations*	✓ Adapt care for vulnerable and marginalized groups (e.g., refugees, LGBTQ+, youth in custody or care, youth with developmental disorders, and ADHD). ✓ Identify intersecting identities and address access barriers with cultural humility.

Learning Format and Level

All theoretical competencies must be achieved at Competence Level A (knowledge/awareness). Theoretical training should be reinforced through structured educational activities, such as case-based seminars, simulations, webinars, e-learning modules, journal clubs, reflective case discussions, and interdisciplinary learning opportunities. Knowledge from undergraduate medical education (e.g., anatomy, pathophysiology, pharmacology, and clinical pharmacology) is assumed. And it should be further developed during training, emphasizing content specific to AYAs and the transition process.

ii. Practical and clinical skills

Application knowledge in a clinical setting is a fundamental goal of training in transitional care. Developing practical and clinical skills is essential due to the unique complexities of AYAs' health, particularly during the transition from pediatric to adult services. These practical skills should be applied across physical, psychological, and social health domains. These competencies should reflect developmental sensitivity, promote interprofessional coordination, and incorporate a biopsychosocial approach to care.

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Practical skills must be acquired at least at a competence level C (with distant supervision), while core EPAs require competence at level D (for independent practice). Skills should be practiced across various care settings, including outpatient clinics, multidisciplinary meetings, acute care services, and community-based environments.

This section summarizes essential practical and clinical skill areas, mapped to the CanMEDS roles and aligned with the UEMS "Training Objectives for UEMS Specialists About the Care of Adolescents and Young Adults" (2022), included in Appendix 1.

No.	Practical and clinical skills	Detailed content outline and Learning Outcomes
1.	*Developmentally appropriate consultation*	✓ Conduct confidential, respectful consultations adapted to age, maturity, and cognitive and emotional level, promoting trust and independence/autonomy. ✓ Adapt communication to the young person's language preferences and functional abilities, including the use of interpreters, sign language, alternative or augmentative communication methods, or proxy communication where required, to ensure full participation. ✓ Create a safe space for disclosure and build trust using appropriate language and rapport-building techniques. ✓ Apply frameworks such as HEADSSS, SSHADESS, or similar validated tools for structured psychosocial assessments. ✓ Clarify boundaries of confidentiality, involving caregivers appropriately. ✓ Assess decision-making capacity and encourage autonomous health choices.
2.	*Comprehensive lifestyle and behavioral assessment*	✓ Identify health risks, including screen time, diet, physical activity, substance use, and sexual behaviors. ✓ Screen for mental health conditions using validated tools (e.g., Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Strengths and Difficulties Questionnaire (SDQ)), developmental disorders (e.g., autism spectrum disorders, ADHD), and learning difficulties. ✓ Assess health literacy, self-care practices, and adherence. ✓ Recognize protective factors, resilience, and personal strengths.
3.	*Physical examination adapted to*	✓ Conduct respectful, developmentally sensitive physical exams, including genital exams when indicated. ✓ Interpret pubertal stage (e.g., Tanner scale), recognizing normal and abnormal variants.

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	adolescents and young adults	✓ Explore self-image, body perception, and the physical impact of chronic illness.
4.	*Management of chronic conditions and transition to adult care*	✓ Address developmental, academic, and psychosocial challenges linked to chronic illness. ✓ Develop and implement individualized, written transition plans in collaboration with the patient and team. ✓ Promote patient engagement, self-efficacy, and shared decision-making. ✓ Organize and participate in joint pediatric–adult consultations and interprofessional meetings. ✓ Evaluate functioning using the ICF framework to identify activity limitations and contextual factors.
5.	*Preventive care and health promotion*	✓ Promote vaccination, sexual health, sleep hygiene, physical activity, and nutrition. ✓ Provide anticipatory guidance adapted to the developmental stage. ✓ Implement screening protocols (e.g., screening for sexually transmitted infections (STIs), obesity, and mental health).
6.	*Acute and emergency care*	✓ Identify and manage urgent or crises (e.g., suicide risk, substance intoxication, acute pain episodes). ✓ Coordinate with emergency, psychiatric, and crisis services. ✓ Apply trauma-informed care principles and initiate brief interventions.
7.	*Ethical, legal, and cultural competence*	✓ Respect for autonomy, beneficence, non-maleficence, and justice by the fundamental principles of bioethics. ✓ Navigate ethical dilemmas related to confidentiality, consent, and capacity, based on national legal frameworks, to avoid inequitable care. ✓ Manage disclosures of abuse or risk appropriately, following legal and institutional guidelines. ✓ Provide culturally sensitive care, using interpreters or mediators as needed. ✓ Advocate for inclusive care environments, addressing bias and stigma.
8.	*Digital and telehealth competence*	✓ Use digital platforms and teleconsultation tools to conduct remote AYAs' care when clinically appropriate, particularly when access to in-person services is limited (e.g., during epidemics, in rural or underserved areas, or when mobility is restricted). ✓ Assess when telehealth is suitable for patients, noting that some situations, like first-time consultations and specific examinations,

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		require in-person visits (e.g., first-time consultations, specific physical examinations such as gynecology or abdominal pain) ✓ Identify and manage the risks and opportunities of digital tools, social media, and patient portals in AYA healthcare, balancing accessibility and engagement with potential harms. ✓ Ensure privacy, confidentiality, and safe communication, particularly when working with minors, and adhere to relevant legal and ethical standards. ✓ Ensure awareness of AI-assisted tools, digital ethics, and cybersecurity risks in youth health data

These competencies should be developed during clinical rotations, interprofessional simulations, case discussions, transition clinics, and supervised consultations. Assessment methods include direct observation, mini-CEX, EPAs, reflective case logs, structured feedback, case-based discussions, multi-source feedback (MSF), and supervisor reviews. Trainees are encouraged to engage in real-life transition cases and interdisciplinary teamwork, which will provide exposure to various models of care. Aligning with the CanMEDS roles ensures these skills are integrated into a holistic, high-quality practice.

iii. Non-technical skills and professionalism

Non-technical skills are crucial in transitional care, where relational dynamics, patient sensitivity, ethical complexity, and cross-sector collaboration play significant roles. These competencies align with the core CanMEDS roles – Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional – and are integrated across all clinical care, learning, and assessment. They are essential when caring for AYAs, a group navigating medical, emotional, and psychosocial transitions.

Medical professionalism is essential for providing high-quality, youth-centered transitional care. It fosters trust, safety, and ethical integrity in interactions with AYAs and their families. Since the transition process often involves sensitive decisions regarding consent, confidentiality, mental health, autonomy, and legal status, trainees must develop the skills to address these issues responsibly and with consideration of developmental factors. Training programmes should prepare trainees to collaborate with parents or caregivers, balancing the young person's right to confidentiality and autonomy with the supportive role of families. Flexible models should be employed, adjusting family involvement based on developmental readiness, cultural context, and specific health needs.

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Below is the competency framework required at Level D (Independent) upon completion of the CAQ in Transitional care:

No.	Core Statements (Domains)	Learning Outcomes
1.	*Ethical practice and patient advocacy*	✓ Uphold confidentiality and informed consent while navigating evolving autonomy in AYAs. ✓ Balance individual rights with safeguarding and mandatory reporting obligations. ✓ Advocate for the rights and access of marginalized youth (e.g., refugees, LGBTQ+, youth in care).
2.	*Reflective practice and clinical excellence*	✓ Engage in continuous self-directed learning and evidence-based care. ✓ Acknowledge personal limitations and seek supervision when needed. ✓ Participate in error analysis, ethical discussions, and case reviews. ✓ Apply functioning-oriented thinking, including frameworks like ICF, to comprehensively assess functioning and disability across domains such as mobility, cognition, self-care, and participation, patient needs, and guide biopsychosocial care planning.
3.	*Leadership, accountability, and teamwork*	✓ Lead and contribute to interdisciplinary transition planning. ✓ Foster respectful, inclusive team dynamics and mentoring of peers. ✓ Demonstrate accountability in care coordination, communication, and follow-through.
4.	*Communication and interpersonal skills*	✓ Build rapport and therapeutic relationships with AYAs and families. ✓ Navigate sensitive, complex conversations with clarity, empathy, and youth-centeredness. ✓ Demonstrate cultural humility in cross-cultural encounters and adapt communication to the developmental stage.
5.	*Diversity, inclusion, and health equity*	✓ Identify and challenge unconscious bias in healthcare delivery. ✓ Tailor care to reflect the needs of diverse AYA populations and social determinants of health. ✓ Collaborate with youth-led and community organizations to improve system responsiveness.
6.	*Resilience and well-being*	✓ Demonstrate awareness of burnout risks in transitional care settings. ✓ Employ reflective practice, time management, and peer support. ✓ Promote healthy workplace environments and a culture of collegiality and compassion.

Integration into training and assessment

Professionalism and non-technical skills in transition care encompass ethical practice, reflective learning, effective communication, and a commitment to justice and equity. These competencies

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are essential for providing effective, ethical, and developmentally appropriate care. These were modeled throughout training and reinforced through faculty role modeling, reflective writing, and structured feedback. By adhering to these principles, specialists certified in transitional care contribute to the health and well-being of individuals and society. By aligning these values with clinical practice, professionals can ensure their work remains patient-centered, equitable, and upholds the highest ethical standards.

Trainees should receive formative and summative feedback through faculty role-modeling during clinical supervision, structured debriefings, case reviews, reflective writing in learning portfolios, and multi-source feedback (MSF) from colleagues, staff, patients, and mentors.

By aligning professional values with daily practice, certified specialists in Transitional care enhance the health system's capability to meet the evolving needs of AYAs, supporting positive long-term health trajectories across Europe.

c. Levels of competence in Transitional care

Training progression in transitional care is based on the principle of progressive independence. This progression is assessed through various domains: knowledge (both theoretical and clinical understanding), practical technical skills (clinical procedures and their application), and non-technical competencies (such as communication, professionalism, leadership), along with clinical judgment in specific contexts. These assessments define the trainee's development and the level of competence expected upon completing their training, reflecting the ability to perform professional tasks safely and independently. Each domain specifies the learning outcomes necessary to achieve the required competency levels determined by UEMS standards. The learning outcomes outlined in this document describe the competencies needed to perform skills and manage patients in independent, autonomous practice.

This progression is essential in transitional care due to the interdisciplinary, developmental, legal, and ethical complexities of working with AYAs. Competency includes not just knowledge but also communication, collaboration, and self-awareness.

