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Evaluation of a Pediatric-Adult Dyad Care Model for Transitioning Youth With Childhood-Onset Systemic Lupus Erythematosus

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ABSTRACT. ***Objective.*** Only 50% of pediatric rheumatology patients transition successfully to adult care. We developed a pediatric-adult provider dyad transition model for youth with childhood-onset systemic lupus erythematosus (cSLE). This model transitions patients from the SickKids Transition Clinic (STC) to the Young Adult SLE (YASLE) Clinic at Mount Sinai Hospital (MSH) at age 18, where they receive combined pediatric-adult care for 4 years before transitioning to adult care. We aimed to evaluate the success of this transition model.

Methods. A retrospective chart review was conducted for patients with cSLE graduating from STC between August 2016 and September 2023. Transition success was assessed using 3 milestones: (1) initial follow-up at the YASLE clinic within 1 year; (2) subsequent follow-up with > 1 YASLE visit; and (3) sustained follow-up at MSH. Data were reviewed as of September 2024.

Results. Among 234 patients with cSLE, 164 transitioned to the YASLE clinic. At STC, 19.5% had active disease (SLE Disease Activity Index 2000 > 4), and 13.4% had Systemic Lupus International Collaborating Clinics/American College of Rheumatology Damage Index (SDI) > 1. The first milestone was achieved by 98.2%, with 96.2% attending their first YASLE visit within 1 year (median time 3.5 months). The second milestone was met by 97.5% attending > 1 visit. By the study end, 94.2% of patients maintained care at MSH, with a median follow-up of 5.1 (IQR 2.7-7.1) years, including 45.3% who graduated from YASLE.

Conclusion. This transition model, incorporating 4 years of combined pediatric-adult care, demonstrated successful transition for youth with cSLE, with > 90% achieving key milestones of initial and sustained follow-up in adult care.

PLAIN LANGUAGE SUMMARY.

Transition care helps teenagers and young adults with long-term health issues like lupus move from pediatric to adult healthcare systems. This process is often difficult, with only 50% successfully making the transition

We developed a new transition model that starts at The Hospital for Sick Children (SickKids) and moves to the Young Adult Systemic Lupus Erythematosus (YASLE) Clinic at Mount Sinai Hospital when patients turn 18. The unique feature of this model is that patients see both pediatric and adult doctors for 4 years before continuing with only the adult doctor.

We reviewed the medical records of all patients with lupus who graduated from SickKids over a 7-year period. Our study showed that this model works well: 98.2% of patients saw the YASLE doctors within a year (usually in about 3.5 months), 97.5% came back for more than 1 visit, and 94.2% kept getting care at MSH for an average of more than 5 years.

We suggest that other clinics use this transition model. Key parts of its success are the teamwork and good communication between the pediatric and adult doctors and with patients and their families.

Key Indexing Terms: adult rheumatology, pediatric rheumatology, systemic lupus erythematosus, transition

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Childhood-onset systemic lupus erythematosus (cSLE) is a chronic multisystem autoimmune disease affecting 3.3 to 8.8 per 100,000 children, with a female-to-male predominance of 4:1, and is associated with greater disease severity and increased damage accrual than adult-onset SLE.[1,2] The transition from pediatric to adult rheumatologic healthcare for youth with cSLE is a crucial period marked by increased vulnerability and a range of challenges, including decreased perceived health, difficulties with medication adherence, increased healthcare utilization, higher rates of anxiety and depression, and disease flares.[2-5]

Transition involves the purposeful movement of youth with chronic conditions from child-centered to adult-oriented healthcare systems.[6] In practice, the transition process is highly variable, ranging from an absence of a structured approach to the implementation of an integrated pediatric-adult transition model.[7] The European Alliance of Associations for Rheumatology (EULAR), the Paediatric Rheumatology European Society (PReS), and a recent Canadian assessment emphasize the need for partnerships and shared responsibility in transitional care involving both pediatric and adult rheumatology providers, patients, and parents, that have been linked to improved outcomes in other chronic conditions.[8-11]

