

Background

- In recent years, there has been a dramatic growth in the number of youth with chronic medical conditions surviving into adulthood
- Youth with chronic conditions transitioning to adult health care experience poor outcomes, including:
 - Poor clinical outcomes
 - Increased health care costs
 - Low patient and family satisfaction
- Recommendations have been made for more effective primary care provider involvement and broader policy which better integrates primary and specialized care

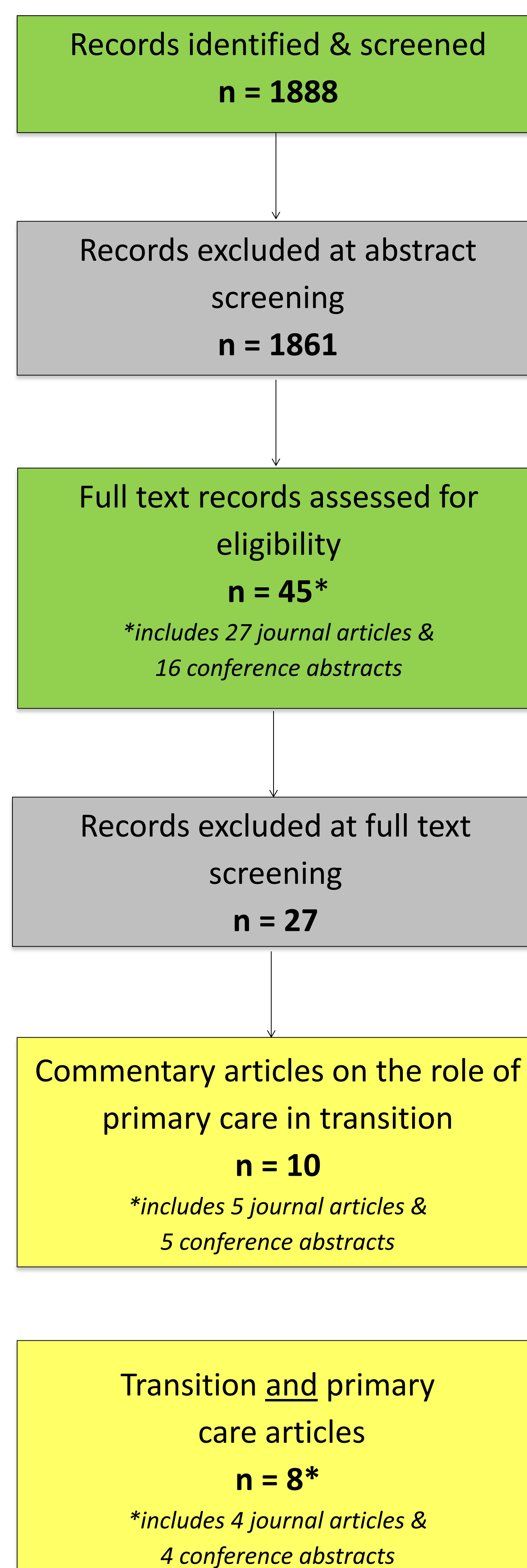
Objectives

The aim of this systematic review is to determine effective interventions to improve the role of primary care providers in the transition from paediatric to adult health care

Methods

- The search was conducted using Ovid MEDLINE, EMBASE, and Web of Science databases for articles and abstracts published in the past 50 years
- Selected articles were screened independently by two reviewers, and data were extracted into summary tables categorizing study details including: country, study subjects, primary care provider type, role/responsibility or intervention description, patient condition, and outcomes
- The search was not limited to individual conditions given that only youth with complex and/or chronic conditions would require transition to adult care
- Articles discussing opinion-based best practice or those defining family/caregivers as primary care providers were excluded

Results



Citation	Intervention	Study Design	Primary Care Engagement	Patient Condition	Results
Hankins <i>et al.</i> 2012	<ul style="list-style-type: none">Pilot program aimed at finding an adult medical home3 components: tour, lunch discussion, scheduling 1st visit	Controlled cross-sectional	Case manager facilitated 1 st appointment w/adult provider of patients' choice	Sickle Cell Disease	<ul style="list-style-type: none">74% (participants) vs. 33% (nonparticipants) completed 1st visit w/adult provider within 3 mo
Overholster <i>et al.</i> 2012 [abstract]	<ul style="list-style-type: none">Thriving After Cancer Treatment Is Complete (TACTIC): 1^o care clinic providing treatment summary & risk-based survivorship care plan	Descriptive pre-post	General internist assumed 1 ^o care responsibility in a multidisciplinary clinic setting	Survivors of childhood cancer	<ul style="list-style-type: none">Improvements in ability to identify resources & health risks (p= 0.03)
Kingsnorth <i>et al.</i> 2012 [abstract]	<ul style="list-style-type: none">LIFESPAN model2 health science centers	Qualitative	Unclear	Cerebral palsy, acquired brain injury	<ul style="list-style-type: none">Lack of access to 1^o care identified as a barrier
McManus <i>et al.</i> 2015	<ul style="list-style-type: none">5 academic pediatric & adult health centre teams consisting of physician & transition care coordinatorAssessed using the Health Transition Index	Time series comparative	Study setting in pediatric & adult 1 ^o care settings	Chronic physical, developmental, mental health conditions	<ul style="list-style-type: none">Improvements in transition quality indicatorsTransition policy & tracking process established
Wallis <i>et al.</i> 2015 [abstract]	<ul style="list-style-type: none">Pilot 1^o care-based transition programGroups: (1) Control (2) Education (3) Educational + in-person group support (4) Additional physician + social work consultsTransition Readiness Assessment Questionnaire (TRAQ)	Randomized control trial	Conducted in pediatric & adult 1 ^o care settings.	Complex chronic conditions	<ul style="list-style-type: none">No significant differences in readiness at baseline & 6 moProviders felt unable to provide assistance
Dorsey <i>et al.</i> 2009 [abstract]	<ul style="list-style-type: none">Transition Nurse Coordinator led program components: health literacy training, skills for adult living, practical transition assistance	Retrospective descriptive	Transition coordinator attended 1 ^o care appointments	Sickle Cell Disease	<ul style="list-style-type: none">1^o care providers identified as a necessary point of contact throughout transition process
Van Walleggham <i>et al.</i> 2006	<ul style="list-style-type: none">Maestro ProjectCommunity-based transition navigation service involving project coordinator	Uncontrolled cohort	Referrals connecting to family physicians	Type 1 Diabetes	<ul style="list-style-type: none">11% were referred to family physicians
Duke & Scal. 2011	<ul style="list-style-type: none">Secondary analysis of the 2005-2006 National Survey of Children with Special Health Care NeedsAssessed transfer to adult providers, future health needs, health insurance & youth taking responsibility	Retrospective cohort	1 ^o care providers were the usual source of care for patients	Special health care needs	<ul style="list-style-type: none">Youth w/a usual source of care were more likely to receive counseling (47% vs. 34%; p<0.001) & take responsibility for their care (79% vs. 64%; p<0.001)

Conclusions

- There are few innovative models of primary care interventions to improve transition outcomes for youth with chronic conditions, and even fewer rigorous evaluations to guide practice or policy
- Future research and policy should focus on developing and evaluating coordinated transition interventions in primary care settings to better integrate primary and specialized care for high need populations