Sickle Cell Adolescent & Young Adult Transition
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TRANSITION

“The Purposeful Planned movement of Adolescents and Young Adults (AYA) From Child-Centered to Adult Centered Care”

The Sickle Cell Adolescent Transition Clinic (SCAT) helps to facilitate a smooth, successful transition.

Comprehensive Team Approach: Nurse Practitioner, Nurse Educator, Social Worker
WHY IS TRANSITION IMPORTANT?

- Individuals with SCD live well into adulthood

- As survival of this population improves, there is an increasing need for improved coordination and transfer to adult care

- Transition of medical care can be a challenging and often difficult major life event (often coincides with other life changes. ex. Leaving for college, starting a new job)

- Patients report leaving pediatric care without adequate preparation
BARRIERS TO TRANSITION

• Lack of transitional support
• Loss of insurance
• Insufficient funding
• No time for transition planning
• Loss of a medical home
• Difficulty finding adult providers
CONSEQUENCES OF INADEQUATE TRANSFER

• Frequent ER visits
• Frequent hospitalizations
• Lack of Continuity of care
• Additional Health Care Cost
• Increase morbidity
• Increase mortality
• Decrease life expectancy
HEALTH TRANSITION IS A PROCESS

- Start early to build skills
- Aim for Independence
- Health care providers are key
- Learn the system
- Successful transition leads to better health outcomes
THE NEED

• Transition needs to be well coordinated.

• Need systematic processes to transition adolescents and young adults (AYA) to adult care.

• Timing should depend on the developmental readiness and health of the individual

• Avoiding abrupt transfer should decrease the tendency for the adolescent to not keep follow-up appointments with the new adult provider
THE NEED FOR EDUCATION

- Education is a key component to success in transitioning young adults with sickle cell disease (SCD) from pediatric to adult care.

- There is an increase in mortality and morbidity during this crucial period that can be linked to lack of knowledge about SCD and common complications that can lead to serious illness and even death.
TRANSITION SHOULD INCLUDE

- Assessment of adolescent/parent readiness
- Help finding the right adult provider
- Encouraging self-efficacy
- Providing self-advocacy training (within and outside of the medical system)
- Equipping AYA with the needed knowledge of SCD
TRANSITION CHECKLIST

• Adult provider receives transfer request from pediatric team
  Medical records/ transition summary/appointment/insurance
• Pediatric visit to adult provider prior to complete transfer
• Adult provider gives “new adult patient” info (visit summary) to pediatric team as appropriate
• Date of transfer mutually agreed
• Pediatric & Adult provider declares successful and complete Transition

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QUESTIONS/ COMMENTS