Various indicators for successful transition have been proposed in line with the above recommendations. They include minimizing the time gap between final pediatric and initial adult clinic visits, promoting patient engagement and attendance of scheduled appointments in the initial year after transition, assessing patient and family satisfaction, and achieving young adult educational and vocational outcomes.[12-16] One study found that 26% of patients with cSLE experience loss to follow-up during transition, defined as > 12 months between pediatric and adult care visits, or end of enrollment.[5] Even among patients who do attend the adult clinic, there is an average interval of nearly 9 months between the last pediatric visit and the first appointment with an adult provider.[5]

Common barriers to successful transition include inadequate infrastructure, insufficient patient preparation, inadequate physician education, and ineffective communication among multidisciplinary teams.[5,17] Guided by literature-identified pitfalls and clinical experience, we enhanced our long-standing cSLE transition clinic by implementing safeguards and targeted strategies. This enhancement included stronger collaboration between pediatric and adult rheumatologists through joint clinics and transition letters to ensure seamless handovers. Currently, most healthcare transition research for this population primarily emphasizes the role of pediatric providers, with insufficient focus on the continuity and long-term care facilitated by the pediatric-adult provider dyad.[14,15] Further, challenges related to accessing and linking data between pediatric and adult healthcare systems significantly impede the effective longitudinal study of transition models.

To address these gaps, this study aimed to evaluate the successful follow-up of patients with cSLE seen at the Young Adult Transition SLE (YASLE) Clinic, in their transition from the pediatric cSLE clinic to adult SLE care.

METHODS

Context. The Hospital for Sick Children (SickKids) pediatric cSLE clinic follows > 200 patients annually, with approximately 15% to 20% transitioning to adult care in any given year. A SickKids Transition Clinic (STC) was established in the early 1990s. Initially, the clinic collaborated with a single adult SLE specialist, ensuring continuity of care for patients. Established in August 2016 at Mount Sinai Hospital (MSH), the YASLE clinic facilitates collaborative care between an adult rheumatologist (AS) and a pediatric rheumatologist (EDS), serving 15 to 20 patients every other Tuesday. In this study, transition refers to the process in which patients receive care from both the pediatric and adult rheumatologists to prepare for adult care, whereas transfer occurs when care is fully assumed by the adult rheumatologist (AS).

Patients eligible for an STC visit are identified through a centralized electronic health record (EHR) list that includes all patients with cSLE attending the pediatric cSLE clinic. This list includes a dedicated column for date of birth and age, allowing the clinical team to systematically flag patients nearing the transition age of 18. STC visits occur 3 to 4 times per year. Scheduling is based on patient age and the adult rheumatologist's availability, with considerations for academic exam periods to minimize disruptions.

At the STC, the adolescent medicine team conducts a workshop with youth covering topics such as transition preparedness, postsecondary education and accommodations, sexual and reproductive health education, and risk reduction for substance use, including cannabis and alcohol. At the same time, a social worker facilitates a parallel group for parents, covering similar topics while also providing ongoing psychosocial support to families. Additionally, a nurse plays a key role in ensuring a smooth and well-supported transition for patients and their families during these visits. During the STC visit, both the pediatric (EDS) and adult (AS) rheumatologists review a comprehensive transition letter summarizing the patient's medical history, treatments, complications, as well as pertinent family, social, and psychosocial factors**.** Patients are seen with their parents in attendance, meet the adult rheumatologist for the first time, and a folder detailing the adult team members, contact information, and service location is provided. An appointment is booked at the YASLE clinic, where the patients receive combined pediatric-adult care for 4 years before transitioning to adult care.

