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

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

REFERENCES

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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) Outpatient</td>
<td>Process starts: 18</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></td>
<td>(Brigham and Women’s)</td>
<td>Transition age: 35 for complex, 25 for primary care</td>
<td></td>
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</tr>
<tr>
<td>Cincinnati</td>
<td>Inpatient consult 2 Outpatient clinics (TYAD – Complex patients, Teen Health Center)</td>
<td>Process starts: 16</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>Process starts: 16</td>
<td>1 FTE physician, 1 FTE social worker, 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>Nemours DuPont</td>
<td>Outpatient</td>
<td>Process starts: 16</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>UCLA</td>
<td>Outpatient (Adult hospital)</td>
<td>Process starts: 15</td>
<td>1 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>
<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></td>
<td></td>
</tr>
</tbody>
</table>

DISCUSSION
- All hospitals surveyed have care models that respond to the needs of young adult patients with chronic conditions.
- Many are in the process of expanding their available services (i.e. hiring providers trained in internal medicine) to care for these older patients safely within the pediatric setting.
- Other hospital systems are putting into place more care-coordinating services to transfer patients to appropriate adult medicine providers in the community.
- 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.