Improving Transition from Pediatric to Adult Sickle Cell Care Using a Transition Checklist

BECU HEALTH



BACKGROUND

- Sickle Cell Disease (SCD) affects over **5,500** individuals in North Carolina.¹
- The transition from pediatric to adult care is a high-risk period marked by increased ED use and hospitalizations.²
- Gaps in health literacy, selfmanagement, and socioeconomic factors worsen health outcomes.
- A standardized transition checklist can guide providers in preparing patients for adult care.

PROJECT AIM

• By April 1, 2025, incorporate the transition checklist into the care of at least 60% of eligible patients (aged 12 and older with SCD) seen at any ECU Health Pediatric Sickle Cell Clinic visit.

PROJECT DESIGN/STRATEGY

Setting: ECU Health Pediatric Hematology/Oncology Sickle Cell Clinics (monthly). **Population:** Patients aged 12+ with SCD. **Tool:** 3-phase Transition Checklist focusing on: Health Knowledge, Health Behaviors, and Socioeconomic Factors. **Team Members:** Providers, Nurses, Social Workers, Child Life Specialists.

Documented in EMR during each visit; advancement to next phase required \geq 80% completion.

Discussed	Competent		Discussed	Competent	
		Healthcare			Health Behaviors
		Living well with SCD			Sexuality
		Periods			High risk pregnancy
		Priapism			Romantic relationships
		Anemia			Stress management
	1	When to call your doctor?			Behavioral pain management
		Meaning of laboratory values		1.	Importance of healthy diet and exercise
		Pain triggers and treatment			Potential impact of SCD on hobbies/intere
		Adherence strategies			Alcohol, tobacco, illicit drug use
		Current medications			Importance of mental health (depression, screening)
		Immunizations			
		Knowledge of genotype			
		Options for adult care			
		MyChart app			
T		provider			
		nursing			
		Physchosocial team			
	-	discussed			
171	1	competent			

Figure A. Phase I Transition Checklist



Figure B. Transition Checklist Implementation Rate by Clinic Date

RESULTS/OUTCOMES

- **54** eligible patients seen from Oct 2024–Mar 2025.
- **35% of patients (n=19)** had checklist documented.
- 5 patients returned for follow-up \rightarrow 100% continuation of checklist.
- Only **2 patients (11%)** advanced to Phase II.
- See graph for visual summary of checklist implementation by clinic date.

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LESSONS LEARNED

 Successful implementation is tied to specific provider engagement. • Variability in staff presence affects consistency. Most patients are not yet transitionready, reflected by low Phase II progression.

• Importance of regular **team**

reeducation and discussion.

NEXT STEPS

• Ongoing staff training and project reinforcement during monthly meetings.

• Collaborate with new **Transition Coordinator** to standardize use.

Explore barriers to Phase II

progression (e.g., patient

understanding, staff comfort).

Evaluate patient and caregiver

satisfaction with the checklist tool.

ACKNOWLEDGEMENTS

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References

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