Parents are welcome to attend the first YASLE clinic visit, whereas for subsequent visits, independent attendance is encouraged to foster autonomy. However, accommodations are made for patients with developmental delays or comorbid neurocognitive and/or psychiatric conditions that may affect their ability to attend alone. During the STC visit, patients and parents are informed of this approach, which is reinforced at the first YASLE appointment by the pediatric and adult rheumatologists, emphasizing self-management and direct communication. Patients also have the option to invite their parents for the visit wrap-up if they choose.

At the first YASLE clinic visit, patients are seen simultaneously by both the pediatric and adult rheumatologists to ensure familiarity and provide a seamless transition to adult care. For subsequent visits, patients alternate between seeing the pediatric and adult rheumatologists separately, ensuring both providers remain up to date on the patient's progress, and enhancing efficiency. Virtual care is available for stable follow-up visits, provided the patient is clinically stable and has had an in-person visit within the past 12 months. After each clinic, a postclinic review is conducted to discuss patient progress and transition planning. At approximately age 22, patients graduate from YASLE clinic and continue their care with the same adult rheumatologist (AS) in the adult clinic, located in the same physical space (Figure 1).

Study population. The medical records of all patients seen at the STC between August 2016 and September 2023 were reviewed. Inclusion criteria were patients who (1) were diagnosed with cSLE, meeting either the 1997 American College of Rheumatology (ACR) criteria or the 2012 Systemic Lupus International Collaborating Clinics (SLICC) classification criteria for SLE[18,19]; and (2) attended the STC clinic between August 2016 and September 2023. Patients who did not satisfy either the 1997 ACR or the 2012 SLICC classification criteria for SLE were excluded.[18,19] We adhered to the SQUIRE (Standards for Quality Improvement Reporting Excellence) guidelines in structuring and reporting this initiative.[20]

Metrics of successful transition. Successful transition was assessed at 3 key milestones to evaluate both short-term and long-term outcomes:

(1) The first milestone (initial follow-up) was defined as the percentage of patients with cSLE who attended the STC and were subsequently seen within 1 year at the YASLE clinic, as documented in the EHR.

(2) The second milestone (subsequent YASLE clinic follow-up) required patients to have at least 1 additional YASLE clinic visit occurring ≥ 12 months after their initial appointment, reflecting ongoing care.

(3) The third milestone (sustained follow-up at MSH) measured long-term retention in care and included patients who either remained in YASLE at the end of the study period or had graduated and continued receiving care under the adult rheumatologist at MSH.

Collectively, these milestones measured the effectiveness of the transition program in fostering initial prompt attendance and sustained continual follow-up. The cohort's status was reviewed as of September 18, 2024.

Demographic and disease characteristics. Data collection encompassed demographic and disease characteristics, including age at diagnosis, sex, disease duration (between date of diagnosis and date of transition), disease activity measured by Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) at transition visit and damage assessed by SLICC/ACR Damage Index (SDI) at transition visit, and clinical and laboratory features throughout disease course up until transition.[21,22] The distance from each patient's home address to the YASLE clinic and transportation time by car was calculated.

A total of 234 eligible patients with cSLE reached the age of 18 years during the period between August 2016 and September 2023 and attended the STC. Of these, the majority (164 patients) transitioned to the YASLE clinic at MSH, whereas 70 patients defined as "Other cohort" are followed in another young adult rheumatology clinic (not part of this study; Figure 2).

Statistical analysis. Descriptive statistics were used, including means, medians, and SDs for continuous variables; frequencies and proportions were used for categorical variables. Fisher exact test was applied to categorical variables to assess significant differences in clinical and laboratory features between the YASLE and Other cohorts; *t* tests were used for continuous variables. A threshold of significance was set at $P < 0.05$.

