

Transition: Changing Old Habits

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Transitioning patients from pediatric to adult care is an issue of increasing concern, especially when it involves children with chronic conditions that are congenital or complex.¹ Care of these children often requires the special expertise of pediatric subspecialists in addition to ongoing primary care. Pediatric specialists and generalists anticipate that patients will age out of their care, yet many adult medicine practitioners do not feel comfortable assuming responsibility for young adults chronically ill with pediatric disorders. A growing array of strategies and interventions are being designed to facilitate this transition, yet they all may not be necessary. The conclusion that a transition to adult care is indicated is generally based on traditional age cutoffs rather than science. Although it would be a significant change, pediatric subspecialists could reframe their services as condition-specific rather than age-specific care and continue to provide care to their aging patients over the life course in conjunction with adult primary care physicians.

THE UPPER BOUNDARY OF CHILD HEALTH CARE

There is no consensus on the appropriate upper age of pediatricians' patients or when youths become adults. Adulthood is more a social construct than a developmental stage. It has no readily identifiable markers such as those that define puberty, the beginning of adolescence. As a socially defined stage of life, there exists great variability about who is considered legally an adult. Even the assumption of "adult" responsibilities, that is, responsibility for meeting one's own basic needs, does not consistently signify adulthood, although perhaps success at that endeavor would count as being an adult. Imaging studies of the brain demonstrate that adult brain size, especially that of the frontal cortex, is attained between the early to mid-20s, but the association between adult brain size and the ability to perform high-level executive functions remains ill-defined.

It was not so long ago that the majority of pediatricians did not consider the care of adolescents within their purview. The American Academy of Pediatrics policy statement encouraging extending care to age 21, issued in 1988, was seen as an overdue acceptance of responsibility.² Yet, like the definition of adulthood, the basis for selecting any particular age as the upper limit of pediatrics, absent any developmental markers, is arbitrary. The desire to set a terminus for pediatric care probably reflects some discomfort on the part of practitioners as well as patients. Practitioners'

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discomfort sometimes is based on a lack of training and experience caring for young adults, although the health care problems of someone 22 or 25 or even 30 years old differ little from those of most adolescents. Certainly, as patients reach adulthood, shifts to patient-centered care and to less familiar adult-to-adult relationships are appropriate. Pediatricians might also feel uncomfortable examining physically larger patients. For their part, patients, being conscious of their development and perhaps leaving home for work or college, might prefer not to share a waiting room with toddlers or primary school children, or they might see changing care from a pediatrician to an adult medical practitioner as a rite of passage. All considered, it seems reasonable to conclude that the ascription of adulthood within health care, as it is in other realms of life, is also primarily a social construct.

CONSULTATION, REFERRAL, AND COMANAGEMENT

Approaches for successful transition from pediatric to adult care are visible in existing patterns of treating patients with chronic health problems. Typically, primary care providers offer a ready source of ongoing care, not only for chronic conditions but also for preventive and acute care. This primary care is augmented by various levels of collaborative care in which specialists provide consultation or comanagement, either intermittent or ongoing care, depending on the needs of the patient and the skill of the primary care provider. The success of these collaborations depends on the quality of intraprofessional communication and clarity about the division of responsibilities. Research has shown substantial dissatisfaction with the quality of these activities,³ yet they are traditional and familiar. To the extent that true comanagement exists, some of these difficulties can be reduced.⁴

At its best, comanagement involves joint or collaborative care planning and provision by ≥ 2 health care providers, at least 1 of whom is a specialist, whose roles are complementary. Such team-based care generally addresses goals shared by the patient and seeks to achieve coordinated, high-quality care.⁵ Each team member contributes to the care of the patient according to the needs of the patient and the skills of the professionals. This description coincides with that of a patient-centered medical home⁶ and applies equally well to the care of children, youth, adults, or older adults.

Primary care practitioners frequently refer to and consult with specialists. General pediatricians are accustomed to consulting with pediatric subspecialists and comanaging complex cases with them; general internists have similar relationships with medical specialists. Figure 1 displays those typical, within-specialty communication patterns (path A).

Path B indicates the communication between pediatric and adult care providers, both generalists and specialists, as they transition care of young adults. This pathway has been recommended as a best practice during the transition process or “handoff,”⁷ but it tends to be underused and short-lived.

Figure 1 also shows 2 other paths for collaboration that are much less frequently used (paths C and D). Path C, consultation between pediatric generalists and adult care specialists, most often occurs when an appropriate pediatric subspecialist is not available (eg, in less densely populated regions) or when a health plan’s panel of providers does not include those subspecialists. Path D, in which adult generalists comanage chronic pediatric conditions with pediatric subspecialists, has been used in the process of transferring care but is rarely used as an ongoing care model. However, if pediatric subspecialists were willing to assume lifelong responsibility for comanaging complex pediatric conditions, age-related discontinuity of care could be substantially reduced, and the need for transition from pediatric subspecialty care for some young adults would be obviated.

COLLABORATION BETWEEN PEDIATRIC SUBSPECIALISTS AND ADULT MEDICAL PROVIDERS

At some point, however discretionary, making the transition from pediatric primary care to adult primary care is desired and usually not problematic for most patients. Adult generalists typically are able to provide primary care to young adults and manage the health problems that arise with aging.

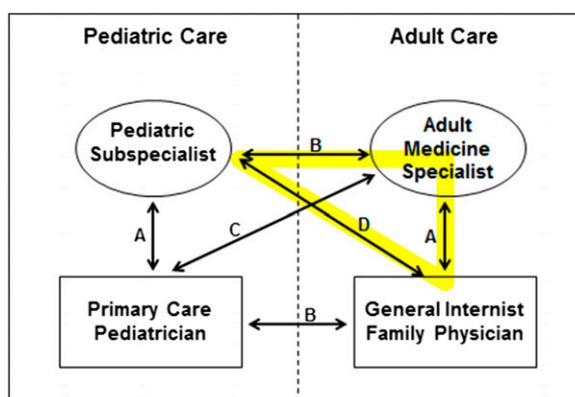


FIGURE 1 Structural basis for collaboration and comanagement in care transition. The highlighted triangle outlines the comanagement that, although unusual and unstudied, could provide lifelong care for youth with chronic pediatric illness after transition from pediatric primary care.

As in the care of their older patients, those generalists appreciate the boundaries of their competencies and comfortably seek consultation with specialists when appropriate for their younger patients.

On the other hand, because pediatric subspecialists are best positioned to care for patients with complex pediatric conditions, there is little justification for transferring their specialty care to an adult specialist who lacks the appropriate skills and experience merely because the patient is an “adult.” The reasons offered to justify this transition have little basis in biology or professional skill. Rather, they are organizational factors that can be addressed by modest redesign of pediatric subspecialty practices to accommodate older patients and related changes in reimbursement policies.

Because they are familiar with using consultation, adult primary care providers can as easily collaborate with pediatric subspecialists for chronic pediatric conditions as they do with adult specialists for complex adult health problems. In fact, as patients age, adult primary care providers can work with both pediatric subspecialists for “pediatric” conditions and adult

medicine specialists for adult-onset health problems in the care of a single patient. The highlighted triangle in Fig 1 outlines those relationships; although unusual and unstudied, it could provide lifelong care for youth with chronic pediatric illness after transition from pediatric to adult primary care. Encouraging and supporting pediatric subspecialists to continue caring for their patients, regardless of age, in collaboration with adult primary and specialty care providers can reduce the need for troublesome transitions for many young adults and ensure quality by maintaining established relationships with experts in their care.

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