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How to Improve the Transition from Pediatric to Adult Health Care Services?

Como Promover o Processo de Transição de Cuidados Pediátricos para Medicina de Adultos?

Keywords: Adolescent Health Services; Pediatrics; Transition to Adult Care

Palavras-chave: Pediatria; Serviços de Saúde do Adolescente; Transição para Assistência do Adulto

We were recently challenged by the transfer of a patient with a previous diagnosis of craniopharyngioma and panhypopituitarism.

This adolescent patient was admitted to the internal medicine ward from the emergency department due to an altered level of consciousness. During the hospitalization, metabolic and infectious conditions were resolved. After the improvement of the patient's medical condition there was an evaluation in the Day Hospital and the medical team wondered about the best follow-up and referral appointments for this patient: pediatric care or adult care?

Advances in medicine have resulted in dramatic increases in the number of children and adolescents with chronic conditions. Transition is formally defined as the purposeful, planned movement of adolescents with chronic medical conditions from child-centered to adult-oriented health care. This step can be challenging for young patients. A poor transition can result in increased morbidity and mortality as well as poor social and educational outcomes and high rates of loss to follow-up and non-retention in care.

The goals of a planned health care transition are to improve the quality of life, maximize independence and mini-

mize interruption in care as a patient moves from a pediatric to an adult sub-specialist.³

There are interesting tools to help clinicians understand when the best time is to perform this transition, such as ON Taking Responsibility for Adolescents/Adult Care (ON TRAC) or Transition Readiness Assessment Questionnaire (TRAQ).^{4,5} Other tools to facilitate transition include joint newsletters, transition appointments involving both adult and pediatric providers, tours of adult facilities, and medical health summaries.⁶

The concept of a planned transition early in the life of a patient should be discussed at the appropriate time, allowing better management of expectations. The patient achieving adulthood is expected to become independent from his parents and become a functioning member of society.⁶

From a clinician point of view, it is essential to obtain a full history: past medical and surgical history, medications and supplements, social history (smoking, alcohol and drug use), exercise, diet, occupation/plans for the future and family history. A Review of Systems sheet that the patient fills out could be helpful for the first appointment.

There are plenty of barriers that could lead to an unsuccessful transfer—from hospital logistics to poor communication between pediatric and adult providers to parents who do not agree with the transfer. The principal barriers to transition are lack of time and training.

In our own experience, there is a great window of opportunity to improve the transfer of patients from pediatric care to adult care. Day Hospital is an interesting alternative to young patients and adolescents, which protects them from bad experiences in an adult ward. Clinicians should be more alert to this important subject and work as a team to successfully transfer patients from pediatric to adult care.

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