RESULTS

YASLE cohort. The 164-patient YASLE cohort was predom-

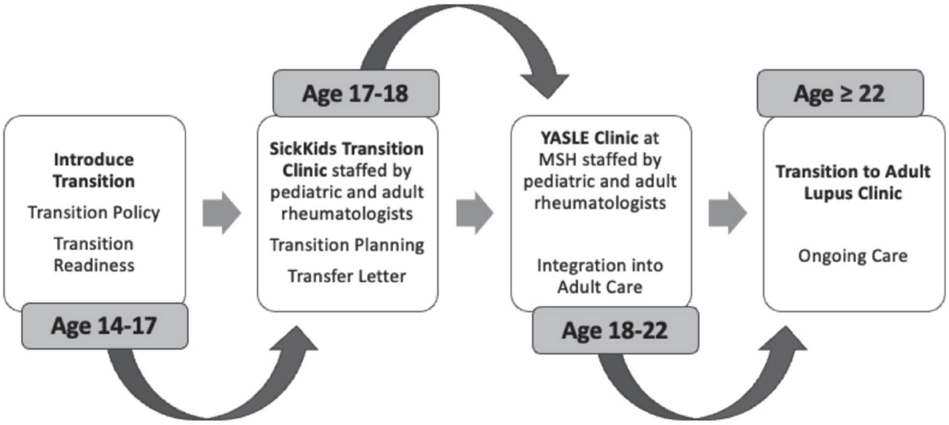

Figure 1. SickKids Transition Clinic is held for those turning 18 years, wherein patients with childhood-onset systemic lupus erythematosus first meet their adult care team and then transition to the YASLE clinic at Mount Sinai Hospital (MSH). This is a combined clinic staffed by a pediatric rheumatologist (EDS) and an adult rheumatologist (AS) who manage all patients collaboratively until patients are approximately 22 years of age, at which point patients are transitioned to the adult rheumatology clinic, staffed by the same adult rheumatologist, located in the same physical space. YASLE: Young Adult Systemic Lupus Erythematosus.

