Opinion

This article was submitted to the BC Medical Journal and printed as a BCMJ Blog February 7, 2018.

Looking Ahead: Transitioning Patients from Community Pediatricians into Adult Care

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The transition of a child from pediatric care to the adult health system is a significant and typically stressful event for young patients and their families. That's particularly true when there are chronic health conditions, developmental disabilities and genetic disorders involved. Children are now surviving complex disabilities, genetic conditions and extreme prematurity, and we are seeing many more of these young patients in our practices.

A child with complex health challenges could have developmental disabilities, mobility/sensory issues, a chronic health condition, and a mental health disorder. Transferring that adolescent needs to take place over time, in an orderly fashion, and with thought and care.

A successful patient transfer for these young people comes down to disconnecting them from one level of health care and connecting them to another. For young people with complex health and developmental issues, that's a lot of reconnections to get right, and not something that we've necessarily had a lot of practice with. My interest in transfer processes began with my own experiences of young patients who needed to move into the adult system but had no family physician.

On the face of it, transfer might look like it's about little more than completing a thorough form and consult letter, but in fact it's an undertaking that's complicated by all kinds of factors.

Transfer is significantly affected by the fact that 30 per cent of British Columbians don't have a family doctor, for instance, or that mental-health supports are neither consistently available nor well-aligned between the child and adult systems. Nor are there any guarantees around availability of adult specialists and allied health professionals to assume some aspects of care.

Then there's the truly diverse array of patient conditions and co-morbidities, family situations, economic well-being, and geographic limitations that come into play.

One of the presenters at a medical conference I attended not long ago noted that while we talk a great deal about "the coming tsunami of frail elderly" and what impact it will have, in reality a tsunami of frail young people is already upon us. Whether we're the medical professionals preparing young patients for transfer or the ones assuming their care, all of our practices will be impacted.

It's wonderful that health advances allow more children than ever to live into adulthood, and that children who once lived in institutions for their entire lives are now growing up with their families. There's a bright new future for young people newly able to look forward to a quality and length of life unheard of even 20 years ago. A well-planned, well-executed transfer as these youth age out of pediatric care is a critical piece of that. To quote Presidge et al, "successful transition from paediatric-centred to adult-oriented healthcare positively influences health outcomes for youth with chronic illness".[1]

Transitioning Patients from Community Pediatricians into Adult Care is a project supported by the Specialist Services Committee (SSC) a partnership of Doctors of BC and the BC government.

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[1] Utility and cost of a renal transplant transition clinic. Prestidge C[1], Romann A, Djurdjev O, Matsuda-Abedini M. Pediatr Nephrol. 2012 Feb;27(2):295-302. doi: 10.1007/s00467-011-1980-0. Epub 2011 Aug 9.