Most core clinical and communication competencies in this training should be achieved at Level D, especially regarding independent management of transition planning, confidentiality, consent, and interdisciplinary collaboration. However, not all trainees are expected to reach Level D in every domain; independent performance (Level D) is required in at least three core EPAs, with Level C expected across all domains. Continuous professional development will further enhance

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the number and level of competencies beyond the core content of ETRs. Competency development will follow the UEMS-recommended framework of progressive independence, with levels defined as follows:

Level	Clinical role description	Knowledge	Skills	Non-technical competencies
A *Observer*	Passive observer under close supervision in structured teaching or clinics.	Understands the principles of transitional care, including developmental differences in AYAs, basic transition models, legal concepts, and the concept of functioning and its relevance in AYAs' health.	Observes consultations on transitions and assessments of patients conducted by experienced clinicians.	Understands team members' roles, listens attentively, and starts reflecting on personal values and biases. Recognizes that functioning is a key component of AYAs' well-being and observes how it influences care.
B *Direct supervision*	Performs tasks with the supervisor present and guidance at each step.	Demonstrates an understanding of chronic conditions and transition protocols with guidance. Describes the domains of functioning and contextual factors using ICF terminology.	Performs parts of the transition assessment while providing immediate feedback (e.g., HEADSSS, SSHADESS, readiness tools). Applies basic functional assessment tools (e.g., WHODAS 2.0 short form) with supervision.	Practices communication with AYAs and their caregivers, coaching interactions; discusses the importance of confidentiality and informed consent. Examines the effects of functional limitations and discusses when referrals for assessment may be necessary.
C *Distant supervision*	Takes responsibility for patient care with a supervisor accessible but	Shows clinical reasoning and the ability to integrate knowledge of developmental and psychosocial factors. Explains	Manages transition planning under remote supervision, with feedback mechanisms, initiates interprofessional	Facilitates discussions, anticipates ethical challenges, seeks feedback, and engages in self-reflection.

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	not always present.	how functioning, environment, and disability interact in AYAs' care.	meetings, and uses validated tools (e.g., TRAQ). Integrates functioning assessments into care planning (e.g., full WHODAS 2.0 or ICF checklist).	Integrates functioning perspectives into care planning
D *Independent*	Practices independently and may supervise others; demonstrates entrustable professional behavior.	Effectively implements evidence-based approaches and adapts transition models to fit clinical settings.	Leads multidisciplinary care, facilitates joint consultations, and independently implements care plans. Entrusted with all relevant EPAs.	Acts ethically, manages conflict, supervises junior trainees, and mentors peers in transitional care. Entrusted with all relevant EPAs.

Trainees should present their completed curriculum (module) when applying for positions across Europe. This includes details about the clinical experiences they participated in and their overall professional development. A well-organized logbook or portfolio should outline the activities and clinical exposure they undertook, records of EPAs achieved, and the assessment tools used. Additionally, it should contain documentation of supervision, self-assessments, and progress evaluations. This approach ensures transparency, supports mobility, and aligns with the European Qualifications Framework (EQF) and the CanMEDS competencies.

Transitional Care-Specific Entrustable Professional Activities (EPAs)

EPAs are specific, observable units of professional practice that can be entrusted to a trainee once they have demonstrated sufficient competence to perform them independently and safely, without direct supervision. EPAs are an essential link between competency frameworks, such as CanMEDS roles or WFME domains, and real-world clinical responsibilities. This connection is vital to ensuring both patient safety and professional accountability.

EPAs are the foundation for a progressive and flexible training approach, allowing trainees to advance at their own pace and ensuring they are ready based on demonstrated competence. In the context of transitional care, EPAs are particularly important because they address the complexities of managing AYAs across varying developmental, legal, and psychosocial areas, often within fragmented pediatric and adult care systems. Entrustment involves more than

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simply completing tasks; it includes trust in the trainee's judgment, professionalism, communication skills, and ability to deliver safe, developmentally appropriate care. EPAs also include evaluations of functioning and participation across medical, psychological, and social domains, using the ICF checklist and WHODAS 2.0 when applicable. This approach guarantees a comprehensive understanding of the capabilities of AYAs and the contextual factors that affect the continuity of care and outcomes.

Transitional care EPAs are designed to align with the UEMS (European Union of Medical Specialists) Educational Training Requirements (ETRs) and reflect key EU directives that promote transparency, professional mobility, and competence-based training. These EPAs support the objectives of Directive 2005/36/EC and Directive 2013/55/EU, which aim to harmonize recognition of qualifications, establish modular, lifelong learning pathways, such as the CAQ, and facilitate mobility of qualified professionals between EU countries. Additionally, Directive 2011/24/EU highlights the importance of continuity of care and interoperability – goals that EPAs help achieve by standardizing transitional care competencies across different specialties and countries.

Drawing on CanMEDS 2015, WFME 2023 postgraduate standards, and WHO's adolescent health frameworks (2015, 2023), these EPAs convert essential competencies into observable and assessable clinical activities. They provide healthcare providers with the practical tools and professional behaviors necessary to deliver care responsive to AYAs. They ensure it is adolescent-responsive, developmentally appropriate, safe, and equitable as they transition to adult health systems.

Transitional care involves a complex interplay of clinical medicine, developmental psychology, patient autonomy, legal variation, and gaps within health systems. EPAs help standardize care by ensuring that clinicians can manage critical transition-related tasks safely and independently. They set minimum expectations for clinical and non-clinical care of AYAs, while supporting developmentally tailored, equitable, and inclusive care. Additionally, EPAs foster interdisciplinary collaboration between pediatric and adult services, support cross-specialty adaptability, and create structured pathways for CPD or CAQ. Moreover, they empower institutions to measure and monitor training outcomes effectively. Regarding the pilot of time-variable flexibility, it is important to maintain EPA-based benchmarks while acknowledging that some trainees may progress at different rates. This reflects a move from time-based to mastery-based training, highlighting competency by design.

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Transitional care operates at the intersection of clinical medicine, developmental psychology, patient autonomy, legal framework variations, and health system gaps. EPAs play a crucial role in standardizing care by:

- ✓ Ensuring that clinicians can safely and independently manage critical tasks related to transitions;
- ✓ Defining minimum expectations for both clinical and non-clinical care for AYAs;
- ✓ Supporting care that is developmentally appropriate, equitable, and inclusive;
- ✓ Promoting interdisciplinary collaboration between pediatric and adult services;
- ✓ Allowing for adaptability across specialties while providing structured pathways for CPD or CAQ;
- ✓ Enabling institutions to measure and monitor training outcomes effectively.

Transitional Care EPAs are designed to be flexible and applicable across various medical specialties, including pediatrics and adult medicine, mental health specialists, and general practice/family medicine. They can also be utilized in mixed services, such as transitional care clinics, adolescent units, and outpatient clinics. Additionally, they can support CPD modules, national boards, or UEMS-recognized CAQ processes. Interprofessional teams, including those in school and occupational health, primary care, and rare disease networks, can also benefit from these EPAs.
Each of the seven EPAs (Appendix 2) includes the following components: a rationale and scope that explains its relevance, specifications, core tasks, and the competencies required for execution. It also outlines the potential risks of failing to perform the EPA properly, aligns with CanMEDS roles, and maps to the necessary knowledge, skills, and attitudes. Furthermore, it recommends assessment tools, specifies the expected level of entrustment, and suggests a timeline for maintenance, such as reassessment (recertification) or ongoing competence.

Entrustment decisions enhance accountability, patient safety, and cross-border recognition of qualifications. By integrating EPA-based education into transitional care, Europe can promote standardized practices, facilitate the mobility of specialists, and ensure that young people receive coordinated, respectful, and effective care during one of the most vulnerable periods of their health journey.

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Transitional Care EPAs summary table (full description of EPAs is presented as Appendix 2)

EPA No.	Title	Specifications	CanMEDS Roles	Entrustment Target	Core Assessment Tools
1	Conduct a transition-oriented consultation.	Includes developmental, cognitive/learning, psychosocial, and medical assessments tailored to AYAs. Use structured tools (e.g., HEADSSS, SSHADESS, TRAQ) to address social context, life changes, and transition readiness.	Medical expert, Communicator, Collaborator, Health advocate, Scholar	Level D	Mini-CEX, case-based discussion, short practice observation, OSCE, portfolio (reflection logs, transition plans), evaluation of work product (consultation notes, letters), patient/family feedback
2	Manage confidentiality, evolving capacity for decision-making, and medical autonomy in AYAs.	Adhere to ethical and legal obligations related to consent, data sharing, and capacity. Maintain autonomy while ensuring safety in line with General Data Protection Regulation (GDPR) and WHO guidelines.	Professional, Communicator, Health advocate, Leader	Level D	Direct observation of communication skills, case-based discussion, legal/policy review, OSCE (ethico-legal scenario), longitudinal practice observation, ethics/peer feedback, portfolio reflections
3	Identify and address developmental, cognitive, and psychosocial factors affecting AYAs during the transition.	Screen for and manage mental health problems, trauma, risky behaviors, and social determinants. Connect AYAs with educational and professional resources, integrate care, and reduce long-term attrition. Conduct assessments of functioning, using	Medical expert, Scholar, Health advocate, Collaborator, Communicator	Level C–D	Mini-CEX, case-based discussion, short practice observation, validated questionnaires (PHQ-9, GAD-7, SDQ, CRAFFT), structured mental state exam, multi-source feedback, reflective logs

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		the ICF checklist, WHODAS 2.0, the GAF scale, etc. When appropriate, coordinate with rehabilitation or other services due to functioning or disability, as national or local laws require.			
4	Promote health equity and provide inclusive, culturally safe care	Tailor care according to individual identity, needs, literacy, and service access. Address systemic bias and provide equitable care planning, especially for LGBTQ+ youth, migrants, and underserved populations.	Health advocate, Professional, Communicator, Collaborator	Level C	Equity checklists, simulation (bias/cultural sensitivity), structured peer/AYA feedback, MSF (esp. nurses/interpreters), evaluation of work product (transition plan/equity documentation)
5	Coordinate the complex, interdisciplinary transfer of AYAs' care	Lead structured handovers between paediatric and adult services, including social, educational, and community stakeholders/systems. Ensure continuity for complex and high-risk patients.	Leader, Collaborator, Medical expert, Communicator	Level D	Direct observation of handovers, transition plan audit, simulation, MSF (incl. allied professionals), portfolio, longitudinal practice observation, evaluation of work product (referral letters, summaries, care plans)
6	Empower AYAs for self-management and shared decision-making	Guide AYAs in developing independence, life skills, and adherence to their treatment plans. Involve	Health advocate, Scholar, Communicator, Professional	Level D	Mini-CEX (goal-setting), case-based discussion, TRAQ, role play/OSCE, AYA/caregiver feedback, portfolio

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		caregivers in a way appropriate for each developmental stage to facilitate the transfer of responsibility. Use validated readiness tools, such as the Transition Readiness Assessment Questionnaire (TRAQ), to support this process.			reflections, mentor reviews, longitudinal practice observation
7	Integrate digital tools and eHealth in transitional care	Use telemedicine, digital health tools (apps), EMRs, and platforms for communication, care, and education, ensuring safety, confidentiality, and inclusion; utilize family-supervised digital resources when necessary.	Scholar, Communicator, Leader, Health advocate	Level C	Digital literacy checklist, OSCE (teleconsultation/e-consultation), simulation (digital safety), portfolio review of digital cases, youth/family feedback, evaluation of work product (telehealth notes, digital documentation)

3. Organization of training

a. Schedule of training

Minimum duration of training

The recommended minimum duration for structured training in Transitional care is 4 to 12 weeks. This training should be delivered through online (virtual) and in-person (onsite) learning, with at least two weeks completed onsite to ensure direct clinical exposure. The duration may vary based on national frameworks, training intensity, and whether the programme is integrated into all adult specialties' curriculum or offered as a CAQ.