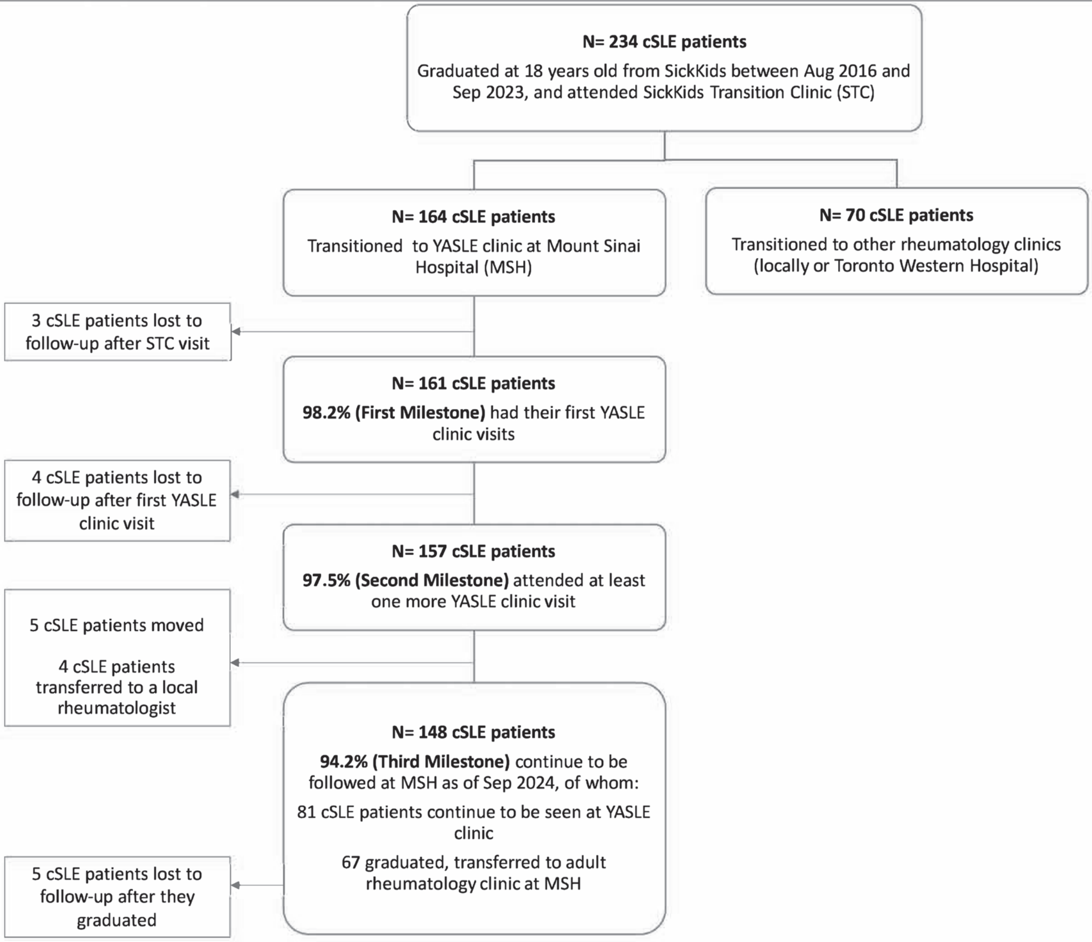

Figure 2. Overview of transition outcomes for patients with cSLE graduating from SickKids at age 18 years between August 2016 and September 2023. The figure illustrates the attendance of patients transitioned to the YASLE clinic at MSH across 3 key milestones: first follow-up at YASLE clinic, subsequent follow-up at YASLE clinic, and sustained follow-up at MSH. cSLE: childhood-onset systemic lupus erythematosus; YASLE: Young Adult Systemic Lupus Erythematosus.

inantly female (87%), with a mean age at diagnosis of 13.1 (SD 3.4) years (Table). The median distance from patients' households to the YASLE clinic was 40 (IQR 22.3-54.2) km, with the longest distance being 1400 km. The median transportation time was 50 (IQR 36-60) minutes by car, with the longest time being 860 minutes (14 hours). At the transition visit, the median disease duration was 4.4 (IQR 2.3-7.2) years. Most patients (80.5%) had quiescent disease, as evidenced by a median SLEDAI-2K score of 2 (IQR 0-4); 19.5% had active disease (SLEDAI-2K > 4). The median SDI was 0 (IQR 0-0), whereas 13.4% had SDI score > 1. One-hundred fifteen (70.1%) were taking ≤ 5 mg of prednisone per day.

Clinical manifestations at the transition visit in order of frequency were malar rash (65.9%), arthritis (56.7%), nephritis (40.9%), nonscarring alopecia (26.8%), photosensitivity (22%), mucosal ulcers (20.1%), neuropsychiatric SLE (15.2%), other rashes (14.6%), serositis (11.6%), myositis (7.9%), and discoid rash (6.7%; Table). Laboratory manifestations and autoantibody profile are shown in the Table. When the YASLE cohort was compared with the other cohort, there were no statistically significant differences in demographic or disease characteristics, or in clinical and laboratory manifestations.

First milestone of transition: initial follow-up at YASLE clinic. Of the 164 patients who attended the STC and were referred to the YASLE clinic, 161 (98.2%) attended their first YASLE appointment, whereas 3 were lost to follow-up after transition, with reasons unknown because of the inability to contact them. Among the 161 patients seen in YASLE, 155 (96.2%) attended their first YASLE appointment within 1 year of transition, with a median time of 3.5 (IQR 2.0–5.2) months. The remaining 6 patients attended their first YASLE appointment > 1 year after their visit to the STC, with a median interval of 13.8 (IQR 12.6–16.1) months.

Second milestone of transition: subsequent follow-up after first YASLE clinic visit. Of the 161 patients seen at the YASLE clinic, 157 (97.5%) returned for at least 1 follow-up visit after their initial appointment. The remaining 4 patients were lost to follow-up, repeatedly missed appointments, and could not be reached for rescheduling.

