

HEALTH CARE TRANSITION IN ADOLESCENTS AND YOUNG ADULTS WITH DISABILITIES

Improving health care transition in adolescents and young adults with disabilities is a challenge shared by both pediatric and adult physicians. Advances in medical care have given physicians the ability to prolong life in children who previously had limited life expectancies. Children with chronic diseases present unique challenges to patients, families, physicians and the health care system. Well organized health care transitions are needed to ensure high quality care. Health care transition is defined as the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-oriented health care systems.

Transitions in Health Care

- Transition is influenced and complicated by multiple concurrent changes in physical and emotional development and social structure during adolescence. Ideally, health care transition does not occur in isolation, but rather is embedded within larger, developmentally appropriate processes that foster independence through education and job training. Although health care transition often leads to transfer of care from pediatric to adult providers, patients of family practice physicians and combined internal medicine/pediatric physicians can undergo transition without transfer of care. To provide high-quality health care, improvement in both transition and transfer are needed.

The Process of Health Care Transition

- Adolescents with chronic illness undergoing health care transition often have substantial unmet needs. Absent or ineffective health care transition for patients with disabilities may result in failure to transfer to adult-oriented systems of care and increased chronic-related complications.
- Transition models generally fall into one of three categories: condition-focused, primary care-based, or adolescent –focused. Condition-focused health transition is structured around a chronic illness and coordinated by subspecialty providers. Primary care-based health care transition is generally coordinated by primary care provides (PCPs) and may be embedded within the larger construct of the “medical home” model, which focuses on care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. In this instance, PCPs coordinate care between subspecialty providers and other members of the health care team. Adolescent-focused health care transition relies on providers trained in adolescent medicine to coordinate care.
- When transition occurs in an organized, timely manner, transfer to adult care can be coordinated by both transferring and receiving physicians. Structured transition programs that allow young adults to meet with new providers before transfer occurs have been shown to increase clinic attendance within the adult health care system and to increase patient satisfaction.
- Health providers need to use transition guidelines, clinical training programs and continuing medical education curricula to educate providers.

QUESTIONS - Talk to others, learn more, share ideas, meet with adult health providers.

- Got Transition is a national resource for youth transitioning to adult health care.
<http://www.gottransition.org/>

ARKANSAS TITLE V CHILDREN WITH SPECIAL HEALTH CARE NEEDS PARENT ADVISORY COUNCIL
recommends this Tip Sheet to help your family in transitioning your young adult.