The training should provide exposure to outpatient clinics and community-based settings, including primary care, where most transitional encounters with AYAs occur. If available,

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participants should engage in dedicated transition clinics and rotate through child and adolescent psychiatry services, adult psychiatry, joint consultations with CAMHS and adult mental health services, chronic care specialties, and school or occupational health. Additionally, they should participate in joint consultations between pediatric and adult care teams, actively engage in interdisciplinary case reviews, contribute to transition pathway planning, and conduct post-transfer follow-up.

This structured approach offers trainees longitudinal, developmentally sensitive, and system-level insights into the transition process, from early planning and readiness assessment to transferring care and providing post-transfer support.

Timing and evaluation structure

Trainees may complete different EPAs across multiple institutions or rotations. To qualify for certification, completing and documenting all seven EPAs is compulsory. Flexibility is maintained to accommodate different national systems, but institutions are encouraged to implement midpoint (formative) evaluations. These evaluations help review progress and provide targeted feedback based on the development of EPAs, final assessments, or project submissions. This process should align with the EPAs' achievement and the CanMEDS roles. A structured portfolio or logbook should track EPA completion, reflective learning, and competency growth.

National authorities are responsible for determining the specific timing of summative assessments. However, training centers must ensure that trainees receive regular supervision, mentorship, and feedback throughout their training period, with EPA-based progress serving as a guide for certification readiness.

b. Curriculum of training

The ETR for the CAQ in Transitional care aims to ensure that trainees develop clinical competence, professional integrity, and a comprehensive understanding of healthcare systems across various settings. This is achieved by imparting essential knowledge, both clinical and non-clinical skills, and caring for AYAs. The training incorporates structured educational formats and workplace-based learning. Learning outcomes are organized around core competencies and role integration as defined by the CanMEDS framework. These are operationalized through assessments linked to EPAs and reflection on practice. The curriculum is tailored to the interdisciplinary nature of transitional care and considers the evolving developmental, psychosocial, and legal complexities facing the AYAs population.

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The curriculum is designed with modular flexibility, allowing for variable progression over time. This structure facilitates trainees' advancement toward independently managing real-world responsibilities in transitional care and aligning with CanMEDS roles and WFME standards. It includes the following core domains:

Domain	Learning objectives/outcomes	Educational methods
1. Biopsychosocial development	Understand typical and atypical physical, emotional, cognitive, and sexual development during adolescence; recognize how neurodiversity and identity formation affect health; apply structured developmental assessment tools.	Interactive lectures, case discussions, simulation, reflective exercises, and short practice observation of consultations.
2. Transitional care frameworks	Utilize structured transition models, identify barriers to successful transitions, use readiness assessment tools (e.g., TRAQ), document findings in portfolios, and distinguish between transfer and transition.	Clinical rotation, workshops, case-based learning, joint pediatric-adult clinics, evaluation of work product (transition plans, readiness documentation).
3. Mental, developmental, and cognitive health and risk behaviors	Recognize early signs of mental distress, substance use, developmental disorders, cognitive/learning disabilities, and trauma; provide trauma-informed care that is developmentally appropriate; apply validated screening tools (e.g., PHQ-9, CRAFFT, SDQ, WHODAS 2.0 short form).	Role-play, interprofessional teaching, simulation, case discussions, structured mental state/cognitive examination training, learning disabilities assessment, psychiatric interviewing, and open dialogue techniques.
4. Chronic conditions in transition	Manage disease-specific care during transitions. Understand challenges related to medications and medical devices, adherence, comorbidities, and polypharmacy in AYAs. Conduct a comprehensive assessment of functioning, and when appropriate, coordinate with rehabilitation or other services due to functioning or disability, as required by national or local laws. Evaluate documentation for accuracy and completeness.	Specialty-specific clinical training, portfolio reflection, interdisciplinary rounds, and evaluation of work product (care plans, referral letters).
5. Reproductive and sexual health	Counsel AYAs on consent, contraception, gender identity, STIs, and confidentiality	Youth-focused consultations, ethics seminars, OSCEs,

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	with cultural competence; demonstrate communication in a supervised setting.	communication skills training, and short practice observation of counseling sessions.
6. Ethics and legal frameworks	Navigate issues of confidentiality, capacity, consent, GDPR compliance, and professional responsibilities across different age groups; critically review documentation for legal/ethical compliance.	Legal case simulations, small-group seminars, policy reviews, ethics-focused OSCEs, and work product revaluations (documentation for compliance with GDPR and consent process).
7. Health equity and vulnerable groups	Identify and address barriers for AYAs from marginalized groups, such as migrants, LGBTQ+ youth, AYAs with neurodevelopmental disabilities (e.g., autism, ADHD), and those in foster care; also, understand the social determinants of health; demonstrate inclusive communication and care planning.	Equity checklists, DEI modules, community-based projects, multidisciplinary simulation, and multi-source feedback from AYAs and peers regarding inclusivity.
8. Digital health and communication	Integrate telemedicine and online tools into AYAs' care while ensuring data protection and inclusivity; address digital literacy and cyber safety; use digital tools appropriately and document their usage; utilize family-supervised digital resources when necessary.	eHealth simulations, digital tool evaluations, OSCE stations, patient feedback on teleconsultations, and evaluation of work product (telehealth notes, EMR entries).
9. Empowerment and self-management	Enhance health literacy, encourage shared decision-making, and promote school progress, professional development, and autonomy; assist AYAs in establishing personalized care and life goals; demonstrate coaching and monitoring of shared decision-making.	Motivational interviewing practice, portfolio coaching, self-assessment tools, patient navigator shadowing, and longitudinal practice observation of shared decision-making.
10. Leadership and interdisciplinary work	Lead interdisciplinary teams, contribute to institutional and national policies, and advocate for transitions; demonstrate leadership behaviors in supervised settings.	Quality improvement project, joint care planning workshops, policy roundtables, team debriefs, and direct/longitudinal observation of leadership in team meetings.

Trainees are expected to apply a curriculum focused on EPAs tailored to transitional care. This includes work-based assessments such as Mini-clinical evaluation exercises (Mini-CEX), case-

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based discussions, and multi-source feedback (MSF). They will also receive longitudinal supervision from mentors and trainers. They will complete a portfolio and logbook with reflections, self-assessments, and evidence of their competencies. This integrated curriculum lays the foundation for trainees to provide developmentally appropriate, ethically grounded, and system-aware care to AYAs across Europe.

c. Assessment and evaluation

A structured and robust approach to assessment and evaluation is essential for maintaining high standards in transitional care training. The goal is to support a culture of continuous assessment that balances both the formative progress evaluation and summative assessment. This can be achieved using a multi-source, real-time framework that integrates frequent structured workplace-based assessments (WPBAs), such as the Mini-CEX and multi-source feedback (MSF), short and longitudinal practice observations, and evaluation of work products, along with longitudinal assessment portfolios that include reflection, planning, and documented EPA-based entrustment decisions. Competence committees synthesize data from diverse feedback sources to support fair, evidence-based, data-driven judgements on progression. This comprehensive approach ensures that trainees gain knowledge and the skills and professional attitudes required to apply it confidently and safely in real clinical environments. Such an evaluation approach reflects performance tied to EPAs, the framework promotes reflective practice, and improves coaching interactions, creating a clear picture of readiness for independent practice. This allows for reliable, defensible entrustable decisions, ensures comparability across training settings, and supports the mobility of qualifications across Europe in line with UEMS, CanMEDS, and WFME principles.

Definitions and Purpose

- ✓ *Assessment* refers to the systematic process of evaluating a trainee's achievement of learning outcomes. This includes formative and summative assessments and involves assigning a value or grade based on clear, predefined criteria. Assessment aligns with EPAs and supports both quality assurance and professional development.
- ✓ *Evaluation* is broader and involves making judgments about the quality of a trainee's performance and progress, the effectiveness of the educational environment, and the attainment of programme goals.

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i. **Formative Assessments**

Purpose: To monitor progress, provide feedback, and support development. Formative assessments occur throughout the programme, helping trainees reflect, improve, and engage in self-directed learning. These assessments are mapped to specific EPAs and CanMEDS roles.

Formative assessment tool	**Function**
Mini-CEX (clinical evaluation exercise)	Observation of AYA consultations in real-time, accompanied by immediate feedback.
Direct observation of procedural skills	Supervised practice of practical or communication-based tasks, such as discussions on confidentiality.
Case-based discussion	A critical review of AYA cases, focusing on aspects such as readiness, ethical dilemmas, and psychosocial challenges.
Teaching observation	Feedback from peers or mentors regarding teaching practices or advocacy efforts directed at colleagues or families.
Structured feedback sessions	Feedback from supervisors should be provided using structured rubrics aligned with EPAs.
Reflection logs	Reflections written by trainees on challenges related to transitions and ethical cases.
Portfolio review	Regular reviews by a mentor or Programme Director will assess the accumulated evidence and learning progress.
Multi-source feedback (MSF)	Comprehensive feedback from peers, nurses, AYAs, families, and allied professionals regarding teamwork and communication.
Feedback tools (e.g., patient/parent questionnaires)	Assess the effectiveness of communication, building trust, and the approach to shared decision-making.
Short practice observation	A focused review of a single clinical encounter, such as a consultation or a discussion about disclosures, with immediate feedback provided.
Longitudinal practice observation	Evaluation of professional development and consistency in multiple interactions or continuity of care scenarios.
Evaluation of work product	Review transition-related documentation (e.g., care plans, referral letters, and transition summaries) to ensure accuracy, clarity, and a youth-centered approach.

Each trainee must maintain a clinical logbook documenting various AYA cases and transitional care activities, a portfolio that includes reflective writings, completed EPA checklists, records of multidisciplinary participation, feedback reports, and a personal development plan.

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ii. Summative Assessments

Purpose: To certify that the trainee is prepared for independent practice at the expected level of competence. Summative assessments are conducted at specific points, such as at the end of a programme or module, by national or UEMS-level processes. These assessments ensure that the trainee has acquired all the necessary competencies to manage transitional care responsibilities independently.

Summative assessment tool	**Function**
OSCE (Objective structured clinical exam)	Simulated youth scenarios include situations such as capacity assessments, digital consultations, and conflicts regarding consent.
Workplace-based assessment	Directly reviewing the performance of trainees in clinical settings or during handovers.
EPA-specific entrustment decisions	Supervisor assessments should utilize structured EPA checklists to evaluate Level C or D achievement.
Final discussion	Evaluates ethical reasoning, interdisciplinary planning, and communication strategies.
Final portfolio and/or Transition project review	A synthesis of reflective work, documented EPAs, and examples of structured transition planning.
Evaluation of work product	Final review of care plans, handover letters, and transition documentation for the summative certification process.