Table. cSLE demographics and disease characteristics (n = 234).

	Both (YASLE and Other), n = 234	YASLE, n = 164
Demographic characteristics		
Age at diagnosis, yrs, mean (SD)	13.2 (3.4)	13.1 (3.4)
Female, n (%)	201 (85.9)	142 (86.8)
Distance to YASLE clinic, km, median (IQR)	–	40 (22.3-54.2)
Transportation time by car, mins, median (IQR)	–	50 (36-60)
Disease characteristics at transition visit		
Disease duration, yrs, median (IQR)	4.4 (2.3-7.2)	4.4 (2.3-7.2)
SLEDAI-2K, median (IQR)	1 (0-4)	2 (0-4)
SLEDAI-2K, mean (SD)	2.1 (3)	2.6 (3.3)
Active disease (SLEDAI-2K > 4), n (%)	39 (16.7)	32 (19.5)
SDI, median (IQR)	0 (0-0)	0 (0-0)
SDI, mean (SD)	0.3 (0.8)	0.3 (0.8)
SDI (score > 0), n (%)	32 (13.7)	22 (13.4)
Prednisone dose, mg, median (IQR)	0 (0-5)	0 (0-5)
Mean (SD)	4.7 (10.4)	5.5 (11.6)
≥ 5 mg/d, n (%)	64 (27.4)	49 (29.9)
Clinical features ever, n (%)		
Nephritis	80 (34.2)	67 (40.9)
Proliferative nephritis[a]	71 (30.3)	62 (37.8)
Neuropsychiatric SLE	35 (15)	25 (15.2)
Arthritis	116 (49.6)	93 (56.7)
Serositis	27 (11.5)	19 (11.6)
Myositis	15 (6.4)	13 (7.9)
Mucosal ulcers	45 (19.2)	33 (20.1)
Nonscarring alopecia	63 (26.9)	44 (26.8)
Malar rash	156 (66.7)	108 (65.9)
Photosensitivity	54 (23.1)	36 (22)
Discoid rash	22 (9.4)	11 (6.7)
Other rash[b]	30 (12.8)	24 (14.6)
Raynaud phenomenon	50 (21.4)	33 (20.1)
MAS	17 (7.3)	10 (6.1)
Laboratory features, n (%)		
Hypocomplementemia	103 (44)	77 (47)
Lymphopenia	126 (53.8)	85 (51.8)
Thrombocytopenia	67 (28.6)	50 (30.5)
Hemolytic anemia	78 (33.3)	63 (38.4)
Autoantibodies ever, n (%)		
Anti-dsDNA	140 (59.8)	104 (63.4)
Anti-Sm	78 (33.3)	62 (37.8)
Anti-RNP	91 (38.9)	72 (43.9)
Anti-Ro	95 (40.6)	68 (41.5)
Anti-La	40 (17.1)	29 (17.7)
aCL	54 (23.1)	40 (24.4)
LAC	38 (16.2)	26 (15.9)

[a] Class III, IV, III/V, or IV/V. [b] Subacute cutaneous lupus erythematosus, vasculitis. aCL: anticardiolipin antibody; cSLE: childhood-onset SLE; LAC: lupus anticoagulant; MAS: macrophage activation syndrome; SLE: systemic lupus erythematosus; SLEDAI-2K: Systemic Lupus Erythematosus Disease Activity Index 2000; SDI: Systemic Lupus International Collaborating Clinics/American College of Rheumatology Damage Index; YASLE: Mount Sinai Young Adult SLE Clinic.

