

Fellows Corner

Healthcare Transition from Pediatric- to Adult-Focused Care: A Former Pediatric Nephrology Fellow's Perspective



By Sai Sudha Mannemuddh



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One thought that stood out during the first year of my fellowship was “healthcare transition from pediatric- to adult-focused care.” When the chart and age indicated readiness for patients’ transitions, I was not prepared. There were a lot of questions. Are they ready? Are they going to do well?

Will they be able to fulfill their dreams and goals? Are these feelings similar to what one encounters when dropping their child off at college? I wondered. I wasn’t sure.

What does transition mean? To understand this better, I decided to make a note of the words that pop into the minds of healthcare professionals when we consider transition. I also asked what was going on in the minds of parents and family members. Most important of all, what was in the minds of patients? Were we all on the same page? If we were, then that would have been great. I was taken by surprise when I saw the results. Take a look at the word clouds in Figure 2 representing what each of us would think. Can you tell which word cloud belongs to whom?

It is easy to recognize the owners of each word cloud. Personally, I felt as if we were talking in different languages. This potential (or real) communication barrier could make the process of healthcare transition challenging. I felt that there was only one way to address this: Have a conversation. Learn the patients’ and their families’ language. The process of healthcare transition involves patients, families, healthcare providers, healthcare systems, and the community.

We have learned that the process of transition of care should begin early, around 12 to 14 years (1), continuing until ages 24 to 26. This might seem very early, but once patients reach the core teenage years, they get busier with their personal lives and education, not to mention peer pressure. Starting the process by helping them understand their disease and medications can be the first step. Once the fear of the unknown disappears, it can lead to the emergence of more responsible and independent behaviors. Encouraging patients to ask questions will allow us to know them as individuals and could also help them when they meet their new care providers during and after transition. Involving patients and families in every step of the process can mitigate their anxiety and improve accountability.

There are six core elements of transition: developing a transition policy, transition tracking and monitoring, assessing readiness for transition, transition planning, transfer of care, and transition completion (2). An algorithm

for transition of care, tailored from McPherson et al. (3), can be adapted for any patient with a chronic medical condition (Figure 1).

With this knowledge, we made a few changes in our program. We started providing chronic kidney disease education flash cards during initial visits and quizzing the patients (>12 years old) during subsequent visits. We also encouraged patients to consider “kidneys” as a topic of choice for their school science projects. A quality improvement project called “Do you know your medications?” directed toward >12 year olds is under way. Other things to consider are developing a transition clinic and giving out a transition passport. Although there are many ways to ensure a smooth transition, I believe this is a start and hope to make improvements as time goes on.

Last, I have a request. Dear adult specialists, whenever you encounter newly transitioned patients, please understand that they are survivors of complex health conditions who may have cognitive impairment and must deal with the challenges associated with a difficult age in life. Also, please be patient, and direct “helicopter parents” to let go, honoring their efforts in helping their children survive.

Acknowledgment

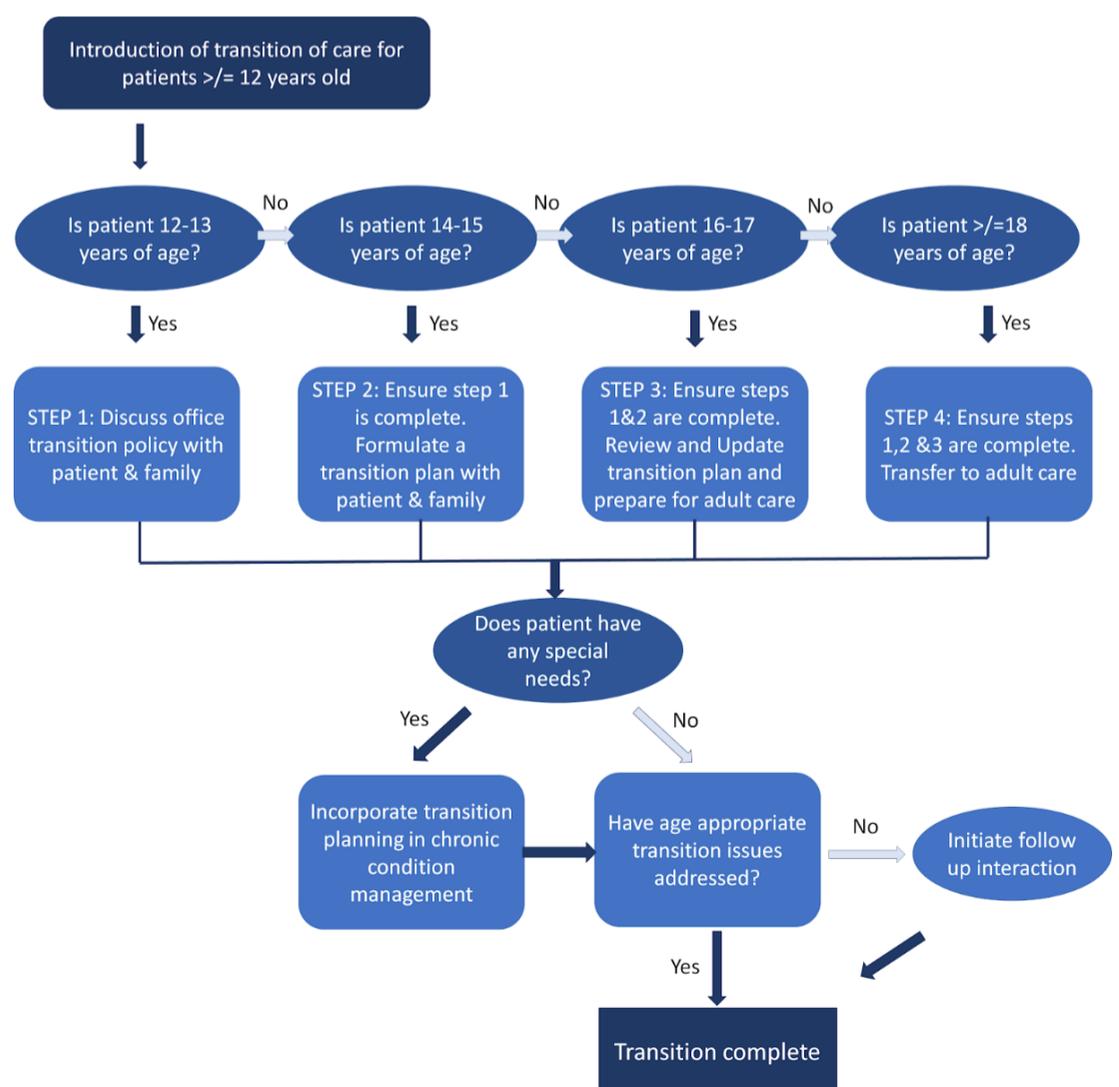
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Sai Sudha Mannemuddh, MD, is a nephrologist at East Tennessee Children's Hospital and clinical assistant professor at the University of Tennessee, Knoxville, TN.

References

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Figure 1. Six core elements of transition



Adapted with permission from McPherson et al. (3)