All final assessments must demonstrate the integration of clinical competence, professionalism, ethical reasoning, and collaboration across systems.

iii. EPA-Based Evaluation:

Each trainee will be assessed against the 7 EPAs defined in the curriculum:

EPA tracking strategy	**Tool/Source**
Entrustment decisions	According to the EPA, the supervisor conducts reviews based on the documented entrustment levels (A–D).
EPA-specific checklists	Skill-based rubrics that are aligned with the CanMEDS roles and clinical milestones.
Portfolio mapping to EPAs	Documentation of tasks, reflections, case summaries, and feedback
Assessment of digital and equity competence	Digital literacy checklists, equity audits, and OSCE stations

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The Programme Director is responsible for ensuring that all components of the portfolio and assessments are completed before the CAQ is awarded. Based on national certification requirements, the certification may be valid for five to ten years (recertification cycles). After this period, recertification requires health professionals to demonstrate ongoing practice and continuous professional development in transitional care, according to national standards. This includes completing a minimum recommended number of Continuing Medical Education (CME) hours in transitional care every five years and dedicating a portion of those hours to specific areas such as youth-centered communication, legal and ethical updates, or chronic care management. Non-formal learning experiences like quality improvement projects, youth-led training, participation in transitional care networks, contributions to scientific articles, engagement with educational training resources, programme development, and fulfilling other requirements are encouraged.

This framework ensures that assessment focuses on testing knowledge and certifying the readiness to deliver safe, coordinated, and developmentally appropriate care to AYAs. This approach aligns with the objectives of the CanMEDS, UEMS, and WFME frameworks for outcome-based, high-quality postgraduate medical education.

e. Governance

Effective governance ensures that the Transitional Care ETR upholds educational integrity, aligns with national and European standards, and provides consistent, high-quality training. It involves clearly defined roles and responsibilities among the Programme Director, trainers, mentors, and training institutions.

The Programme Director oversees its structure, ensuring its content aligns with national and European frameworks. This role involves coordinating curriculum delivery and providing support to trainees. The Programme Director plays a crucial role in evaluating the programme and guiding trainees effectively. Key responsibilities include ensuring adherence to assessment standards, conducting regular reviews with each trainee, and offering individualized coaching and remediation. Additionally, the Programme Director oversees summative assessments and prepares trainees for certification.

Programmes should include Competence committees, which are trained review panels that regularly assess EPA progress. They synthesize data from multiple sources, such as EPAs, multi-source feedback (MSF), and portfolios, to make holistic decisions regarding entrustment and trainee progression. Competence Committees must implement structured and transparent decision-making processes that include anti-bias principles. All members should undergo regular

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training in recognizing implicit bias, cultural safety, and equitable assessment practices. This training is essential to ensure that decisions regarding entrustment and certification are fair, consistent, and inclusive.

Each trainer supervises clinical learning, providing real-time feedback and coaching while assessing trainees based on EPAs. Mentors facilitate continuous development by guiding reflective practices, offering career orientation, and helping create personal development plans. Additionally, faculty development that includes coaching skills is essential for supporting and sustaining the growth of trainees.

III. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as a trainer

a. Requested qualification and experience

Transitional care trainers are crucial in providing high-quality, developmentally appropriate education and should be formally acknowledged through national or institutional frameworks. Their qualifications must encompass both clinical expertise and teaching competency.

Trainers in transitional care should:

- ✓ Be certified specialists in relevant clinical disciplines such as pediatrics, adolescent medicine, child and adolescent psychiatry, psychiatry, internal medicine, general practice/family medicine, public health, or other specialties;
- ✓ Have at least three years of post-specialist clinical experience in their area of practice and be recognized by national regulatory or accrediting authorities;
- ✓ Actively engage in direct clinical care involving AYAs, including responsibilities related to their transition;
- ✓ Be recognized as qualified trainers by national regulatory or accrediting authorities;
- ✓ Complete comprehensive, formal, structured faculty development "Training the Trainers" programmes in medical education and mentorship. These programmes should cover areas such as assessing EPAs using narrative feedback, coaching for performance improvement, leading competence committees, promoting reflection, and professional identity formation. This training should align with UEMS guidance, WFME recommendations, and national standards, demonstrating the ability to apply these concepts in real-world training environments.

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Additionally, the roles of Programme Directors and mentors include:

- ✓ Programme Directors must be certified specialists with at least five years of post-certification experience and demonstrate formal training and leadership in postgraduate education, curriculum implementation, and quality management.
- ✓ Mentors should have at least five years of post-specialist clinical practice, actively participate in teaching and mentoring, and be officially appointed by the training programme or a national authority. While mentors may also serve as trainers, their primary focus should be on providing personalized guidance and supporting the longitudinal development of trainees.

b. Core competencies of trainers

All trainers must exhibit skills beyond clinical knowledge, especially in postgraduate education and the development of learners.

Domain	**Required Competencies**
Curriculum expertise	Comprehensive understanding of transitional care, adolescent development, the CAQ curriculum, and the EPA framework; ability to apply CanMEDS roles in training design.
Educational skills	Understanding the principles of modern medical education, including formative and summative assessments, as well as educational methodologies such as simulation, OSCE, and portfolio assessment.
Assessment and feedback	Proficient in providing constructive, actionable feedback; utilizing tools such as MSF, Mini-CEX, case-based discussions, and EPA checklists; and assisting trainees experiencing difficulties.
Mentoring and supervision	Ability to create a safe and inclusive learning environment; provide career guidance and supervise reflective practices and self-assessment.
Professionalism and role-modelling	Dedicated to ethical behavior, youth-centered values, and equitable care; demonstrate commitment to equity and inclusion by completing periodic bias recognition, cultural safety, and developmentally appropriate communication training; capable of modeling professional standards and compassionate values in clinical practice.
Interdisciplinary leadership	Encourage interprofessional learning and collaboration among specialties; participate in co-teaching and navigate complex transitional care cases.
Ongoing professional development	Dedication to ongoing enhancement in clinical teaching, CPD activities, and engagement in educator peer networks.

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Trainers should model ethical and professional behavior while engaging in reflective practices, prioritizing their well-being to maintain effective education. Resilient educators are better equipped to mentor trainees and create a safe, youth-responsive learning environment.

2. Quality management for trainers

Ensuring the quality and accountability of trainer performance is essential for achieving educational excellence. Institutions and Programme Directors are critical in implementing systems that foster continuous development and quality assurance.

Institutional and Administrative Support

Institutions must allocate protected time and provide administrative support for training and supervision responsibilities. It is essential to have qualified trainers to maintain safe trainee-to-trainer ratios and ensure continuous supervision. Programme Directors should monitor trainer workloads to balance service and teaching, thereby preserving educational quality.

Trainer skills improvement and evaluation

- ✓ Develop faculty development frameworks to ensure that trainers are proficient in coaching, providing feedback, and understanding assessment literacy.
- ✓ All trainers should have access to CPD and training in medical education, focusing on youth engagement, EPAs, integration of CanMEDS roles, ethics of transition, anti-bias, and cultural safety.
- ✓ Institutional support should also include resources for psychological well-being, mentoring skills, and interprofessional collaboration.
- ✓ Trainers must undergo regular evaluations, including structured feedback from trainees (e.g., anonymous surveys or multi-source feedback), peer or supervisor reviews of teaching performance, and analyses of trainee outcomes and EPA achievement rates.
- ✓ The results of these evaluations should be used to identify trainers who need improvement, recognize high-performing educators, and promote best practices across programmes.

Trainer resilience and capacity building

Trainers play a crucial role as role models, and their well-being directly affects the quality of teaching and patient safety. Institutional policies aimed at developing trainers should include dedicated time for supervision, access to psychological support, opportunities to participate in peer reflective groups, and ongoing professional development. The UEMS recommends that trainers engage in CPD, emphasizing leadership, well-being, and burnout prevention. All of these resources are vital for maintaining educational quality and clinical excellence.

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IV. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

1. Process for recognition as a training center

a. Requirement on staff and clinical activities

Institutions must adhere to well-defined structural, clinical, and academic standards to ensure high-quality and harmonized training in Transitional Care for AYAs across Europe.

Minimal number of patients cared for as inpatients and as outpatients; a minimal number of (surgical) procedures
Training centers must ensure that trainees can access diverse AYAs in outpatient and inpatient settings across disciplines relevant to transitional care. This includes a minimum of 20 documented outpatient encounters and at least five inpatient cases, which should reflect the wide array of transitional needs for AYAs. Additionally, trainees are encouraged to participate in joint consultations or shadowing opportunities in multidisciplinary or transition-specific clinics whenever possible.

Range of clinical specialties required for the training programme
The programme must expose trainees to core disciplines, including adolescent medicine, pediatrics, and internal medicine. Additionally, trainees should gain experience in at least three other relevant specialties based on their foundational training. These may include child and adolescent psychiatry, adult psychiatry, adult medical specialties, gynecology or urology, physical and rehabilitation medicine, psychology, public health, school or occupational health, special educators, and general practice/family medicine. The training setting should accurately reflect the real-world environment of transitional care, encompassing community-based and outpatient services, often the primary points of contact for AYAs.

Composition and availability of faculty
Every trainee must have an assigned educational supervisor, a certified specialist in adolescent, pediatric, or adult specialties related to transitional care. Supervisors must be available for at least three formal review meetings throughout the training period: at the beginning, midpoint, and end. Additional ad hoc meetings are encouraged as needed. Mentors and Programme Directors should be available to support the ongoing development of trainees, promote reflective practice, and assist in integrating EPA-based learning. Trainees should be able to change supervisors, if necessary, with clearly defined institutional policies to facilitate this process.

Training programme defined, guidelines for application

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Institutions must implement a structured training plan that delivers all components of the certified curriculum. A minimum of 4–12 weeks is required (depending on programme intensity), including both onsite (in-person) and virtual (online) training.

Core educational formats should include:

- ✓ outpatient and bedside teaching
- ✓ case-based learning
- ✓ structured role-play and communication training
- ✓ journal clubs and evidence-based medicine sessions
- ✓ audit and quality improvement activities
- ✓ interdisciplinary team meetings and transition planning sessions
- ✓ simulations (e.g., confidentiality scenarios, digital consultations)
- ✓ patient-led teaching, where possible

Every trainee should conduct a final review of their portfolio and EPAs during a structured exit meeting.

Trainee /trainer ratio

Research shows that trainee fatigue and staff shortages directly lead to increased clinical errors and negatively impact learning and patient care. Institutions should maintain a trainee-to-trainer ratio of 4 to 6 trainees per trainer. Exceptions can be made in larger or networked programmes, but the ratio should not exceed 7 to 1. These guidelines help promote safe clinical practice, support professional development, and reduce the risks associated with burnout. They also facilitate meaningful supervision, personalized feedback, and opportunities for direct observation and assessment of EPAs.

Relevant scientific activity

Training institutions should promote academic exploration in adolescent health and transitional care. They should encourage participation in case presentations, scientific professional conferences, research methodology workshops, and projects on quality improvement or service evaluation. Additionally, trainees should be required to submit at least one scholarly work, including a conference abstract, poster, publication draft, or a structured transition project report. Maintaining a logbook and portfolio of scientific activities for each trainee is also important.

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A system for support, counselling, and career guidance of trainees

Training institutions need to establish a strong and structured support system for trainees. This system should include individualized mentorship, regular career planning, and reflective supervision. Mentors must assist trainees with self-assessment, goal setting, and progression towards key competencies. This provides opportunities to pursue CAQ, or CPD modules, and leadership roles in transitional care. Regular discussions should focus on academic progress, personal development, and potential career pathways. Additionally, institutions must provide trainees with access to confidential psychological and emotional support services, especially considering the emotionally complex nature of transitional care for AYAs. These services should encompass counseling, peer support groups, and referral pathways, all within a culture that actively reduces stigma and encourages early help-seeking. Annual appraisals of trainers and educational staff should incorporate feedback from multiple sources, including trainees and institutional evaluation metrics, to enhance the quality of education and responsiveness to trainees' needs.

