TRANSITIONING FROM PEDIATRIC TO ADULT HEALTHCARE: EXPLORING THE PRACTICES AND EXPERIENCES OF CARE PROVIDERS

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Introduction

Youth with complex care needs (CCN) require significant health, educational, and/or social assistance beyond what is generally required by their peers. These youth experience complex chronic conditions that were once seen as fatal and are now increasingly associated with survival into adulthood. As they approach adulthood, youth are required to transition from family-centred pediatric healthcare to individual focused adult healthcare. Current transition practices, when present, are reported to be disorganized and disjointed, resulting in health status deterioration and an increase in complications due to unmet needs for youth/young adults with CCN.

Objective

The purpose of this study is to develop a broader understanding of the current transition practices, experiences, as well as recommendations of primary care practitioners, specialists, and subspecialists in the support of New Brunswick youth with CCN as they transition from pediatric to adult healthcare.

Methods

The exploratory study uses a qualitative descriptive design. A purposeful sample of 15 care providers in New Brunswick and IWK pediatric specialists who support New Brunswick youth with CCN in the transition from pediatric to adult healthcare were interviewed individually using a semi-structured interview guide. Participant demographics can be seen in Table 1.
Data analysis was completed using thematic analysis following the six phases outlined by Braun and Clarke (2006).

	Pediatricians	Pediatric Subspecialists	Primary Care Providers	Adult Specialists
Gender				
Male	1	3	1	3
Female	2	2	3	-
Location				
New Brunswick	3	2	4	3
Nova Scotia	-	3	-	-
Setting				
Hospital	-	3	-	2
Community	-	-	4	-
Combined	3	2	0	1

Table 1. Participant demographics

Findings

While the majority of transitions to adult healthcare were perceived by study participants to be successful, the method of delivery was unguided and variable with each transfer having the potential for failure.
The importance of continuous care from pediatric to adult healthcare was emphasized. Furthermore, all participants recommended enhancing their knowledge of available community and clinical resources. Additionally, the implementation of a care coordinator was almost unanimously recommended by study participants. Study themes are presented in Table 2.

What are the current practices and experiences of care providers?	1. Collaboration with Care Providers 2. Time of Transition Initiation 3. Use of Transition Resources 4. Access to Adult Providers and Services
What are care providers' recommendations to improve transition practices?	1. Knowledge and Skills 2. Continuity of Care 2.1. Collaboration 2.2. Point Person 3. Resources 3.1. Transition Strategy 3.2. Caregiver Resources 3.3. Virtual Visits

Table 2. Study themes

Recommendations

The findings help pave a path toward policy change and further development of an evidence informed, patient and family-centred transition intervention. Recommendations include an over-arching policy to guide the process that has room for flexibility as it relates to specific conditions, clinics, geographical regions, and individual patients. Transition practice is recommended to include a period of shared practice between pediatric and adult services under the oversight of a transition coordinator. Additionally, psychosocial resources for caregivers of youth were suggested in order to support the family.

This study demonstrates the current transition practices of care providers in NB which brings us a step closer to bridging that gap in care and improving healthcare delivery

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