



Transition Care for Children With Special Health Needs: Technical Brief Number 15

Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

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There is no uniformly accepted age at which pediatric care is inappropriate and adult care should be sought for every patient. Nonetheless, some practices do have age cut-offs, and there comes a time when adult providers may be better able to serve the needs of patients whose medical concerns are more adult in nature, including for example reproductive and other issues. In addition, the inclusion of adults in pediatric practices can create discomfort and challenges for other pediatric patients and their families, and pediatricians can find themselves addressing medical issues of adults for which they are less prepared. Therefore, at some point, most pediatric patients should and do move into the adult care system. An effective transition process from a pediatric to an adult health system should ensure continuity of developmental and age-appropriate care. In 2002 the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP) coauthored a consensus statement: “The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood.” This process can be challenging, particularly for children and youth with special health care needs (CSHCN), defined as individuals having or being at risk of “a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.” Examples of adolescent populations with special health care needs that need transition support range widely, including those with chronic illnesses such as diabetes or sickle cell disease and individuals with developmental disabilities that are associated with a host of challenges ranging from higher risks of specific health outcomes to the need for special support in navigating the health care system. Over the past few decades, the prevalence of childhood chronic conditions also has been steadily increasing, with an associated increased risk of a range of health problems and persistent impact into adulthood for many affected individuals. Potentially serious health-related consequences may be associated with suboptimal or incomplete transition to adult care. Gaps in care in transitions have been associated with poor health outcomes, increased hospitalizations and more complications and failure to access care in populations with diabetes, arthritis, and sickle cell disease. This report focuses specifically on transitions of care from pediatric to adult services for individuals with a chronic health condition.

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