Coordination eases the transition from pediatric to adult health care

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New research in the *Journal of Adolescent Health* finds that when a young person moves from pediatric care to an adult practice, the transition is eased and better care is provided when formal processes are in place for the handoff. The transition of care was found to be most effective if planning begins when patients are 12 to 14 years old.

"There are about 18 million adolescents ages 18-21 in the United States," explained lead author Margaret McManus, MHS, of the National Alliance to Advance Adolescent Health in Washington, DC. About 25 percent of them have chronic conditions, she said, and "most are ill-prepared for adult-centered care."

McManus and her colleagues measured the effectiveness of the "Six Core Elements of Health Care Transition," a quality-improvement model for transitioning from pediatric to adult primary care. The six core elements include 1) having an office policy on transition, 2) provider knowledge and skills related to transition, 3) a registry that identifies transitioning youth, 4) transition preparation, 5) transition planning and 6) transfer of care.

The researchers worked with five large primary care practices in Washington, DC: two adolescent clinics, one pediatric clinic, one family medicine clinic and one internal medicine clinic. Altogether, 528 youths took part in the study.

The five practices participated in a learning collaborative that focused on implementing and evaluating the six core elements to improve transition from pediatric to adult care. The majority of patients studied were African-Americans enrolled in a Medicaid managed-care organization.

Each practice formed a team that comprised a physician, a care coordinator (e.g., nurse or social worker) who focused on transition and the young patient or parent/caregiver. Over two years, the teams attended five day-and-a-half-long learning sessions, with coaching calls and on-site visits for further assistance.

The researchers observed substantial improvements in transition processes at all five practices. McManus said the improvements included "developing transition policies, systematically tracking transitioning youth, planning care and transferring to adult care with current medical information."

Several challenges were identified in sustaining the care transition model, e.g., the lack of payment for the added transition work, lack of functionality of EHRs for the transition core elements, and lack of care

coordination infrastructure, particularly at the adult sites.

Luci Belnick, MD, an Orlando-based physician with nearly 30 years' experience in internal medicine, noted that mishandled care transitions may cause serious and avoidable mistakes. "A receiving physician may waste a lot of goodwill and money repeating tests that have already been done or treatments that have already failed," she added.

Belnick warned that children with serous chronic illnesses need greater education about their chronic conditions and how adult health care works. Nonetheless, she observed that many of her new young adult patients had to leave their pediatric practices without any preparation when they turned 18. "If I were a pediatrician caring for kids with chronic medical conditions," she said, "I would have my families start that [transition process] well before the 18th birthday."

She added that preparing summaries for complex patients moving on takes a lot of time, for which physicians receive no compensation. "Most physicians," she said, "will resent doing it" under such circumstances.

More information: "Pediatric to Adult Transition: A Quality Improvement Model for Primary Care." Margaret McManus, Patience White, April Barbour, Billie Downing, Kirsten Hawkins, Nathalie Quion, Lisa Tuchman, W. Carl Cooley, and others. *Journal of Adolescent Health*. Published online: October 3, 2014

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