Promoting trainee well-being and supportive learning environments

Institutions must prioritize fair treatment, non-discrimination, and psychological safety for all trainees. They should establish clear procedures for addressing concerns confidentially and without the risk of retaliation. Creating a psychologically safe, inclusive, and developmentally sensitive training environment is essential for optimizing trainees' learning, performance, and retention. Research highlights that supportive mentorship, flexible training arrangements, protected time for rest and reflection, and acknowledgement of personal life circumstances (e.g., parenting, illness, burnout) are key drivers of educational success and professional sustainability. Trainees working in transitional care are frequently exposed to high psychosocial complexity and clinical uncertainty. As such, institutions must implement proactive well-being strategies, including accessible mental health and well-being resources, normalized channels for requesting help, routine wellness check-ins and reflection sessions, integration of mindfulness, empathy-building, and self-reflective practices into supervision and teaching. These strategies build resilience, prevent burnout, foster empathy, maintain professionalism, and promote safer, more compassionate patient care.

Support for trainer well-being and reflective supervision

Trainers and Programme Directors should receive ongoing support through designated time for teaching, access to national or European "Training the Trainers" updates, opportunities for peer networking, and leadership development initiatives. Institutions should prioritize the well-being and professional development of trainers and mentors. Structured support should include access to mental health services, training on burnout prevention, stress management resources, and

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opportunities for reflective supervision. Trainers must be equipped to recognize early signs of distress in themselves and their trainees. When trainers receive adequate support, they become more effective in delivering education, providing mentorship, and ensuring patient safety.

b. Requirement on equipment, accommodation

To ensure that training institutions can support the development of competencies in Transitional care for AYAs, the following infrastructure and resources must be in place*:*

Medical-technical specialty-specific *equipment*
Training centers must ensure the following:

- ✓ Access to diagnostic and therapeutic equipment necessary for AYAs' care across various specialties, including gynecological and urological examination tools, psychiatric/psychometric assessment instruments, and other necessary testing based on specialty needs and requirements.
- ✓ Availability of age-appropriate tools and settings, including youth-friendly consultation rooms prioritizing privacy, informed consent, and effective communication.
- ✓ Implementation of electronic health records (EHR) systems that enable secure documentation, confidentiality management, and interdisciplinary information exchange.

Clinical and educational activities support trainees' competence acquisition and physical spaces for study to ensure a learning environment.
To effectively support both education and care delivery, institutions should provide the following:

- ✓ Dedicated and quiet workspaces for trainees, equipped with desks, ergonomic seating, internet access, and lockable storage for personal and sensitive materials.
- ✓ Private consultation rooms are suitable for individual, family, or group meetings, designed with youth-sensitive principles. These should ensure confidentiality, create a welcoming atmosphere, and include non-stigmatizing features.
- ✓ Meeting rooms equipped for multidisciplinary team discussions, supervision, teaching sessions, and hybrid learning that combines in-person and remote participation.
- ✓ Shared interprofessional environments, such as adolescent or transitional care clinics, to promote exposure to team-based care.

Opportunities for Research and Development, and physical spaces and resources for research
Institutions should create an environment that promotes:

- ✓ Participation in clinical research, audits, and quality improvement projects focused on AYAs' health and care transitions.

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- ✓ Designated time within the training programme for research activities.
- ✓ Access to institutional review boards, supervisors, and support staff for statistical or research needs.
- ✓ Opportunities to present research at local, national, or European conferences, including those in AYAs' transitional care or medical education.

Information technology support: those required for research, healthcare information systems, patient data, electronic or distance learning resources

- ✓ Up-to-date library resources include physical and online access to medical journals, e-books, clinical guidelines (e.g., NICE, WHO, EU), and educational databases.
- ✓ Robust computing and digital infrastructure, such as computers with secure clinical access, licensed medical and research software (e.g., case logbooks and epidemiological research), learning management systems or e-learning platforms for remote modules and recorded seminars.
- ✓ AI-supported and simulation tools, where available, to train skills such as digital consultations, confidentiality scenarios, and case-based reasoning (e.g., preparation for OSCE and ethical dilemmas).

Virtual and Artificial Intelligence Resources

Institutions must provide or facilitate the following:

- ✓ Access to webinars, telemedicine simulations, and virtual case reviews.
- ✓ Digital literacy training modules and preparation for e-consultation related to EPA 7 (eHealth integration).
- ✓ Secure platforms for submitting portfolios, EPA checklists, assessments, and reflections.

Additionally, digital tools should support real-time communication with mentors, encourage peer collaboration, and provide access to patient education resources.

2. Quality management within training institutions

Practical training in Transitional care for AYAs necessitates a strong governance system that guarantees AYAs responsive healthcare, consistent educational standards, clinical excellence, and accountability. This system should include accreditation, regular audits, faculty development, transparent reporting, and alignment with national and EU health workforce strategies.

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Accreditation and reaccreditation by the national competent authority
All institutions that offer the CAQ in Transitional care must be formally accredited by their national competent authority. Accreditation is granted based on several criteria, including institutional capacity, clinical volume, educational infrastructure, and the qualifications of trainers. Reaccreditation must occur at least every five years and is based on measurable standards such as clinical outcomes, trainees, patients, families, and other third parties' feedback, EPA entrustment rates, and research activity. Institutions must demonstrate compliance with national and European training regulations, as outlined in Directives 2005/36/EC and 2013/55/EU, which pertain to professional mobility and training quality.

Clinical Governance
Institutions must commit to clinical governance frameworks by providing safe, evidence-based care responsive to AYAs. This includes implementing policies that ensure patient confidentiality, consent, and legal protection. Additionally, there should be mechanisms to address patient safety, incident reporting, and continuous quality improvement. For trainees, it is essential to guarantee mentorship, supervision, and access to interdisciplinary consultation, including mental health, reproductive health, and AYAs' health.

Manpower planning is part of the defined national manpower plan.
Training centers must align with national and European health workforce planning to ensure the availability of qualified professionals in AYAs' transitional care. This involves monitoring demographic trends and the prevalence of chronic diseases among youth. Additionally, it is important to ensure a balanced distribution of trainees in high-need areas and to maintain sustainable trainee-to-trainer ratios, ideally at 4:1 or lower. Furthermore, resources should be provided for the long-term development of workforce capacity.

Regular reports on teaching and scientific activities are sent to the relevant authorities
Centers are required to submit annual reports to the appropriate authorities or national bodies. These reports should include the following information: the number of trainees and trainers; a description of structured training activities, such as seminars, bedside teaching, and simulations; completion rates for portfolios and logbooks; research projects, publications, and conference presentations by trainees; feedback mechanisms and quality improvement measures.

Internal auditing and quality assurance
Internal audits must be conducted at least once a year to review teaching quality, EPA implementation, assessment systems, trainee supervision and progression, and trainer development and support.

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External auditing
External audits should be conducted during the reaccreditation process or through national training oversight bodies. These audits may include peer reviews from other institutions or representatives from the UEMS. Additionally, audits should assess compliance with the WFME 2023 Postgraduate Medical Education (PGME) standards, including patient-centered care, digital learning, and interdisciplinary collaboration.

Transparency of training programmes
Training institutions should maintain clear and accessible documentation regarding the curriculum and essential requirements for EPAs, criteria for entry and progression, opportunities for research, clinical placements, the structure of supervision, and mentor assignments. They should also outline grievance procedures and support mechanisms available for trainees.
Training centers need to publish detailed information about their services, their staff's specialties and expertise, and the training programme's overall structure. There should be readily available contact information for a designated individual who can address inquiries from prospective trainees.

Progression through the training programme should be evaluated based on clear and transparent criteria. Any delays in a trainee's progress should be communicated in advance, except in cases involving health issues or professional conduct. Moreover, support systems must be established to assist trainees who face challenges in meeting training requirements. Prospective trainees must have access to public information (e.g., via websites or national registries), including the name of a designated programme contact.

It is recommended that structured program-level evaluations be periodically conducted to monitor educational effectiveness, trainee satisfaction, and alignment with national standards administered by the Competence Committee.

Structure for the coordination of training
Each Organizing Department must appoint a Programme Director, a certified specialist with at least five years of post-certification clinical and educational experience. The Programme Director should have completed formal training, such as the UEMS, national, or local training center recognized "Training the Trainers" course, and demonstrate formal training and leadership in postgraduate education, curriculum implementation, and quality management. The Programme Director oversees curriculum delivery, assessments, and coordination between mentors and trainers, and organizes and delivers the training programme locally. For larger training schemes,

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appointing a deputy or forming a training committee may be necessary to manage the programme effectively.

In cases where training placements are spread across multiple sites, it is important to carefully balance the educational benefits with the impact on the trainee's personal and family life.
A Training Committee is recommended in larger centers, especially when training spans multiple specialties or institutions. Coordination meetings should be held regularly (at least twice a year) between Programme Directors, mentors, and trainers to review progress and provide updates on the curriculum.

Framework of approval – how are they approved
Every programme must receive formal national approval, coordinated by the appropriate certifying or governmental authority in AYAs' health, transitional care, or medical education. The implementation of the transitional care curriculum must adhere to the following requirements: periodic national or regional inspections, compliance with the approved ETR and CanMEDS-aligned EPAs, feedback from stakeholders (including trainees, trainers, patients, and their families), and a review of cross-border compatibility and transferability, as outlined in Directive 2011/24/EU on cross-border healthcare.

By incorporating EPAs, CanMEDS roles, and a learner-centered progression that varies over time, this ETR reflects the latest advancements in postgraduate medical education and serves as a model for harmonizing transitional care training across Europe.

