A Transition Process to Adult Healthcare for Youth with Medical Complexity

**CHAMPLAIN COMPLEX CARE PROGRAM**
- Champlain Complex Care Program (CCP) is a partnership of organizations providing care coordination, holistic family-centered care, single point of access-key worker, assists with system navigation
- For children and youth with medical complexity (CMC) from birth to 18 years of age
- CMC account for 0.67% of all children (Ontario study), account for almost a third of childhood spending!
- The program succeeded (Pilot project data not yet published)
  - Reduction of preventable emergency visits and hospitalization's length of stay
  - Improved satisfaction
  - Improved health for this unique population.

**BACKGROUND: TRANSITION TO ADULT HEALTHCARE**
- Population of CMC is increasing: increased awareness of the need for transition
- Age of transfer is 18 years in Canada
- Care Model pediatric vs adult: family centered, developmentally age appropriate, parental involvement, multidisciplinary team approach, youth autonomy and knowledge of condition
- No equivalent adult program for YMC
- Competing priorities in adult healthcare system: complex geriatric vs young complex adult with unique rare disease and technologies

**OBJECTIVE**
- Need for a formalized, effective transition to adult care services
- Develop a transition process for youth with medical complexity (YMC).

**RESULTS**
- Documents identified for transition process included
  - Good-to-Go program
  - CQCT resources
  - PCMCH report
  - Shared experience from other services: Oncology, Cardiology, Nephrology
- DSA provided limited data (lack of unifying diagnosis, hospital based) about:
  - The number of YMC who have transitioned
  - The impact on the adult healthcare system those who will transitioned

**CLINICAL INTERVENTION UNIQUE TO CMC**
- 2 YMC transitioned to adult healthcare
- 1 YMC stayed 1 year beyond the age of 18
  - Team familiarity with complex respiratory and cardiac care needs for gastrostomy surgery
  - Optimized post-surgical recovery
  - Access for pediatric orthopedic surgery: in the end family opted against pursuit of the procedure
- Referral adult specialists/providers for each condition
- Early identification of a Primary Care Provider (PCP): 1 PCP was identified at time of transfer
- Discharge meeting (telehealth, phone conference)
- Preparation comprehensive care plan documents, specialists and provider summaries/lists contacts
- Facilitating liaisons with social services, funding processes and community nursing services
- CCP support communication up to 2 years after transfer
- Legal implications and processes reviewed
- Reviewed Care Directives plans

**INTER-ORGANIZATIONAL INTERVENTION**
- Identified and Meeting with head of internal medicine MD, ambulatory care Internist and adult hospital administrative executive
- Shared pilot project experience and outcomes
- Scan of health care utilization; decision support assessment of adult with medical complexity (AMC)
- Between the age of 18 yrs-25 years using same criteria as project

**DISCUSSION**
- CMC is a small growing population which accounts for a substantial proportion of health care costs and they have very unique needs for transition
- Limited data on number of youth with chronic medical complexity who will be transitioned in the coming years, their care needs and system impact
- As an intervention the CCP has developed an Enhanced Transition Process Tool for CMC-see handout
- Continue to work with adult providers by identifying PCP, specialists interested in this population
- Encourage development of transitioning expertise
- Trial referral process with internal medicine

**CONCLUSION**
- Ensure effective collaboration with adult providers at all system level during the transition process and for CCP ongoing commitment of support beyond the age of transfer
- The CCP team has successfully partnered with the adult providers and has initiated a pilot process for transition which will specifically address the unique needs of this population.
- Continue inter-organizational networking and assessment of impact and healthcare utilization for AMC

**METHODS**
- Environmental Scan
  - Transition processes
  - Adult healthcare Services
- Consultation with partner organizations
  - Identified and met with head of internal medicine MD, ambulatory care internist and adult hospital administrative executive
  - Shared pilot project experience and outcomes
- Decision support assessment (DSA) for adults with medical complexity (AMC)
- Family participation and feedback

**REFERENCES**

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The authors also wish to acknowledge the partners of both the initial pilot and the new program. The partner logos are listed above.