Transition to adult health care: an unfinished business

Nowadays we know that most chronically ill children and adolescents will at some point require transition to adult health care. When the time comes, it poses a new challenge to pediatricians: finding a treatment team willing to take over the care and follow-up and establishing a smooth process in the transition between both teams so as to maintain an adequate health care in adult life.

The problem of transition is global and has been causing "headaches" for more than 20 years. As early as the 1990s, several publications addressed this issue and in 2002 the American Academy of Pediatrics published a consensus statement on health care transitions for patients with special health care needs. However, 10 years later, it was observed that the implementation of transition programs had not been achieved and the problem remains unresolved to this date.[1–3]

The transition implies not only a change in health care providers and centers, but also a change in the modality of care. Traditionally, pediatric care is family-centered, with fundamental parental involvement in decision-making; patients become progressively more involved as they acquire autonomy. In the follow-up of patients with chronic diseases, a relationship of trust is established that develops over the years and that must be rebuilt once the management team changes. In addition, adult medicine tends to focus on an autonomous patient, who usually speaks for themselves and is responsible for therapeutic decisions.[4]

It has been shown that this transition period, from pediatric to adult health care, is a time of particular vulnerability. The clinical course of patients may present a setback, health care costs are higher, and there are more emergency department consultations, hospitalizations, and psychological stress in everyone involved.[5]

Barriers to the transition to adult medicine emerge from different areas and many situations jeopardize its success:[6]

- Patient-related factors and their ability to manage their disease: reaching 16, 18, or 21 years of age does not necessarily ensure that a young person without cognitive deficit is in a position to take charge of their health.
- Factors related to the underlying disease: its characteristics and evolutionary stage have an impact on the opportunity for transition. Should a change in a management team be considered in a palliative care patient? Is it ethical? Is it timely? Is it empathetic?
- Reluctance on the part of adult care physicians, who are faced with conditions of pediatric origin in which they have little experience and distrustful families used to a different health care system.
- Reluctance on the part of pediatricians, who often prolong the process, are reluctant to let the patient go, and even face institutional inconsistencies, where some services are willing to transition the patient while others are not, thus sending a confusing and ambiguous message.

In addition, the great differences in health care systems that coexist in our country –and fundamentally the absence of standardized transition policies at the public health sector– cause multiple difficulties at the time of developing patient transition and transfer strategies.

Those of us who work in children's hospitals assume that the transition process is easier in general hospitals, where pediatric and adult clinicians and specialists work alongside, thus generating an implicit bridge that is easy to cross. However, the study by Vaiman et al., carried out in a community general hospital has demonstrated how a situation that could be considered "ideal" is not necessarily accompanied by good results. Of 372 patients included in the analysis, only 37% participated in a transition process, of whom 38% went on to see adult care physicians. The good news is that those who managed to cross the bridge achieved a high rate of continuity with the receiving teams.[7] It would be possible to explore about the fine details of this and analyze what other factors determined the success or failure in the final transfer of the patients who initiated the transition. The options are multiple, ranging from the personal characteristics of patients and the financing systems to the geographic origin and administrative issues, among others.

The reality is that the transition process is an unfinished business, which in most cases relies on individual efforts and contacts between health care providers, rather than on health policies. A lot of time, will, effort, and imagination are required to move forward. There is a long way

to go. Measuring the results of our actions and having a diagnosis of the situation is only the first step.

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