The articles in part 2 of this two-part issue of *Pediatric Annals* describe the transition planning needs for adolescents and young adults receiving services in three distinct areas of health care: autism spectrum services, allergy/immunology services, and cardiology services. We end the series with a discussion of two hospital-based transition programs aimed at meeting the needs of any adolescent who would benefit from planning services in regards to a change in care.

In the first article, “Transition Issues and Challenges for Youth with Autism Spectrum Disorders,” Dr. Fred R. Volkmar, Dr. Scott L. J. Jackson, and Logan Hart describe the unique needs of youth with autism spectrum disorders (ASD), highlighting that although 20% of patients achieve high levels of self-sufficiency and independence, more than 50% of emerging adults still require full-time care. A variety of barriers to being self-sufficient are reviewed, including struggles with depression and anxiety, in part due to the challenges in meeting social expectations for this age group. Specifically, after completing high school, many people with ASD lose access to education and social services, making it even harder to pursue education, significant social relationships, and find a career. Recommendations for developing transition programs for youth with ASD are offered, including job coaching, social skills training, academic assistance, psychosocial counseling, and peer mentorship.

In the second article, “Transition of Adolescents and Young Adults with Congenital Heart Disease: Challenges, Progress, and Future Improvements,” Dr. Jeremy Nicolarsen highlights that the care of children with congenital heart disease (CHD) has improved such that most patients can expect to survive into adulthood. However, the variation and complexity of managing patients with CHD renders a “one-size-fits-all” approach to transition planning unfeasible. The difficulty in gaining access to appropriate care is underscored by the fact that 42% of adults with CHD experience gaps in care of more than 3 years. Thankfully, the American Board of Internal Medicine and the American Board of Medical Subspecialties have developed a 2-year fellowship in adults with CHD. This recognition of the need for formalized training and support will hopefully increase the number of providers available to facilitate the transfer of care.

In the next article, “Transitioning the Allergy/Immunology Patient from Childhood to Adulthood,” Dr. Flavia C. L. Hoyte reviews the unique needs of youth with chronic allergic and immunologic conditions. Of particular interest is the fact that allergy/immunology is not a pediatric or an internal medicine subspecialty. The American Board of Allergy and Immunology is a single board that requires fellows to cross-train in pediatric and adult care, offering a unique set of skills and experiences that can facilitate transition planning. Although many health care providers focus on one developmental group (eg, children/adolescents or adults), allergists and immunologists often pair with other specialists in private practice (or internal medicine) to facilitate a lifespan approach to care. This article describes how many childhood diseases change over time, and underscores the need to educate adolescents and emerging adults about the expected trajectory of their illness.

The final article, “Transition Consultation Models in Two Academic Medical Centers,” by Dr. Jessica I. Gold, Rebecca Boudos, Dr. Parag Shah, and Dr. Rita Rossi-Foulkes discusses two hospital-based programs aimed at improving the health care transition process. The Supporting Adolescents with Independent Living Skills program in-
cludes a formal transition clinic, a life skills program, and a workforce development program. The transition clinic is staffed by a physician and social worker, and visits are structured around the six Got Transition core elements as outlined in the article. The life skills program occurs once per year and is a 6-week group-based program aimed at facilitating adolescents’ knowledge of their own medical conditions, insurance options, issues around education and employment, as well as learning strategies to access independent living resources. Finally, the workforce development program offers 120 hours of supervised and paid work experience with mentorship in resume building, interviewing skills, and social behavior at work skills.

The medicine-pediatrics consultation service offers a different approach to hospital-based programming, in which residents obtain 20 hours of formal training in the issues of transition planning. This Medicine-Pediatrics Program for Adolescent and Adult Transition to Health offers a transition care elective in which a medicine-pediatrics resident is paired with a faculty member who has transition planning expertise, and together, they offer consultative services to hospitalized patients to facilitate the transfer of care. Topics often addressed during these consults include insurance coverage, referrals to adult primary and specialty care services, creating portable health summaries and issues related to education, vocational training, and independent living. Electronic medical record templates and transition-readiness checklists were developed to facilitate the development of portable health summaries. Both hospital-based programs receive a great deal of support from their institutions, are well-received by their patients, and are valued by their health care professional colleagues.

We hope that this compilation of articles leads to increased research on the development, evaluation, and dissemination of transition-focused programs. We also hope that these articles help clinicians translate similar functions into their own clinical practices, thereby improving the psychosocial and medical outcomes of the families they serve.

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About the Guest Editors

Jill Weissberg-Benchell, PhD, CDE, is a pediatric psychologist and a certified diabetes educator with over 25 years of research experience and clinical work with children, adolescents, and their families. She is a Professor of Psychiatry at Northwestern University’s Feinberg School of Medicine. She has published numerous research articles and offered workshops and lectures addressing issues such as improving self-management behaviors, family adaptation and coping, building adolescent resilience, the use of technology (continuous glucose monitor, pumps and the artificial pancreas), and transitioning from pediatric to adult care. Dr. Weissberg-Benchell has co-authored two books, one that focuses on transitioning from pediatric to adult care, and another that centers on working with adolescents with type 1 diabetes.

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Jeremy Nicolarsen, MD, FACC, completed medical school and his Internal Medicine-Pediatrics residency at The University of Chicago. From there, he went to Denver, CO, to complete a combined “Med-Peds” cardiology fellowship in Pediatric Cardiology and Cardiovascular Disease (adult cardiology) while additionally completing 19 months of training in the care of adults with congenital heart disease. He is now the Director of the Providence Adult and Teen Congenital Heart Program in Spokane, WA, and with his team, has created (and always continues to develop) a transition program for adolescents and young adults with congenital heart disease (CHD). Dr. Nicolarsen is passionate about this vulnerable population and has participated in the American College of Cardiology efforts to improve transition for teens with CHD and hopes to continue to work with his colleagues in the adult CHD community to improve the continuous care of these patients.

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