The Frontier of Transition Medicine: A Unique Inpatient Model for Transitions of Care

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The transition of care from pediatric to adult providers has drawn increased national attention to the survival of patients with chronic childhood conditions into adulthood.ttps://www.ncbi.nlm.nih.gov/books/NBK11432/ While survival outcomes have improved due to advances in care, many of these patients experience gaps in medical care when they move from pediatric to adult healthcare systems, resulting in age-inappropriate and fragmented care in adulthood.[4] Many youth with chronic childhood conditions are not prepared to move into adult healthcare, and this lack of transition preparation is associated with poorer health outcomes, including elevated glycosylated hemoglobin and loss of transplanted organs.[5-7] National transition efforts have largely focused on the outpatient setting and there remains a paucity of literature on inpatient transitions of care.[8,9] Although transition-age patients represent a small percentage of patients at children's hospitals, they accumulate more hospital days and have higher resource utilization compared to their pediatric cohorts.[10] In this issue, Coller et al.[11] characterize the current state of pediatric to adult inpatient transitions of care among general pediatric services at US children's hospitals. Over 50% of children's hospitals did not have a specific adult-oriented hospital identified to receive transitioning patients. Fewer than half of hospitals (38%) had an explicit inpatient transition policy. Notably only 2% of hospitals could track patient outcomes through transitions; however, 41% had systems in place to address insurance issues. Institutions with combined internal medicine-pediatric (Med-Peds) providers more frequently had inpatient transition initiatives (P = .04). It is clear from Coller et al.[11] that the adoption of transition initiatives has been delayed since its introduction at the US Surgeon's conference in 1989, and much work is needed to bridge this gap.[12]

Coller et al.[11] spearhead establishing standardized transition programs using the multidisciplinary Six Core Elements framework and highlight effective techniques from existing inpatient transition processes.[13] While we encourage providers to utilize existing partnerships in the outpatient community to bridge the gap for this at-risk population, shifting to adult care continues to be disorganized in the face of some key barriers including challenges in addressing psychosocial needs, gaps in insurance, and poor care coordination between pediatric and adult healthcare systems.[4]

We propose several inpatient activities to improve transitions. First, we suggest the development of an inpatient transition or Med-Peds consult service across all hospitals. The Med-Peds consult service would implement the Six Core Elements, including transition readiness, transition planning, and providing insurance and referral resources. A Med-Peds consult service has been well received at our institution as it identifies clear leaders with expertise in transition. Coller et al.11 report only 11% of children's hospitals surveyed had transition policies that referenced inpatient transitions of care. For those institutions without Med-Peds providers, we recommend establishing a hospital-wide transition policy, and identifying hospitalists trained in transitions, with multidisciplinary approaches to staff their transition consult service.

Tracking and monitoring youth in the inpatient transition process occurred in only 2% of hospitals surveyed. We urge for automatic consults to the transition service for adult aged patients admitted to children's hospitals. With current electronic health records (EHRs), admission order sets with built-in transition consults for adolescents and young adults would improve the identification and tracking of youths. Assuming care of a pediatric patient with multiple comorbidities can be overwhelming for providers.[14] The transition consult service could alleviate some of this anxiety with clear and concise documentation using standardized, readily available transition templates. These templates would summarize the patient's past medical history and outline current medical problems, necessary subspecialty referrals, insurance status, limitations in activities of daily living, ancillary services (including physical therapy, occupational therapy, speech therapy, transportation services), and current level of readiness and independence.

In summary, the transition of care from pediatric to adult providers is a particularly vulnerable time for young adults with chronic medical conditions, and efforts focused on inpatient transitions of medical care have overall been limited. Crucial barriers include addressing psychosocial needs, gaps in insurance, and poor communication between pediatric and adult providers.[4] Coller et al.[11] have identified several gaps in inpatient transitions of care as well as multiple areas of focus to improve the patient experience. Based on the findings of this study, we urge children's hospitals caring for adult patients to identify transition leaders, partner with an adult hospital to foster effective transitions, and to protocolize inpatient and

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outpatient models of transition. Perhaps the most concerning finding of this study was the widespread inability to track transition outcomes. Our group's experience has led us to believe that coupling an inpatient transition consult team with EHR-based interventions to identify patients and follow outcomes has the most potential to improve inpatient transitions of care from pediatric to adult providers.

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