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Glossary including a list of acronyms with explanations

AAC – alternative and augmentative communication
AA-HA! – Global Accelerated Action for the Health of Adolescents
ADHD – attention-deficit hyperactivity disorder
AMSE – the Association of Medical Schools in Europe
AYAs – adolescents and young adults
CAMHS – Child and Adolescent Mental Health Services
CanMEDS – Royal College of Physicians and Surgeons of Canada Physician Competency Framework
CAQ – Certification of Added Qualification
CBME – competency-based medical education
CPD – Continuing Professional Development
CRAFFT – Car, Relax, Alone, Forget, Family & Friends, Trouble – a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12–21. (*Available at: Get the CRAFFT – CRAFFT*)
CRAFFT + N – Car, Relax, Alone, Forget, Family & Friends, Trouble, Nicotine (*Available at: 2.1-CRAFFTN_Selfadministered_2018-04-23.pdf*)
EAP – the European Academy of Paediatrics
EMR – electronic medical records
EPAs – Entrustable Professional Activities

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EQF – European Qualifications Framework
ETR – European Training Requirement
EUSUHM – European Union or School and University Health and Medicine
EuTEACH – European training in effective adolescent care and health team
GAD-7 – General Anxiety Disorder-7 scale (*Available at: Patient Health Questionnaire (PHQ) Screeners. Free Download | phqscreeners*)
GAF – Global Assessment of Functioning Scale *(Available at: Microsoft Word - axisv.doc*)
GDPR – General Data Protection Regulation
HEADSSS – Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety and abuse (Questionnaire) (*Available at: 17.-HEADSSS-Assessment.pdf*)
EHR – electronic health records
IAAH – International Association for Adolescent Health
ICF – WHO International Classification of Functioning, Disability, and Health
mini-CEX – mini-clinical evaluation exercises
MJC – Multidisciplinary Joint Committee
MSF – multi-source feedback
NICE – National Institute for Health and Care Excellence
NICE QS140 – NICE Quality standard 140: Transition from children's to adults' services (*Available at: Overview | Transition from children's to adults' services | Quality standards | NICE*)
NMCAs – National Medical Competent Authorities
OSCE – Objective structured clinical exam
PGME – Postgraduate Medical Education
PHQ-9 – Patient Health Questionnaire-9 (*Available at: Patient Health Questionnaire (PHQ) Screeners. Free Download | phqscreeners*)
SDQ – Strengths and Difficulties Questionnaire (*Available at: sdqinfo.org/py/sdqinfo/b0.py*)
SSHADESS – strengths, school, home, activities, drugs, emotions/eating, sexuality, safety (Questionnaire) (*Available at: Chapter 32: The SSHADESS Screening: A Strength-Based Psychosocial Assessment*).
STI – Sexually transmitted infections
TRAQ – Transition Readiness Assessment Questionnaire (*Available at: The TRAQ in Different Languages*)
UEMO – European Union of General Practitioners
WFME – World Federation for Medical Education
WPBAs – workplace-based assessments
WHO – World Health Organization
WHO-5 – The World Health Organization-Five Well-Being Index (*Available at: The World Health Organization-Five Well-Being Index (WHO-5)*)

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WHODAS 2.0 – WHO Disability Assessment Schedule 2.0 (*Available at: WHODAS-03(23Nov09).book*)

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Appendices, including general UEMS documents

Appendix 1. Training objectives for UEMS specialists pertaining to the care of adolescents and young adults (version Sept 2022)
Appendix 2. Entrustable professional activities (EPAs) in Transitional Care for Adolescents and Young Adults (AYAs)
Appendix 3. Document written by TF Green and Sustainable Medical Practice (available at https://www.uems.eu/documents)
Appendix 4. Document written by TF Equality, Diversity and Inclusivity (available at https://www.uems.eu/documents)

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APPENDIX 1
Training objectives for UEMS specialists pertaining to the care of adolescents and young adults, Version September 2022

Context
Worldwide, the specific health needs of adolescents and young adults (AYA), defined as individuals aged 10 to 24, are increasingly recognized. This phase of exploration and shaping one's identity drives opportunities and risks, such as improved self-confidence, health-enhancing behaviors, poor therapeutic adherence, and lack of long-term vision, potentially interfering with treatment. Both specialists and primary care practitioners (e.g., in-practice pediatricians, general practice/family medicine specialists, and school physicians) can play a pivotal role in tailoring their approach to the specific needs of AYAs. This training package has been developed by UEMS Multidisciplinary Joint Committee members in Adolescent Medicine and Health (Chair, Prof. P.-A. Michaud, Lausanne, Switzerland), an initiative launched by the European Academy of Pediatrics. The content has been carefully discussed and reviewed by the MJC members and an international group of experts working in the field and belonging to the Euteach training program (www.euteach.com).

The present document lists a set of practical, clinically oriented, holistic objectives that should allow all European specialists and primary care providers (pediatricians and family physicians) to respond better to the special health care needs of AYAs. They are competency-based and integrate knowledge, attitude, and skills. In this respect, they are inspired by the CanMEDS model and the "EPA" (Entrustable Professional Activities) approach. They can be freely adapted to the specific healthcare approaches and topics of various UEMS specialties (including pediatricians) and family physicians. Additionally, they should be applied considering the variety of cultural and legal frameworks of European countries. Soon, it is foreseen to develop an accompanying tutorial (content, slides, and videos) to assist trainers in implementing and developing teaching sessions.

The health care provider initiates and conducts the consultation with an AYA patient in a developmentally appropriate way (considering the patient's puberty stage, age, as well as cognitive & affective level)

- ✓ Offers a setting that respects privacy and guarantees a trustworthy, empathetic, and respectful relationship with the patient,
- ✓ Explains confidentiality and makes sure to get time alone with the patient for an appropriate part of the consultation. Agrees with the AYA on what to disclose or not to disclose to the parent/guardians by the end of the consultation

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- ✓ Uses developmentally appropriate communication skills: adapts language and wording to the age/cognition, verifies that the patient understands the information
- ✓ Clarifies the reason for the consultation, its goal, and process. Gives the parents/guardians time to voice their worries
- ✓ Is attentive to cues for undisclosed problems ("hidden agenda").
- ✓ Assesses the adolescent's capacity for autonomous decision-making (competence)
- ✓ Involves the parents/guardians in the evaluation, treatment, and further measures, balancing the importance of the patient's privacy and increasing autonomy on one hand and the communication within the family on the other hand
- ✓ Pays attention to the needs of AYA minority groups, low socio-economic groups, the homeless, refugees, and LGBTQ. Collaborates with a trained interpreter when meeting AYAs & their families of foreign origin/cultural context.

The health care provider assesses and responds to the patient's lifestyle/behavior in a non-judgmental way, paying extra attention to areas prone to be problematic in the age group, and the AYA's resources *(The HEADSSS acronym provides valuable guidance in this regard)*

- ✓ Assesses the patient's cognitive and affective development and daily functioning
- ✓ Identifies AYAs' personal and environmental resources/protective factors, including the presence of a trusted adult(s)
- ✓ Discusses daily leisure, diet, sports, and social activities
- ✓ Assesses school/academic performance, screens for learning difficulties and other conditions (developmental/neurocognitive) leading to poor academic outcomes
- ✓ Screens for overt and covert symptoms of depression and/or anxiety in exploring mood, behavior, and expectations. Identifies self-harm, suicidal ideation, and former or planned suicide attempts, as well as any victimization or violence
- ✓ Explores the value of substance use from the patient's viewpoint, the patient's use/misuse of drugs, the associated risk factors, the perceived range of consequences, and the preparedness for change
- ✓ Discusses screen/internet/social media misuse and its health consequences
- ✓ Respectfully explores sexuality and reproductive life, including questions of gender identity and sexual orientation. Responds appropriately to everyday situations
- ✓ Assesses safe/unsafe sexual behavior and risk for sexually transmitted infection and treats or refers for treatment; identifies need for contraception and responds empathetically to a suspected or verified pregnancy (pregnancy test, referral)
- ✓ Opens up for disclosure of subjection to violence and involvement in criminal activity.

The healthcare provider performs a physical examination, taking into account the

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patient's growth and development

- ✓ Explains the process of any physical examination and the reasons for it
- ✓ Adapts the examination to the AYAs' complaints/symptoms, physical/sports activity, social, and professional background
- ✓ Follows a sequence that respects patient comfort and intimacy
- ✓ Evaluate and comment on the patient's pubertal stage (e.g., Tanner stage)
- ✓ Assesses systems that change, particularly during puberty (skeletal, sight, skin, etc.)
- ✓ Investigates body shape's representations and self-image within the cultural and social context

The health care provider provides appropriate care to an AYA living with a chronic condition and facilitates transition and adaptation to adult health care settings

- ✓ Assesses the impact of a chronic condition on the patient's daily functioning
- ✓ Fosters an inter-professional approach and collaborates with the appropriate resources and people to assist the patient in coping with the chronic condition and life
- ✓ Promotes optimal adolescent development: minimizes the impact of the chronic condition on education and social life, together with interdisciplinary team members
- ✓ Promotes self-confidence and the capacity to manage health and illness
- ✓ Beyond the care of the chronic condition itself, addresses the basic health care needs of the patient (HEADSSS, immunization, complaints regarding general health)
- ✓ Participates in the transition process from pediatric to adult health care settings: preferred age for transfer, adolescent's expectations, available support during the transition (e.g., clinical nurse, social worker, and psychologist), and joint consultation with both pediatric and adult health care provider. The AYA is actively involved in all transition decisions.

Training tool

Teachers and mentors who want to set up training sessions (bedside, small groups, Lectures) can access a series of concrete training tools developed by EuTEACH faculties (www.euteach.com) to cover the UEMS training objectives. They can be handy to professionals who are not familiar with the field of adolescent medicine and health. They are *freely accessible* at the following link.

In addition, the Euteach website offers a set of educational illustrations on how to organize and deliver effective and interactive training: https://www.unil.ch/euteach/home/menuinst/how-to-teach/interactive-teaching-methods.html

Document "*Training objectives for UEMS specialists pertaining to the care of adolescents and young adults, Version September 2022*" is available at: https://www.uems.eu/documents

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APPENDIX 2
ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAs) IN TRANSITIONAL CARE FOR ADOLESCENTS AND YOUNG ADULTS (AYAs)
Prepared by the UEMS Adolescent Medicine and Health Multidisciplinary Joint Committee,
Version October 2025

EPAs are the foundation for a progressive and flexible training approach, allowing trainees to advance at their own pace and ensuring they are ready based on demonstrated competence. In the context of transitional care, EPAs are particularly important because they address the complexities of managing adolescents and young adults (AYAs) across varying developmental, legal, and psychosocial areas, often within fragmented pediatric and adult care systems. Entrustment involves more than simply completing tasks; it includes trust in the trainee's judgment, professionalism, communication skills, and ability to deliver safe, developmentally appropriate care.

Each EPA defines a crucial unit of work essential for transitional care, which can be entrusted to a trainee upon demonstrating sufficient competence. They are organized according to UEMS standards and aligned with CanMEDS roles. Entrustment decisions enhance accountability, patient safety, and cross-border recognition of qualifications.

EPA 1
CONDUCT A TRANSITION-ORIENTED CONSULTATION

***Rationale**:*
Adolescents and young adults (AYAs) require developmentally appropriate assessment as they are continuously going through stages of identity formation, psychosocial change, and chronic disease management. Identifying the prevalence of psychiatric conditions, developmental, and mental health problems is crucial, as they may interact with both physical health problems and risky behavior. Assessing the physical, psychosocial, educational, and relational aspects of this age group and addressing or avoiding health and disease-related factors is important for healthcare providers, and these assessment skills need to be trained.

***Specification**:*
Conduct a structured, comprehensive, and holistic assessment of AYAs with chronic diseases and health problems, considering their developmental stages, maturity, and medical, psychosocial, and transitional needs. This assessment should assess and adjust maturity in the biological, psychological, cognitive, and sexual domains. Determining the psychosocial factors that may

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support or hinder self-care and health management is also essential. This assessment can be carried out directly as part of the structured transition model visit or indirectly included in any consultation with the AYA.

