Transition to Adult Care

Concerns regarding effective transitioning programs that lead to successful transfer of care transcend our borders. Helping adolescents and emerging adults remain healthy is a global issue.

The articles in this issue describe the development and evaluation of transition-focused programs in three different countries. Patience H. White, MD and colleagues describe the design and implementation of a transition program based on a collaborative quality improvement approach among pediatric, family medicine, and adult providers in Washington, DC. The goal of this program is to translate the six core practice elements of the “GotTransition” education package into practice.

Lead physicians from among these practices met to maintain a mutually collaborative spirit. A learning collaborative was developed in which providers attended quarterly meetings over an 18-month period. Transition policies, tools, and implementation strategies were shared and discussed. In between these meetings, practices enacted changes and assessed their impact. The importance of collaboration among practice groups, the availability of easily customized tools and portable medical summaries, and the willingness of pediatricians to be available to their adult colleagues after patient transfer were all highlighted as important aspects of this project.

Janet E. McDonagh, MD, and Karen L. Shaw, PhD, describe their efforts in providing developmentally-appropriate transition programming for emerging adults with rheumatologic disease in the United Kingdom. Their program addresses both transition planning and transfer of care.

With respect to transition planning, their program provides training for adolescents and parents in self-management skills concerning their medical regimen. Individualized transition checklists are completed during clinic visits, resulting in improved satisfaction with care. Adolescents meet with their providers without their parents, increasing their sense of self-efficacy as active participants in their own care plans.

An institutional commitment to providing developmentally-appropriate services is seen through the researchers’ creation of an adolescent-driven DVD and book chapter for providers and for patients on communication approaches and advocacy skills. The program also facilitates transfer of care through the work of a transition coordinator, much like the patient-navigator in the Canadian program. After use of a coordinator began, loss to follow-up decreased from 30% to 2%.

Norma Van Wallaghem, MSc, RD, CDE and colleagues describe a community-wide effort to improve transition services among youth with type 1 diabetes mellitus (T1DM) in Canada. They hired a “patient navigator” who maintained contact with young people, providing support and identifying barriers to accessing medical care. An advisory group was started, including emerging adults with T1DM and community-based stakeholders, to build partnerships and improve outcomes. Data from this project show increased medical follow-up visits in adult-care facilities, reduced morbidity and mortality, and the creation of clinics dedicated to the needs of emerging adults. These promising results have been translated into a patient-navigator program for patients with type 2 diabetes mellitus (T2DM) among Canada’s First Nation population, a group that tends to live in remote areas of the country. Thus far, patient navigators are developing relationships in communities where T2DM is prevalent, connecting with existing community support systems.

I hope this issue will lead to increased research on the development, evaluation, and dissemination of transition-focused programs. Programs need to address systems issues as well as patient-specific and family-specific issues that impact transition planning and transfer of care. I also hope that these articles will help clinicians to better understand the findings in their own clinical practices, thereby improving the psychosocial and medical outcomes of the families in their care.

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