Due to improvements in pediatric medicine, youths with chronic conditions are increasingly living into adulthood. How can healthcare providers ensure continuity of care as patients transition from a pediatric to an adult care setting?

The study’s goal was to survey large pediatric academic institutions to describe several representative models of transition medicine delivery. We assayed six core elements of transition policy.

Six Core Elements of Health Care Transition
1. Transition Policy – share with providers, staff, youth and families
2. Transitioning Youth Registry – spreadsheet that stores health information
3. Transition Prep – assess and track readiness
4. Transition Planning – address transition gaps, arrange an adult primary care practice
5. Transition and Transfer of Care – send a transition package
6. Transition Completion – contact 3 months post transfer to ensure success

We chose 6 large pediatric hospitals for our survey. Representatives from these hospitals were interviewed about their transition model, including services and practices, using a standardized interview format. Suvery topics included:
- health care transition process
- barriers and how they have been addressed,
- method(s) of communication of services to institution and community at large
- clinical structure, staffing, funding and training of transition personnel

Boston, Cincinnati, and Nemours all have an inpatient pediatrics service for transitioning young adults.
Boston, UCLA, and Baylor all have outpatient transition clinics held in the adult hospitals, whereas Cincinnati, Hasbro and Nemours hold outpatient clinics in the pediatric hospitals.
All of the hospitals sampled transition patients at 21 years old, with the exception of Boston children’s which allows complex patients to transition at 35 years old and non-complex patients to transition at 25 years old and UCLA which transitions patients at 25 years old.

Boston Children’s is the only hospital of the six hospitals that transitions patients from both the pediatric side and adult side, and utilizes an inpatient consult transition service.

Models of Transition Medicine among large academic pediatric centers in the US
Abbie Armstrong, BS, Lisa Tuchman, MD
Children’s National Medical Center, Washington, DC

RESULTS

<table>
<thead>
<tr>
<th>Pediatric Hospital</th>
<th>Structure</th>
<th>Transition Age</th>
<th>Staffing</th>
<th>Funding</th>
<th>Unique Aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>Inpatient (Children’s) and Outpatient (Brigham and Women’s)</td>
<td>Process starts: 18, Transition age: 35 for complex, 25 for primary care</td>
<td>1 physician, 3 med-peds residents, 1 coordinator, 1 social worker</td>
<td>N/A</td>
<td>Monthly conferences to discuss transition care</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>Inpatient consult 2 Outpatient clinics (TRYAD – Complex patients, Teen Health Center)</td>
<td>Process starts: 16, Transition age: 21</td>
<td>3 med-peds physicians, 1 manager, 1 social worker</td>
<td>Hospital</td>
<td>Pilot research projects Med-peds residents Medical student elective</td>
</tr>
<tr>
<td>Hasbro</td>
<td>Outpatient</td>
<td>Complex patients</td>
<td>N/A</td>
<td>N/A</td>
<td>Consultation clinic is held once a month in children’s neurodevelopment center</td>
</tr>
<tr>
<td>Nemours DuPont</td>
<td>Inpatient consult Outpatient</td>
<td>Process starts: 16, Transition age: 21, Complex patients</td>
<td>1 FTE physician, 1 FTE social worker, 1 admin coordinator, 1 medical assistant</td>
<td>Division of Pediatrics</td>
<td>Research on parent/young adult anxiety U. Delaware conducting outcomes research on transitioned patients</td>
</tr>
<tr>
<td>UCLA</td>
<td>Outpatient (Adult hospital)</td>
<td>Process starts: 15, Transition age: 25</td>
<td>1 physician, 2 med-peds residents, 1 coordinator, 1 social worker</td>
<td>Med-peds residency program Revenue</td>
<td>Two week required rotations in HCT for med-peds residents</td>
</tr>
<tr>
<td>Baylor</td>
<td>Outpatient (Adult hospital)</td>
<td>Process starts: 16</td>
<td>1.6 FTE physician, 1 nurse care coordinator, 1 medical assistant, 1.5 FTE social worker</td>
<td>Revenue Donations Grants</td>
<td>Do not transition on the pediatric side</td>
</tr>
</tbody>
</table>

REFERENCES

AAA would like to thank Dr. Lisa Tuchman, Ilana Spitz, Jenn Gode, the Gill Fellowship Program, The George Washington University and Children’s National Medical Center.

ACKNOWLEDGEMENTS

For reprints or more information, please contact: Abbie Armstrong at abbiearmstrong@gmail.com