

# The Impact of Structured Models of Care on Hospitalization and Continuity of Care In African American Young Adults With Sick Cell Disease.

Ritaj Salamáh<sup>1 2</sup>

<sup>1</sup>Health Services Mentorship Program, George Mason University; <sup>2</sup>Chantilly High School

## Introduction

Sickle cell disease (SCD) is a genetic blood disorder that affects hemoglobin, causing red blood cell to be sticky and sickled-shaped. Causing anemia, severe pain, acute chest syndrome, infection, organ damage, and frequent hospitalizations. Approximately 100,000 people live with SCD in the united states, 90% being African Americans. Mortality rates among young adults with sickle cell disease (SCD) increases 2.3 fold during the transition from pediatric to adult care(Lee et al., 2019). Young adults with SCD face many challenges when transitioning from pediatric to adult care. Including access to care, race, and financially burden. These challenges contribute to hospitalization and mortality during the vulnerable period. Understanding these barrier can improve health care outcomes for young adults transitioning from pediatric to adult care.

## Objectives

Objectives of this study:

- Identity gaps in the transition from pediatric to adult care among African Americans young adults with SCD.
- Evaluate the correlation between between transition gaps and continuity of care.
- Would a structured model of care reduce transition gaps.

## Methods

Database used: pubmed

Key words: Sick cell disease, pediatric to adult care, transition of care, African Americans, transition readiness, Six Core Elements of care. To conduct this study I used 7 peer review sources.

Inclusion criteria:

- Included young adults transitioning from pediatric to adult care
- Peer review article published in English

Exclusion criteria:

- Published before 2016
- Studies not focused on SCD

## Results

The literature finds that the transition from pediatric to adult care can be challenging for young adults with SCD due to gaps in preparation decreasing continuity of care. The 6 Core Elements of care provides a structured process that includes transition planning, readiness assessment, tracking patients, transferring care, and connecting patients with adult healthcare providers.

A study using the 6 Core Elements of care included 37 young adults with SCD. After participating in the transition program, 100% completed an initial visit with an adult provider, compared with 50% before the program, and 78% stayed engaged in adult care. These findings demonstrate improved transfer and continued engagement with adult healthcare.

The SMART model study examined transition readiness amount young people with SCD was influenced by factors such as knowledge, communication, skills and confidence, developmental maturity, motivation, emotional well-being, and expectations.

Six Core Elements Transition Program

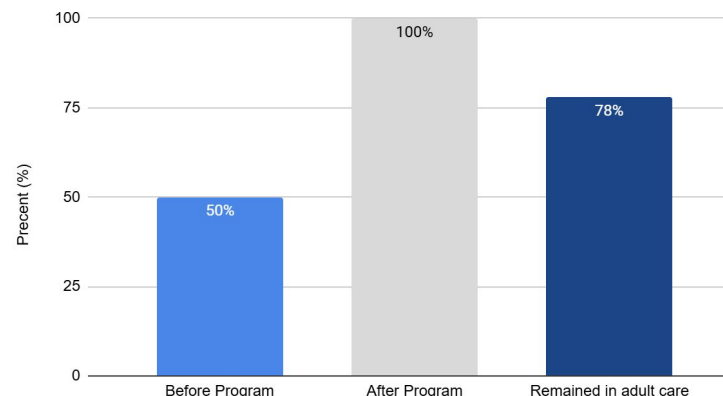


Figure 1. Six Core Elements Transition Program Outcome

## Discussion

The findings suggest that structured transition programs can support young adults in maintaining care through the transition to adult care. The Six Core Elements study showed improvement in connecting patients with adult providers and keeping them engaged in care. The SMART Model also shows that successful transition depends on patients being prepared to manage their condition, communicate with providers, and take on more responsibility for their healthcare.

Maintains continuity of care is important for preventing health care complications that could lead to hospitalization. When patients are prepared and remain connected to adult healthcare providers, they may be better able to manage their SCD and receive treatment when problems occur. However, the available studies do not provide enough direct evidence to conclude that structured transition programs reduce hospitalization rates or mortality specifically among African American young adults with SCD.

## Conclusion

Over all, structured transition models, including SMART model and the 6 core elements of care can be used to help young adults with SCD prepare for transition to adult care and maintain care. The evidence suggests that these models can improve transition readiness and continuity of care which can lower hospitalization for young adults with SCD. These findings could help health systems improve transition programs, maintain continuity of care and reduce hospitalization for young adults with SCD.

## References