Third milestone of transition: sustained follow-up at MSH. Of the 157 patients who attended at least 2 YASLE clinic visits, 148 (94.2%) were being followed at MSH at the end of the study, with 81 (54.7%) continuing in the YASLE clinic and 67 (45.3%) having graduated. Of the 9 patients no longer followed at MSH, 5 moved, and 4 transferred to a rheumatologist closer to their home. Among those who graduated, 62 (92.5%) continued care with the adult rheumatologist (AS) in her adult rheumatology clinic at MSH, whereas 5 (7.5% of graduates) were lost to follow-up, with reasons unknown owing to the inability to contact them. After a median follow-up of 5.1 (IQR 2.7-7.1) years, 143 (87.1%) of the initial 164 patients who attended the STC continue to have their care at MSH. The longest follow-up time is 8.3 years.

DISCUSSION

This study demonstrates the success of our structured pediatric-adult dyad transition care model in promoting and maintaining continuity of care across all 3 milestones for youth with cSLE during the pivotal transition from pediatric to adult care. Building on previous work suggesting models of transition care for patients with cSLE, our present study describes a structured, collaborative model involving a 4-year integrated continuum of care between pediatric and adult rheumatologists following graduation from pediatric care.[23-25]

High initial attendance marked the first milestone of success in our transition model, with 98.2% of patients referred from the STC to the YASLE clinic attending their first YASLE appointment. Among these, 96.2% attended their first appointment within 1 year of transition, with a median time of 3.5 (IQR 2.0-5.2) months, well below the 1-year benchmark. Conversely, prior studies on patients transitioning from pediatric to adult SLE care reported intervals of 8 to 11 months between the final pediatric visit and the first adult appointment.[2,3] This underscores the effectiveness of an integrated, prompt, and comprehensive transition process in facilitating continued care in the adult system, effectively minimizing the time gap between pediatric and adult services. Indeed, this approach to adult-provider engagement has been shown to be essential for a successful transition from pediatric to adult care, as shorter intervals between final pediatric and initial adult appointments increase the likelihood of establishing consistent adult care.[17,26]

The second and third milestones of our transition model demonstrated sustained follow-up rates and were similarly robust. Specifically, 97.5% of patients attended at least 1 YASLE follow-up appointment, and 94.2% of those who had at least 2 YASLE clinic visits continued their care at MSH for a median of 5.1 years (IQR 2.7-7.1), with the longest follow-up reaching 8.3 years. Among them, 45.3% have graduated thus far from YASLE and transitioned to care under the adult rheumatologist. These findings underscore the durability of our transition model in achieving high levels of continuity in care with adult healthcare services.

Importantly, this high level of continued attendance was maintained despite potential barriers, such as distance from the adult specialty center, which is often recognized as a significant risk factor for poorer transition outcomes. For many youths, navigating logistical challenges such as travel distances can complicate consistent attendance at appointments and lead to attrition.[27] However, YASLE patients consistently attended their appointments despite residing at considerable distances from the clinic, as evidenced by our data. The high continued attendance further underscores the effectiveness of our transition model.

Beyond logistical challenges, clinical factors such as disease activity may play a role in the success of transition.[3] In this study, 80.5% of patients with cSLE who transitioned had mild disease, as indicated by a median SLEDAI score of 2, a median SDI score of 0, and a low oral prednisone dose (< 5 mg/day). Although disease activity plays a crucial role in facilitating a successful transition, it is not sufficient on its own to ensure a smooth transition to adult care for patients with cSLE.[5] Some transition models postpone the move to adult care until youth are well into their postsecondary studies, to ensure medical and social stability.[28] In contrast, our model successfully transitioned patients at 18 years of age regardless of disease activity, demonstrating that an early, structured transition process can still maintain high attendance rates across different transition milestones as well as continuity without compromising care even during major stressful life events.

