



The 65th ASH Annual Meeting Abstracts

POSTER ABSTRACTS

901.HEALTH SERVICES AND QUALITY IMPROVEMENT - NON-MALIGNANT CONDITIONS

Improving Transition of Emerging Adults with Sickle Cell Disease to Adult Care through a Multidisciplinary Process: The Development of a Transition Clinic to Support Transition Success

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The transition period from pediatric to adult care is challenging for people with sickle cell disease (SCD). Emerging adults with SCD who do not successfully transition have increased acute care utilization, worsened disease severity, and are at risk for early death. Several patient-level and system-level factors impact success of transition. A structured process using tested interventions increases the success of transition for patients with chronic diseases. We sought to develop a multidisciplinary transition program for young adults with SCD using the Got Transition basic components of health care transition, including a dedicated "Transition Clinic."

We established a multidisciplinary transition program for emerging adults with SCD at Cincinnati Children's Hospital (CCHMC) in March 2019. We used QI methods to implement and track transition processes based on the customized Six Core Elements of the Health Care Transition Model (policy/guide, tracking and monitoring, readiness, planning, transfer of care, and transition completion) and the ASH transition toolkit for SCD. The transition team includes physicians, psychologists, nurse practitioners, social workers, and nurse care managers at the pediatric and adult SCD programs (CCHMC and University of Cincinnati) who meet regularly to discuss transitioning/transferring patients, patients who completed transfer, and topics related to transition. Patients are approached at age 14 with a goal to transfer to adult care at age 21. We implemented a "Transition Clinic" dedicated to addressing transition-specific issues (progress on TRAQ-derived goals, self-management, financial counseling, academic planning, introducing members of the adult team). Patients ≥ 18 y.o. are encouraged to attend at least one transition clinic before transfer of care. We measured the short-term success of transition by successfully completing a visit with adult provider within 6 months of the last pediatric visit. We collected data on patients who did and did not attend transition clinic. Between March 2019 and September 2022, 29 emerging adults reached age 21 and transferred to adult care. The mean age of transfer was 21.5 y.o. The patients' genotypes were: 20 HbSS, 7 HbSC, 1 HbSD and 1 HbS β -thalassemia. Overall, 19/29 attended at least one transition clinic; 18/19 who attended transition clinic had follow up data from an adult facility compared to 5/10 who did not attend transition clinic. Of patients who attended transition clinic, 17/19 completed a visit with an adult provider within 6 months of the last pediatric visit compared to 1/10 in patients who did not attend. The mean time between the last pediatric visit and first visit with an adult provider was 77 days among those who attended transition clinic vs 321 days among those who did not attend a clinic. There was no difference between the 2 groups in age of transfer (21.6 vs 21.2 y.o), sex (females 47% vs 40%), or insurance type. However, the proportion of patients with SS genotype was higher among patients who attended transition clinic compared to those who did not (SS 79% vs 50%).

Our team successfully developed and implemented a transition clinic, as part of a multidisciplinary transition program, to support the successful transition of young adults with SCD to adult care. Most patients who attended a transition clinic made it to an adult provider within 6 months. Individuals who did not attend transition clinic were more likely to be lost to follow up or have delayed adult care. Future research should examine the barriers to clinic attendance as there is likely a correlation

between patients who have the tools to be able to attend a transition clinic and patients who are successful navigating a new medical system. Considering patients with HbSS had a more successful transition, next steps should include identifying factors that contribute to their success to better support patients with other genotypes. In conclusion, the implementation of a multidisciplinary process by a dedicated pediatric and adult team may increase SCD patients' success to transition to adult care. Efforts should be made to understand barriers for patients with non-SS genotypes and patients who have been unable to attend a transition clinic. Long term goals include identifying ways within the pediatric clinic to better incorporate the adult team and to measure long-term success of transition and its impact on health care utilization.

Disclosures No relevant conflicts of interest to declare.

<https://doi.org/10.1182/blood-2023-177747>