Transitioning Patients from Community Pediatricians into Adult Care Project: Overview

— By Dr. Aven Poynter
President, BC Pediatric Society

Transitions are difficult at the best of times, and B.C. Community Pediatricians support their patients through one of the biggest transitions anyone ever makes: Becoming an adult.

For young people with complex health and social needs, that transition to adulthood also comes with the challenge of finding their fit in the adult system of care. For them, it's a time of shifting from family-oriented care to individual services. For Pediatricians, it's a time of referring patients to new supports and services that aren't always there.

B.C.'s Community Pediatricians transition an estimated 250 to 300 young people with complex health needs into the adult care system every year. It's much like putting together 300 complicated jigsaw puzzles, because each aspect of a young person's pediatric medical care now has to find its match in the adult system.

Transitioning these youth is relatively new work for many Pediatricians. We know from the research that enhancing transition supports improves patient care among youth and young adults with chronic health conditions.[1] As noted in the previous newsletter, BCPS has launched a new project to support Pediatricians when transitioning these young patients to the adult system. Thanks to the excellent feedback received during our environmental scan of selected B.C. Pediatricians, GPs and Adult Specialists earlier this year, we identified 5 tools that we're developing over the next year as supports for the process.

The BC Pediatric Society has identified 5 tools that will be developing over the next year as supports for the process.

1. A form that works for both the referring and the referred-to Physicians, and are adapted to the needs of Community Pediatricians as well as Physicians and Specialists taking on these young patients. These forms will permit Pediatricians to efficiently and easily summarize a young patient's medical conditions and history, and note any particulars around how the conditions impact on that youth's life and other relevant information specific to the patient;
2. Regional information to link with GPs and Adult Specialists known to be accepting youth with complex health/social needs and/or mental health disorders;
3. Easy and centralized access to information about organizational resources for Pediatrician reference or to share with families, youth and other care providers;
4. Fee-for-service codes for Community Pediatricians in acknowledgement of the work costs associated with supporting patients in their transition;
5. Case studies of B.C. Community Pediatricians sharing how these tools worked for them

Much has changed in the 20 years of these children growing up, and the time has never been better to check in on our transition supports to Pediatricians. I'm a co-leader of this project along with Dr. Todd Sorokan. The physician reps on the steering committee are Dr. Sandy Whitehouse, the Pediatrician who led the BC Children's ON TRAC transition project, and Dr. Beth Watt, a Family Physician from Langley.

We want the tools that come out of this process to be simple and useful. We heard in the environmental scan that Doctors need a simplified form that doesn't reinvent the wheel if Pediatricians and GPs have already been sharing information; works for Physicians and Specialists on both sides of the transfer process; and is something

...continued next page

more than just a listing of medical conditions. And the work to complete that form and other transition-related activities needs to be supported by new fee-for-service codes.

These young people don't fit into predetermined little boxes. Each of them has distinctly different needs. The child attached to a clinic for metabolic conditions doesn't just need the adult version of that clinic when she turns 19 - she may need a heart specialist, a gastroenterologist, additional support from Community Living B.C., a fresh look at her mental health needs, or any number of other things. This project can't address all the challenges facing this young and ground-breaking cohort as they age out of pediatric services, but we hope it will at least provide a few more tools for managing transitions.

Some of the challenges of transition are beyond the control or scope of this project, of course. When families don't have a GP, that stops the best-laid plans. We can't control wait lists for community services, or make it so every youth automatically connects to a GP and the right assortment of Specialists by the time age 19 rolls around. Resources developed through this project may support Pediatricians through this process.

We'll be reviewing our work to date on this project in September, with further consultations later in the fall. Watch for regular updates in every newsletter about the progress of the project, and the lessons and learning emerging as these tools are developed and tested.

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.

Further reading:

Planning transitions: www.bcmj.org/shared-care/when-chronic-care-youth-age-out-transition-planning

Defining transition: www.cps.ca/documents/position/transition-youth-special-needs

[1] For instance, see Lewis, J., & Slobodov, G. (2015). Transition from pediatric to adult health care in patients with chronic illnesses: An integrative review. *Urologic Nursing*, 35(5), 231.

Consultation Schedule 2016

As part of our work to develop resources to support Community Pediatricians in their work to transition adolescent patients into adult care, we are hosting Consultation dinner sessions as follows:

October 11: Kelowna

October 13: Fraser Health - location TBA

October 17: Prince George

October 18: Vancouver

October 19: Nanaimo

Please consider joining a session in your region and extending the invitation to your Family Physician and Adult Specialist Colleagues who share/accept transitioning patient referrals from Community Pediatricians.

To register or for additional information please contact:

Shahin Kassam R.N., B.N., M.N., Coordinator
shahin.bcps@gmail.com
778-228-8020

Self-Control of Childhood Chronic Illness May Improve Later Health Management

A study in Preventing Chronic Disease found that youths who felt in control of their chronic illness were more likely to follow doctor's recommendations and develop self-management skills that would help with a transition to adult care, compared with those who felt their health was controlled more by their parents or by chance. The findings were based on data involving 163 children ages 6 to 17.