


Transitions From Pediatric to Adult Care

Global Pediatric Health
Volume 4: 1–2
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DOI: 10.1177/2333794X17744946
journals.sagepub.com/home/gph


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Received August 2, 2017. Accepted for publication October 20, 2017

The process of transition of care of adolescents with special health care needs has been recognized as a priority in the past years, especially with the new advances in medical technology that has improved the lives of children with chronic conditions. The prevalence of adolescents between 12 and 18 years with special health care need is 18.4%, a double that of young children.¹

Health care transition is the process of changing from a pediatric to an adult model of health care. There are significant differences between adult and pediatric health care model, which may affect adherence by young adults with chronic diseases. Pediatric care is family oriented and relies on significant parental involvement in decision making; however, adult care is patient-specific and requires autonomous, independent skills of patients, without many interdisciplinary resources. Health care transition is important for all youth, even if they do not have special needs in order to maximize lifelong functioning and well-being.² Although several models have been proposed, it is widely accepted that a well-timed transition from child-oriented to adult-oriented health care is specific to each person, and ideally should occur between the ages of 18 and 21 years.

Position statements by the leading primary care organizations, including the American Academy of Pediatrics in 2002 and 2011, are a step toward addressing this need. In 2002, a consensus statement coauthored by the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians-American Society of Internal Medicine was published, stating the importance of supporting and facilitating the transition of adolescents with special health care needs into adulthood. The consensus statement articulated 6 “critical first steps” to ensuring the successful transition to adult-oriented care:³

1. Ensure that all young people with special health care needs have an identified health care professional who attends to the unique challenges of transition and assumes responsibility for current health care, care coordination, and future health care planning.

2. Identify the core knowledge and skills required to provide developmentally appropriate health care transition services to young people with special health care needs; and to make them part of training and certification requirements for primary care residents and physicians in practice.
3. Prepare and maintain an up-to-date medical summary that is portable and accessible, providing a common knowledge base for collaboration among health care professionals.
4. Development of up-to-date and detailed written transition plans, in collaboration with young people and their families.
5. Ensure that the same standards for primary and preventive health care are applied to adolescents.
6. Ensure that affordable, comprehensive, and continuous health insurance is available to young people with chronic health conditions throughout adolescence and into adulthood.

After more than a decade of effort, widespread implementation of health care transition systems has not been realized. A recent review revealed that more than half of the adolescents with chronic health conditions report inadequate support and services during their transition to adult health care.¹ Many factors have been recognized as obstacles to a proper transition of care including inadequate planning, poor service coordination, lack of resources, and gaps in education and training. A survey revealed that majority of general internists and pediatricians are not comfortable providing primary care for young adults with chronic illnesses of childhood origin, such as cystic fibrosis and sickle cell disease.⁴ Other factors identified are the physical and psychosocial developmental changes that accompany adolescence,

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some of which adult doctors may not be used to. Together, these challenges contribute to potentially serious health-related consequences including patient disengagement, poor treatment adherence, increased hospitalization rates, and overall detrimental health outcomes.⁵

The role of pediatricians in the process of transition of care is especially important, since we are in frequent contact with the adolescents and build a close relationship with their families. The process begins with the development of a transition policy and its dissemination to all families, to ensure they can understand that transition planning will be part of chronic care management. This plan should be developed with the adolescents and family members, and should be updated in subsequent visits until the patient is ready for implementation in early adulthood. It is important to document the steps to be conducted to meet the identified needs, as well as identifying appropriate adult care resources. Tools we can implement in our practice are the “Transition Youth Registry” to track the progress of each patient in the transition process, and a “Longitudinal Readiness Checklist” to assess the adolescent’s ability for independence and self-management. Other tools can also be found online as part of the “Got Transition” program from the National Health Care Transition Center. Finally, we should ensure an appropriate coordination between pediatric and adult specialties and subspecialties involved in the transition process.

Transition of care should also be part of the didactic curriculum in residency programs. There is lack of training in transition of care at many levels including undergraduate/graduate medical education and maintenance of certification. One third of the programs have not provided any education about transition of care. Recent graduates of pediatric residency programs have also recognized gaps in training to deal with children with chronic illnesses.⁶

Our role goes beyond the care of patients with chronic diseases. There is an increasing demand for transition services in the pediatric population, creating a need to conduct outcome research to develop transition policies and programs. Current guidelines are mostly based on expert opinion, since the evidence on transition outcomes is limited.⁷ Priorities for future research should include measuring transition readiness and skills, transfer-of-care processes, and posttransfer health outcomes, including long-term impact in the improvement of care for these patients.⁶ These results may drive future changes in health policy, financing, and medical education.

Author Contributions

CC: Contributed to conception and design; drafted the manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

EK: Contributed to analysis; critically revised the manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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