EPA 1	**Conduct a transition-oriented consultation.**
Key tasks	✓ conduct consultations adapted to the individual's age, maturity, cognitive/emotional level, and communication abilities. ✓ use interpreters, sign language, alternative and augmentative communication (AAC), or proxy communication as needed to ensure mutual understanding and patient engagement. ✓ assess the developmental maturity of the individual and explore their social support using tools like HEADSSS, SSHADESS, and similar assessments. ✓ screen for decision-making maturity and transition readiness using the TRAQ tool. ✓ evaluate transition-related health literacy and life skills. ✓ discuss expectations and clarify the visit's purpose, agenda, and duration. ✓ address confidentiality and explain its limitations. ✓ conduct a structured biopsychosocial interview, focusing on strengths and protective factors. ✓ identify social determinants, life goals, and anticipated social transitions (e.g., education, school performance, employment, living arrangements, relationships). ✓ screen for general physical and mental health, developmental disorders, learning disorders, lifestyle choices, and risky behaviors. ✓ for minors, identify the needs and challenges of caregivers related to the adolescent's condition and provide adequate support. ✓ review pediatric health, therapies, adherence, side effects, and immunization records. ✓ check current healthcare contacts and ensure continuity of care plans. ✓ build rapport and address any revealed risks or healthcare needs. ✓ collaborate with pediatric teams and child and adolescent mental health care teams.
Potential risks in case of failure or if missed	✓ missed diagnoses (e.g., mental health, substance use, or social vulnerabilities) or other underrecognition of issues ✓ delayed intervention ✓ ineffective patient engagement and non-adherence to treatment plans ✓ fragmented care, leading to disjointed patient experiences ✓ discontinuity in care and loss of follow-up after patient transfer ✓ legal risk arising from misunderstandings regarding autonomy and confidentiality

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	✓ poor long-term health outcomes, poor professional development, and lack of autonomy
CanMEDS roles	Medical expert, Communicator, Collaborator, Health advocate, Scholar
Required knowledge, skills, attitudes	***Knowledge*** – understanding the developmental stages of adolescence and emerging adulthood; transition policies; readiness models; and adequate documentation. Familiarity with psychosocial screening frameworks, life skills, autonomy, and consent laws. Awareness of the needs and concerns of AYAs, as well as psychosocial issues and common challenges they face, knowledge of chronic condition trajectories and adolescent-specific difficulties, along with principles of trauma-informed care. ***Skills*** – proficiency in motivational interviewing, active listening, tailored to the AYA, recognition of cultural diversity, risk screening and psychosocial support, development of transition plans, shared decision-making and interdisciplinary communication, use of electronic medical records. ***Attitudes*** – demonstrating a youth-centered approach, and effectively adapting communication to meet language, cultural, and functional needs; documentation should reflect how these strategies supported shared understanding; key attitudes – respect for autonomy, privacy, diversity, empathy, patience, cultural humility, flexibility, non-judgmental communication, and proactive thinking in transition planning.
Assessment tools	*To assess knowledge* – case-based discussion (focusing on developmental stages and HEADSSS, SSHADESS, or similar frameworks), portfolio entries that include reflection logs, transition plans, TRAQ readiness tools; *To assess skills* – mini-CEX (consultation performance assessment), short practice observation (to evaluate trust-building, confidentiality), OSCE scenarios (to evaluate structured communication and consultation skills); *To assess attitudes* – evaluation of work product (consultation notes, summary letters, communication with primary care providers), multi-source feedback (from peers, patients, families, team members).
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or after significant updates to transition care policy or AYA care standards.

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EPA 2
MANAGE CONFIDENTIALITY, EVOLVING CAPACITY FOR DECISION-MAKING, AND MEDICAL AUTONOMY IN ADOLESCENTS AND YOUNG ADULTS (AYAS)

***Rationale**:*
During the transition from dependency (when legal minors may be mature enough to make certain decisions) to adulthood (when individuals are adults but may still need additional support to make a successful transition), it is important to understand the changing rights, different laws on consent and confidentiality, and the professional obligations in other jurisdictions, accompanied by ethical considerations and empowerment strategies. This EPA focuses on ethical and legal care, supporting and promoting autonomy and trust.

Specification:
Address the practical, emotional, and legal implications of working with adolescents and young adults (AYAs) and their ability to give informed consent, rights to confidentiality, data protection, and information disclosure.

EPA 2	**Manage confidentiality, evolving capacity for decision-making, and medical autonomy in AYAs.**
Key tasks	✓ assess the capacity of AYAs to make shared decisions and, if applicable, document the rationale for medical autonomy; ✓ clarify the laws on consent; ✓ ensure confidentiality and demonstrate a commitment to support and maintain mutual trust between the caregiver and the AYAs. ✓ regularly provide time for patients to be alone during at least part of the consultation. ✓ ethically involve caregivers, and inform adolescents and caregivers about confidentiality and its limitations or exceptions. ✓ make sure the patient genuinely agrees to the participation of student or junior staff, and allow for the option to withdraw consent during the consultation or examination. ✓ address exceptions and situations of partial autonomy, especially when parental or caregiver involvement is complex (e.g., risks of harm, reporting requirements, crises that may require a temporary suspension of confidentiality, and multidisciplinary safeguarding actions). ✓ adhere to General Data Protection Regulation (GDPR) and national legislation regarding consent. ✓ inform and implement proper documentation procedures for at-risk patients (e.g., those experiencing honour-based oppression or similar

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	issues). ✓ encourage discussion of sensitive topics, while, if appropriate, advise against impulsive or excessive disclosures of sensitive information, particularly if follow-up may not be feasible.
Potential risks in case of failure or if missed	✓ loss of patient trust or confidentiality ✓ legal and ethical violations ✓ harm due to inappropriate autonomy ✓ reduced patient engagement and non-compliance ✓ undocumented decisions leading to inconsistency in care
CanMEDS roles	Professional, Communicator, Health advocate, Leader
Required knowledge, skills, attitudes	***Knowledge –*** understanding of national and EU laws, such as GDPR; awareness of e-records for at-risk patients; knowledge of minors' legal rights, consent thresholds, and confidentiality standards; familiarity with ethics frameworks emphasizing autonomy and beneficence; comprehension of WHO guidelines for assessing and supporting the capacity for autonomous decision-making. ***Skills –*** proficient in ethical reasoning and decision-making; capable of mediating and resolving conflicts; skilled in legal and clear communication with diverse stakeholders; adept at maintaining precise legal documentation. ***Attitudes –*** commitment to respecting the autonomy, rights, and dignity of AYAs; integrity; ethical and cultural sensitivity; a non-judgmental approach; dedication to transparency, positive youth development, and youth empowerment.
Assessment tools	*To assess knowledge* – legal case-based discussions (focusing on consent, confidentiality, data protection), legal and policy review (including national laws, GDPR, UEMS guidance); *To assess skills* – direct observation of communication and procedural skills (related to confidentiality discussions), objective structured clinical examination (OSCE) (with ethical–legal scenario), longitudinal practice observation (to ensure consistency in supporting autonomy); *To assess attitudes* – ethics feedback (from supervisors, peers, AYAs), portfolio reflections on ethical dilemmas encountered during practice.
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or whenever there are significant legal updates.

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EPA 3
IDENTIFY AND ADDRESS DEVELOPMENTAL, COGNITIVE, AND PSYCHOSOCIAL FACTORS AFFECTING ADOLESCENTS AND YOUNG ADULTS (AYAS) DURING THE TRANSITION

Rationale:
Existential, developmental, cognitive, psychosocial, and mental health problems are prevalent in adolescents and young adults (AYAs) with chronic diseases. They are an integral part of the transition process, as it is their main priority. To provide holistic care, addressing these stressors for AYAs is important. This EPA assesses identity, education, employment, sexual well-being, family planning, future goals, and coping strategies.

Specification:
Identify and address common factors that can negatively affect AYAs in transition and overall quality of life in chronic and complex conditions. This includes psychosocial well-being, resilience, employability, academic opportunities, housing options, presence or absence of social or relational support, and AYA-specific needs. It is important to consider their emerging identity formation, to carry out screening on mental health, cognitive/learning abilities, and substance use, social stressors, resilience, explore lifestyle choices, and provide practical or emotional support.

EPA 3	**Identify and address psychosocial factors affecting AYAs during the transition.**
Key tasks	✓ conduct open, developmentally appropriate mental health conversations and structured mental state exams by a trusted clinician, especially when self-reports are insufficient or suggest distress and mental health difficulties ✓ assess AYA´s situation, mental health and social support using validated Patient-Reported Outcome Measures (PROMs) as needed (e.g., WHO-5, PHQ-9, GAD-7, SDQ) in electronic versions when it's possible. ✓ conduct a comprehensive assessment of functioning, using WHODAS 2.0, the ICF checklist, GAF scale, or other tools to understand the patient's capabilities; when appropriate, coordinate with rehabilitation or other services due to functioning and disability by national and local laws. ✓ screen for self-harm, family conflict, and trauma. ✓ screen for substance use using the CRAFFT, and/or CRAFFT+N tools. ✓ assess and discuss how a disability or chronic condition may affect developmental domains, cognitive abilities, and psychosocial functioning. ✓ evaluate the need for referral or follow-up for developmental, cognitive, mental health, or substance use concerns.

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	✓ promote resilience and coping strategies, including counseling and encouraging a healthy lifestyle. ✓ address emotional distress related to transitions, stigma, school/work changes, and family/peer dynamics. ✓ integrate mental health care into overall treatment. ✓ discuss issues related to identity, relationships, and existential questions. ✓ explore sexual health and well-being generally, and in the context of living with or receiving treatment for a chronic condition or disability (including menstrual health and gender identity issues). ✓ identify potential needs for vocational or educational services and facilitate referrals or contact.
Potential risks in case of failure or if missed	✓ missed or late diagnoses (e.g., depression, eating disorders, ADHD) ✓ unaddressed trauma ✓ suicide or self-harm risk ✓ short- and long-term disengagement from self-management and healthcare follow-up, poor health outcomes ✓ school or work drop-out and absences
CanMEDS roles	Medical expert, Scholar, Health advocate, Collaborator, Communicator
Required knowledge, skills, attitudes	***Knowledge*** – developmental psychology focusing on AYAs; understanding developmental stages and identity formation; trauma-informed care approaches; awareness of neurodiversity; understanding of gender and sexual development; knowledge of local support services. ***Skills*** – proficiency in motivational interviewing techniques for AYAs; experience with risk assessment and screening; short-term counseling abilities; mental health first aid; interdisciplinary referral and care planning. ***Attitudes*** – empathy and active listening; openness to diverse identities and needs; a youth- and family-centered approach; commitment to empowerment, resilience-building, and harm reduction; emphasis on cultural safety and inclusivity.
Assessment tools	*To assess knowledge* – case-based discussions focusing on developmental and psychosocial challenges, use of validated tools (CRAFFT, PHQ-9, SDQ, and structured mental state examination); *To assess skills* – mini-CEX (for psychosocial assessment encounters), short practice observation targeting developmental and psychosocial assessment; *To assess attitudes* – multi-source feedback (from team members, AYAs, and families), reflective logs (to evaluate aspects of identity, resilience, coping).
Entrustment target	Level C–D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or after significant changes in practice, policy, inactivity, or major guideline updates.

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EPA 4
PROMOTE HEALTH EQUITY AND PROVIDE INCLUSIVE, CULTURALLY SAFE CARE

Rationale:
Healthcare inequalities disproportionately affect marginalised, vulnerable adolescents and young adults (AYAs), including migrants, refugees, LGBTQ+ young people, and people experiencing poverty. The EPA defines how to provide safe, inclusive, appropriate, and timely transitional care.

