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EDITORIAL

Pediatric-to-Adult Nephrology: The Handoff

One of the most often discussed topics in health care is the "handoff," that is, the communication of the care plan of a patient from one provider to another. In football, the most basic of running plays involves the handoff, and to the spectator, it seems simple but it isn't. Talented athletes and attributes such as strategy, coaching, practice, cooperativity, and synchronicity need to be considered together to make the play work, over and over. It isn't easy in medicine either, much less with pediatric nephrology, to which this issue of *Advances in Chronic Kidney Disease* has been dedicated, under the expert guidance of pediatric nephrologist, Dr. Tej Mattoo. Handoffs, these important transitions of care, take place literally thousands of times daily in busy hospitals. They may involve physicians, nurses, and other members of health care teams. The handoff process may include discussions of medications, diagnostic testing, monitoring of critical functions, and humanistic components that involve family and loved ones and broach cultural, religious, and socioeconomic issues. Content of the communication must be complemented by directionality, efficiency, and documentation, which is, hopefully, digital and automated. Thus, the handoff, with an intended purpose to maintain patient stability and improve patient outcomes, may also inform diagnosis, prognosis, and complex personal issues.

The handoff discussed in this issue of *Advances in Chronic Kidney Disease* represents the transition of care that must occur for those pediatric individuals who survive CKD into early adulthood and beyond. Previously, for many renal illnesses, this transition never took place, attributable to anticipated death before adulthood. Now, many more patients with CKD due to pediatric disorders require adult nephrologists, as a result of improved diagnostic capabilities and therapies, and demise is fortunately uncertain for several disorders. One outstanding example of this is primary hyperoxaluria, and sufferers from this rare illness may now survive and thrive into adulthood. Similarly, incremental improvements in renal replacement therapy of pediatric patients have improved patient survivorship, and this is in no small part linked to greater opportunities for kidney transplantation resulting from enhanced survival.

In a multilateral consensus statement in 2002, the American Academy of Pediatrics, American Association of Family Physicians, and the American College of Physicians–American Society of Internal Medicine emphasized that "physicians have an important role in facilitating transitions to adulthood and to adult health care for young people who are least likely to do it successfully on their own."[1] The goals of this policy statement, targeted for 2010, were to ensure that physicians who provide primary or subspecialty care to young people with special health care needs could do the following: (1) understand the rationale for transition from child-oriented to adult-oriented health care; (2) have the knowledge and skills to facilitate that process; and (3) know if, how, and when transfer of care is indicated. Unfortunately, 2010 has passed, and a major survey of our health care system's collective ability to achieve these goals reported that we failed to achieve any modicum of success for any of the 3 stated goals.[2]

Many reasons for the dismal result were cited. Specifically, there was a lack of an identified staff person to "carry the ball" and facilitate the transition of care, that is, no running back, whereas, occasionally, the pediatrician does not want to "let go of the ball."[3] Multiple barriers to transition were mentioned as well, including financial, psychosocial, and developmental tools that evaluate the readiness of the child and the family's readiness to transition. Worse yet, the physician component at the nexus of care in this complicated constellation is unprepared, that is, no quarterback. Pediatric and adult nephrologists have expressed anxiety regarding the process. Even worse, adult nephrologists, in general, clearly

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lack training in the basics of pediatric nephrology. At the other end of the spectrum, only recently has geriatric nephrology been considered necessary as a curricular requirement for nephrologists-in-training.

In terms of the direction of adult nephrology training programs, there is no absolute requirement that exposure to pediatric kidney problems must occur during fellowship. Within the rubric of a conventional 2-year clinical program, there is little time for meaningful exposure to children with kidney disease as well. This confession echoes the painful truth among most U.S. training programs with regard to exposure of fellows to peritoneal dialysis, that is, these programs are often insufficient and barely serviceable. In addition, many academic programs do not have periodic multidisciplinary conferences involving pediatric and adult nephrologists and renal transplantation surgeons. Finally, the worst possible scenario is when the pediatric nephrologist-quarterback has no adult nephrologist to "hand off the ball to." This adverse circumstance possibly results from inadequate training, lack of time to effectively make the transition, and inadequate reimbursement for doing so. Obviously, there is work to do.

When the handoff works, the successful running play is a beautiful orchestration of movement and represents a summation of multiple efforts. When a similar handoff occurs between the pediatric nephrologist and an adult nephrologist, the probability of patient success is greatly enhanced. Most often, children with kidney disease, along with their families and other loved ones, suffer greatly in many ways as they grow up. To fumble the ball in the crucial transition of care of pediatric patients, and after so many years, would be heartbreaking, pointless, and irresponsible. Clearly, all interested parties must make for the best handoff possible and run with the ball.

Acknowledgments

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Editor

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