



Transitional care and a lesson from the pandemic



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To the Editor:

Re: *Barriers in transitioning urologic patients from pediatric to adult care* by Claeys et al., a lesson from the COVID-19 pandemic may also present a novel opportunity.

The authors should be congratulated for providing a contemporary overview of the needs, challenges, and principles involved in caring for our pediatric patients as they near adulthood.

It is useful to remember that the health system of the past took care of everyone regardless of age. The pediatric-adult care divide has had the unintended consequence of creating the now decades-old pediatric transitional care crisis. This divide is an anachronistic and artificial line created a century ago and continues to be promulgated by health policies, hospitals, and payers. Its creation was necessary to improve care on the front end of the life spectrum. However, these stakeholders have been unwilling to expend traditional pediatric resources on the next key point in the spectrum: pediatric patients becoming young adults; a phase of life far more complex than simply reaching a specific age.

Based on our and others' recent experience with clinical care adjustments to the COVID-19 pandemic, we hypothesize that virtual care (e.g., telemedicine) provided by pediatric urologists can deliver the majority of follow-up non-invasive care to the majority of our patients who may require it, well into adulthood. These specialists are the *de facto* undisputed experts in these patients' pre-existing urologic conditions diagnosed in childhood. Such experts can detect and prevent problems earlier, keep adult care costs down, and proactively refer as well as advise on intervention. The overhead costs to pediatric institutions of the virtual approach would

be minimal when compared to the present barrier costs of in-person bricks and mortar transitional clinical care.

Interventions will still require coordination with adult systems and adult colleagues, but will be more timely and appropriately guided, with fewer delays or errors in diagnosis, and with anticipated lower overall costs to health systems globally.

The authors state '*The main barrier in postponing transition was the long-standing bond between the patient and the pediatric provider.*' Indeed, this long-standing relationship could be exploited as a positive driver of ongoing virtual care engagement between the pediatric urologist and their now-adult patient.

Certainly, healthy children are often impatient to join the adult world. As long-term pediatric patients, however, the notion of 'transition' can mean loss of a trusted life-long relationship with their pediatric urologist. A virtual care approach could provide the best of both worlds, easing them into adulthood without cutting the care cord unnecessarily or prematurely.

As pediatric specialists we may forget that in caring for children we care for a moving (growing) target. We agree with the authors that we can and must do better at preparing our patients earlier and proactively for their own personal adulthood. It is likely an easier expectation to train ourselves to understand the psyche of the young adult than to expect adult providers to learn the intricacies of pediatric urology conditions they rarely otherwise see. Moreover, many pediatric urologists initially trained in adult urology.

Adult providers are often reluctant to take on care of potentially active congenital conditions with which they have little familiarity. With expert virtual care backup for a pre-existing pediatric urology condition, adult providers might be more likely to accept such

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adult patients knowing pediatric urology guidance remains engaged and readily available. Moreover, adolescent and young adult urology support groups can be successfully virtualized, and the pandemic has revealed (to us) that even coordinated multidisciplinary care visits work well by telemedicine.

Establishing and maintaining dedicated multidisciplinary pediatric/adult transition teams is theoretically attractive but complex and of questionable sustainability and generalizability: otherwise, they would be commonplace by now. The original pediatric urology service remaining appropriately engaged virtually with periodic follow-up adult care

would ease the ultimate handover to and coordination with the adult system if and when invasive testing or surgery may be required. As such, 'transitional' care could become truly patient-specific and patient-centered, rather than trying to build transitional systems that have, till now, proven very difficult to achieve. Payers might also become convinced to see virtualization as a positive value proposition in transitional care.

Lastly, this approach would have an (originally) unintended but welcome benefit: we would at last open true long-term windows into the adult consequences of our interventions.