# Bridging the Gap: Bringing Pediatric and Adult Specialists Together to Achieve Continuity of Care

**Specialist Services Committee YOUTH TRANSITION PROJECT**

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The landscape continues to shift in relation to the lifespan of children with chronic care conditions. What was once fatal in childhood, is no longer. We need to improve continuity of specialist care for youth with chronic conditions/disabilities who are transitioning from pediatric care to the adult care system.

## AIMS

- Improve continuity of specialist care for youth with chronic health conditions/disabilities who are transitioning from pediatric care to the adult care system
- Improve the experience of patients, families, specialists, and FPs at transition and transfer
- Align with the Shared Care Initiative to improve transition process

## CONTEXT

SSC Youth Transition Project is a key component of a Province-wide transition initiative, ON TRAC for Youth, **http://ontracbc.ca**

2012 BCMA Policy, "Closing the Gap: Youth Transitioning to Adult Care in BC," provides a framework for transition planning

## WHY FOCUS ON YOUTH TRANSITION

- Young adult survivors of pediatric conditions are at risk of adverse outcomes
- Continuity of care disrupted at transfer
- Patients/families confront a new and unfamiliar system of care
- Transitioning youth often rely on emergency services, increasing overall system costs

### Significant system-level challenges to transition:

- Lack of formalized transition processes and procedures
- Inadequate and/or delayed transfer of medical records
- Limited access to specialists/sub-specialists in areas of BC
- Disrupted relationships with FPs while youth in pediatric care
- Lack of organizational structures, resources, and reimbursement for complex care management/coordination in the adult system

**STRATEGY: FACILITATE CONTINUITY BY DEVELOPING CONDITION-SPECIFIC LONG TERM CARE PLANS (LTCPs) THAT CLARIFY PROVIDER ROLES AND CARE REQUIREMENTS.**

## ACTIVITIES/EVALUATION:

1. Engage adult and pediatric specialists, FPs, and allied health.
2. Develop LTCPs for youth with cardiac and neurologic conditions.
3. Utilize a structured case-review process to evaluate uptake and efficacy of plans and impact on patients and providers.
4. Modify LTCPs based on case review findings.
5. Develop training tools/modules for physicians.
6. Identify system improvements to facilitate adult specialist care.
7. Identify strategies/mechanisms for providing allied health support for adult specialists managing care.
8. Develop strategies for knowledge translation/dissemination, sustainability, and scalability to other chronic conditions.

## LESSONS LEARNED

- Team engagement of stakeholders clarifies issues and processes
- Identify Most Responsible Physician (MRP) when clarifying roles
- Incorporate established guidelines and consensus statements
- Adapt LTCPs for cognitive impairment/dependence of patients
- Address geographic barriers and access to services
- Achieve consensus on format to allow for scalability
- Ensure electronic platform to facilitate access and utility

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