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?

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.

- 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

This 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.

Boston, Cincinnati, and Nemours all have an inpatient pediatric 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.

Understanding how other institutions have responded to these challenges successfully is important to consider when designing how Children’s National Medical Center will design a model to transition youth.

We find the following to be critical to the transition model: partnering with key departments, expanding the workforce to include care coordinators and social workers, and recognizing that transition services are provided on an ongoing basis as needs and priorities change.

**RESULTS**

**PURPOSE**
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?

**AIMS**
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.

**METHODS**
- 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.
  - Survey 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

<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 Inpatient (Children’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>
<td></td>
</tr>
<tr>
<td>Cincinnati Inpatient &amp; Outpatient</td>
<td>Process starts: 16 Transition Age: 21 Complex patients</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>
<td></td>
</tr>
<tr>
<td>Hasbro 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>
<td></td>
</tr>
<tr>
<td>Nemours DuPont Inpatient consult</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>
<td></td>
</tr>
<tr>
<td>UCLA Outpatient (Adult hospital)</td>
<td>Process starts: 15 Transition Age: 25 Complex patients</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>
<td></td>
</tr>
<tr>
<td>Baylor 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>
<td></td>
</tr>
</tbody>
</table>

**REFERENCES**
- Dr. Ka‘e O’Hare, MD, Transition Coordinator at Boston Children’s Hospital.
- Dr. Ellen Fremion, MD, Internal Medicine-Pediatrics, BCM Transition Clinic.
- Cory Nourie, Patient Transition Social Work Coordinator, Nemours DuPont Hospital in Delaware.

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