Specification:
Identify systemic barriers and apply equity-focused, culturally safe approaches to communicating, planning services, and providing inclusive and accessible care for AYAs. It is important to address health inequalities by tailoring care and considering language, gender, socio-economic status, trauma history, and individual capacity.

EPA 4	**Promote health equity and provide inclusive, culturally safe care.**
Key tasks	✓ identify the social determinants of health, which include housing, economic status, immigration issues, education, work, social networks, and sexual identity; ✓ use equity checklists and address implicit biases; ✓ apply culturally appropriate communication techniques; ✓ use interpreters and cultural liaisons as needed; ✓ adapt care for neurodiverse youth or those with low literacy skills; ✓ implement trauma-informed care practices; ✓ ensure shared decision-making between caregivers and adolescents; ✓ create an appropriate environment for encounters by identifying and addressing any physical, emotional, or other barriers in the setting; ✓ adjust and accommodate follow-up and treatment plans according to cognitive, cultural, socio-economic, or other factors; ✓ assess how the beliefs of both AYAs and their caregivers or trusted adults impact the condition and its treatment; ✓ evaluate the need for education or additional support for caregivers and trusted adults to enhance their ability to support the AYAs and promote their autonomy; ✓ connect to community services.
Potential risks in case of failure or if missed	✓ dropout from care ✓ patient disengagement and systemic mistrust ✓ health inequities ✓ loss of referrals to social services for financial assistance

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	✓ poor health outcomes
CanMEDS roles	Health advocate, Professional, Communicator, Collaborator
Required knowledge, skills, attitudes	***Knowledge*** – Understanding health disparities and principles of health equity; developing transcultural competence; recognizing intersectionality; implementing inclusive communication practices; addressing communication barriers for AYAs; utilizing nonverbal communication aids; and being informed about LGBTQ+ issues. ***Skills*** – recognizing and mitigating biases; engaging in cross-cultural and inclusive communication; planning equity-based care; working effectively with underserved communities; and facilitating shared decision-making. ***Attitudes*** – embracing humility and persistence; fostering inclusivity, openness, and reflexivity; committing to justice and social accountability; and demonstrating flexibility.
Assessment tools	*To assess knowledge* – equity checklists to identify systemic barriers and recognize biases, simulation with bias and cultural safety scenarios; *To assess skills* – case-based discussions focusing on equity and accessibility planning, structured feedback from peers, nurses, and AYAs regarding inclusivity; *To assess attitudes* – multi-source feedback (from supervisors, allied professionals, AYAs), evaluation of work product such as transition plans, and documentation to ensure they reflect inclusivity and accessibility.
Entrustment target	Level C
Period to expiration if not practiced	Undergo diversity, equity, and inclusion (DEI) training every five to ten years based on national or local certification requirements.

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EPA5
COORDINATE COMPLEX, INTERDISCIPLINARY TRANSFER OF ADOLESCENTS AND YOUNG ADULTS' (AYAS') CARE

Rationale:
Successful transition of complex cases involving adolescents and young adults (AYAs) requires collaboration between pediatric and adult health services. In the transition from pediatric to adult care education, mental health and social sectors might be involved, especially for individuals with chronic illnesses or disabilities. This EPA focuses on continuity, consistency, and success in managing high-risk cases.

Specification:
Coordinate and manage the interdisciplinary transition of AYAs with chronic or rare conditions, as well as complex medical, neurological, or psychosocial needs, as they move into adult care. This process may involve working with education, justice, and social care systems where needed and relevant.

EPA 5	**Coordinate complex, interdisciplinary transfer of AYAs' care.**
Key tasks	✓ develop individualized written transition plans in collaboration with the patient; ✓ coordinate referrals by preparing both the patient and their family for the transfer process; ✓ actively seek ways to involve schools, social services, and other community supports to facilitate the transition in various aspects; ✓ address the concerns of AYAs and their caregivers or trusted adults regarding the transfer; ✓ lead multidisciplinary case meetings, engaging both pediatric and adult teams in joint planning, and social services in collaboration with AYAs and their families, if applicable; ✓ collaborate with the referring parties (pediatric or others) and the parties receiving the referral; ✓ ensure continuity of care post-transfer, making sure that access to healthcare (including prescriptions and communication) is uninterrupted, especially for complex or rare diseases; ✓ monitor the adaptation process post-transfer and follow up as needed; ✓ request feedback after the transfer.
Potential risks in case of failure or if missed	✓ care fragmentation, , and patient drop-out ✓ gaps in treatment and poor adherence ✓ decompensation, readmissions, or complications

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	✓ poor health outcomes ✓ patient and family distress or disorientation
CanMEDS roles	Leader, Collaborator, Medical expert, Communicator
Required knowledge, skills, attitudes	**Knowledge** – familiarity with general transition frameworks such as the Six Core Elements, Got Transition, and Stepstones; understanding of chronic illness-specific transition models; awareness of care pathways across youth services **Skills** – proficient in project management and handover coordination; effective in team leadership and interprofessional teamwork; skilled in inter-agency communication; capable of facilitating joint visits; experienced in crisis planning and safety-netting. **Attitudes** – committed to accountability and team collaboration; proactive and advocacy-oriented; inclusive of families; patient and flexible; persistent; and knowledgeable in holistic/system thinking.
Assessment tools	*To assess knowledge* – joint case presentation (interdisciplinary transition plan), case-based discussion (complex cases); *To assess skills* – direct observation of team handovers, simulation (complex interdisciplinary scenario), longitudinal practice observation (repeated team coordination); *To assess attitudes* – multi-source feedback (including input from allied professionals), evaluation of work product (referral letters, transition summaries, care plans, trajectory review), portfolio (examples of collaborative practice).
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or following any restructuring or reform of the health system.

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EPA 6
EMPOWER ADOLESCENTS AND YOUNG ADULTS (AYAS) FOR SELF-MANAGEMENT AND SHARED DECISION-MAKING

***Rationale*:**
Adolescents and young adults (AYAs) who have become more responsible for their care during the transition period need to develop the self-management skills necessary for shared decision-making, so that AYAs can adhere to their treatment regimen and self-care, become more self-confident, and achieve better long-term health outcomes. This EPA highlights how to provide a supportive and safe environment for self-management and improve problem-solving skills in AYAs.

Specification:
Improve self-care behaviors and skills of AYAs with chronic conditions related to health literacy, goal setting, and self-management by structured training, coaching, and shared decision-making. This approach is essential to promote long-term engagement and success.

EPA 6	**Empower AYAs for self-management and shared decision-making.**
Key tasks	✓ assess readiness for self-management using tools like the Transition Readiness Assessment Questionnaire (TRAQ) or other readiness assessment tools; ✓ apply motivational interviewing techniques; ✓ explore knowledge about the condition, medications, medical devices, appointments (including healthcare organization and regulations), and previous health history; provide education as needed; ✓ increase awareness among AYAs about their strengths, resources, and protective factors; ✓ encourage communication and boost confidence in shared decision-making; ✓ promote responsibility through goal-setting and self-monitoring; ✓ validate positive health behaviors and acknowledge achievements; ✓ empower autonomy by supporting the patient and caregivers in gradually shifting responsibility, and facilitate support from trusted adults or partners as they transition into young adulthood; ✓ utilize patient organizations, peer groups, or young advisory boards in individual encounters and while planning transition strategies; ✓ encourage patients and caregivers to participate in peer learning; ✓ review personal goals and plans regularly.

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Potential risks in case of failure or if missed	Low confidence and dependency, poor adherence, incomplete transfer, regression in adult care, poor health outcomes, and caregiver burnout or resistance.
CanMEDS roles	Health advocate, Scholar, Communicator, Professional
Required knowledge, skills, attitudes	***Knowledge*** – understanding the principles of adolescent development and autonomy, behavior change theories, health coaching models, and motivational enhancement techniques. ***Skills*** – proficient in coaching and teaching, utilizing strengths-based goal-setting, engaging caregivers in supportive care, and evaluating readiness for change. ***Attitudes*** – maintain a supportive and empowering approach, foster a growth mindset, and respect the learning curve and developmental timing of AYAs.
Assessment tools	*To assess knowledge* – case-based discussions on health literacy, goal-setting, and decision-making theory, the TRAQ tool for assessing self-management readiness; *To assess skills* – mini-CEX (focusing on goal setting and decision-making consultation), objective structured clinical examination (OSCE), or role play with standardized patients to assess shared decision-making scenarios, longitudinal practice observation to track progression of shared decision-making; *To assess attitudes* – feedback of AYAS and their caregivers (regarding empowerment and communication), portfolio reflections on challenges of coaching self-management, mentor reviews assessing attitudes toward empowerment and partnership.
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles.

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EPA 7
INTEGRATE DIGITAL TOOLS AND E-HEALTH IN TRANSITIONAL CARE

Rationale:
Adolescents and young adults (AYAs) are digital natives. Effective and safe use of digital tools, telehealth, and e-health platforms increases engagement, reduces barriers, and promotes empowerment and autonomy. All healthcare professionals need to be aware of health technologies and digital communication during transition, especially in remote settings with complex needs.

Specification*:*
Use safe, appropriate, youth-friendly digital platforms (telehealth, apps, electronic medical records (EMR), and patient portals) for care, education, and communication with AYAs in transition, ensuring safety, confidentiality, and digital inclusion. When working with AYAs with special needs, it is important to integrate family or caregiver supervision when appropriate while promoting the adolescent's autonomy and active participation in digital care.

EPA 7	**Integrate digital tools and e-health in transitional care.**
Key tasks	✓ assess digital health literacy skills; ✓ conduct e-consultations; ✓ utilize secure messaging, portals, and telehealth for follow-up during transitions; ✓ engage AYAs in digital self-management and guide them on using health apps and platforms; ✓ adapt digital communication to ensure it is age-appropriate. ✓ monitor for signs of digital disengagement; ✓ educate on cyber safety and confidentiality, ensuring equitable access to technology.
Potential risks in case of failure or if missed	Privacy and confidentiality breaches, patient disengagement, digital exclusion, technology misuse or over-reliance, disconnection from services, misinformation, and unsafe practices.
CanMEDS roles	Scholar, Communicator, Leader, Health Advocate
Required knowledge, skills, attitudes	***Knowledge*** – understanding principles of e-health application ethics and EU General Data Protection Regulation (GDPR); digital health literacy skills evaluation; etiquette for teleconsultations; health apps and tools commonly used by youth.

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	Skills – conducting telehealth consultations, managing risks in digital communication, creating youth-centered messaging, and detecting digital red flags. ***Attitudes*** – an openness to innovation, a proactive approach to promoting cyber literacy, and caution in safeguarding personal boundaries.
Assessment tools	*To assess knowledge* – digital literacy checklist (safe use of platforms), portfolio review of digital cases (telehealth, apps, EMR usage); *To assess skills* – objective structured clinical examination (OSCE) station (teleconsultation, eHealth integration), simulation (technical scenario, confidentiality in digital use), evaluation of work products (telehealth notes, use of eHealth tools, eHealth documentation); *To assess attitudes* – feedback from AYAs and families regarding their experience with digital care, and platform audits to ensure inclusive and safe use of digital tools.
Entrustment target	Level C
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or when significant national or EU legislation changes occur.