The strength of our transition model lies in its collaborative, structured approach, which holistically addresses both medical and psychosocial concerns during this critical period. This approach is largely built on the active engagement and commitment of both pediatric and adult rheumatologists, ensuring evidence-based, patient-centered continuity of care. It incorporates effective communication strategies, such as sharing the patient's clinical history and psychosocial context during STC visits and providing formal, comprehensive transition letters to equip adult care providers with a thorough understanding of the patient's needs.[24,25] This approach has been linked to high patient and parent satisfaction, improved disease control or remission, reduced hospitalization rates, and sustained continual follow-up in adult care.[28-31]

Pretransition interactions with the adult rheumatologist and continued pediatric rheumatologist involvement likely contributed to the model's success, as studies show that early engagement with adult clinicians improves clinic attendance and care retention, and fosters familiarity, trust, and emotional preparedness.[12,13,23,32-34] These interactions allow patients to set realistic expectations, address concerns about differing care systems, and establish a clear point of contact for managing disease flares.[28] This proactive and familiar approach not only alleviates common barriers but also creates an environment of support that encourages progressive self-management. The inclusion of a pediatric rheumatologist in the adult care setting during the acclimation period further supports this transition. This provides patients with cSLE with a gradual adjustment period, fostering confidence and continuity.[26,35] There were no direct costs associated with implementing this transition model, as it was integrated within existing clinical workflows. However, some strategic trade-offs were considered. The buy-in and commitment of the physicians involved is critical to the model's success, as these cases are often complex, visits are often lengthy, and the remuneration is no different for these than for a more straightforward chronic disease follow-up in our provincial fee-for-service model. Ultimately, this pediatric-adult dyad transition care model effectively meets the unique needs of patients with cSLE, enabling comprehensive co-management and laying the foundation for sustained healthcare outcomes.

We acknowledge limitations inherent to this study's retrospective design and reliance on chart review to ascertain the transition plan. Reasons for loss to follow-up were not always documented or available. The generalizability of our model to other healthcare systems may be limited because of differences in healthcare infrastructure, insurance coverage, and provider reimbursement models, which can affect care continuity and transition processes. A key feature of our combined clinic model is that both adult and pediatric rheumatologists can bill separately during the same visit; however, we acknowledge that this may not be feasible in other healthcare settings, posing a potential limitation. Currently, psychosocial support in the YASLE clinic relies on external resources, but we have recently developed a collaborative YASLE-Psychiatry clinic and plan to formally evaluate this in future studies. Other elements of the transition process that need to be evaluated prospectively are beyond the focus of this study, including evaluating patient satisfaction with the transition process, evaluating disease activity and damage progression, and assessing healthcare maintenance, medication adherence, healthcare utilization, and mortality rates.

In conclusion, this study highlights the success of our structured pediatric-adult dyad transition care model in fostering prompt initial attendance and ensuring continuity of care for youth with cSLE during the critical transition from pediatric to adult healthcare. Nearly all referred patients (98.2%) attended their first YASLE appointment, with 96.2% seen within a median time of 3.5 months. Sustained follow-up was equally robust, with 97.5% of patients returning for at least 1 additional visit, and 94.2% remaining in care at MSH after attending at least 2 visits despite challenges such as traveling significant distances to attend the YASLE clinic. Notably, 87.1% of the initial cohort remained under care at MSH after a median follow-up of 5.1 years, with the longest follow-up extending to 8.3 years. These results underscore the strength of this model rooted in collaborative care across all 3 milestones of transition, and communication between pediatric and adult rheumatologists and with the patients and their families. This model provides a replicable framework for optimizing chronic disease care transitions, as its principles are not exclusive to SLE care. This study supports a strong case for broader implementation of this transition model across other subspecialties, advocating for its widespread adoption.

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CONTRIBUTIONS

TET, AS, EDS: conceptualization, methodology, data curation, writing original draft, reviewing and editing. AK, LTH, DML, AT: reviewing and editing.

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COMPETING INTERESTS

The authors declare no conflicts of interest relevant to this article.

ETHICS AND PATIENT CONSENT

This study was conducted in accordance with local guidelines and protocol approved by the quality improvement (QI) committee. This study was approved as a QI initiative through SickKids (project number: QIP-2002-02-15T19-56-17) and MSH QI stream.

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