

study compared all AYA with SCD or thalassemia who turned 18 years between August 1, 2013 and August 1, 2015. There were two patient cohorts: prior to and after the introduction of the formal program. Data from one year prior to last appointment at HSC and one year after the first appointment at TGH were collected. The effects of covariates on imaging/clinic/transfusion/subspecialist appointment attendance, medication adherence and hospitalizations were analyzed by multivariable regression.

Results: 112 patients met the criteria for transfer/transition, 51 transferred prior to August 1, 2014 and 61 through the CSTP. No significant differences were observed in baseline demographics. The CSTP significantly reduced the proportion of patients lost to follow-up from 29% (11/38) to 7% (4/57) ($P=0.0335$). The presence of the CSTP was independently associated with a significant increase in the proportion of patients on hydroxyurea or iron chelation who maintained or improved their medication adherence to ≥ 4 days a week ($P=0.047$, LR 4.668). A trend towards improvement or maintenance of $\geq 90\%$ attendance to appointments was observed ($P=0.096$, OR 2.254). Variations in appointment attendance can be explained by patient's age, distance from the hemoglobinopathy center, and English as patient's first language. No independent predictor was found in frequency of hospitalization. No new overt strokes or deaths occurred in the year after moving to the adult center.

Conclusions: CSTP with dedicated TN was significantly associated with reduction in the number of AYA lost to follow-up, and improvement and maintenance of fair to good medication adherence. Further analysis of economic benefit and patient satisfaction will be conducted. A clustered randomized-controlled trial will be forthcoming to determine the effectiveness of this transition model of care on AYA patients with sickle cell disease.

Sources of Support: Funding for the transition program provided by the SickKids Foundation, University Health Network Division of Medical Oncology & Hematology, and an unrestricted grant from Novartis and ApoPharma.

72.

LIVING WITH A CHRONIC CONDITION AND RISK BEHAVIORS



Joan-Carles Suris, MD, MPH, PhD¹, Christina Akre, PhD¹, Yara Barrense-Dias, MA¹, André Berchtold, PhD².

¹Lausanne University Hospital; ²Lausanne University.

Purpose: To assess whether living with a chronic condition (CC) is associated with risk behaviors among youths.

Methods: Data were drawn from the baseline wave (2014-15; N=5179) of the GenerationFree survey, a longitudinal study among post-mandatory youths aged 15-24 years in Fribourg, Switzerland. Students were divided into three groups depending on whether they reported having a CC or not: healthy controls (no CC: N=4529; 46.2% females), CC without limitation (CCWL: N=536; 52.6% females) and CC limiting daily activities (CCLDA: N=114; 58.9% females). At the bivariate level groups were compared on socio-demographic data and six risk behaviors (current smoking; current (at least once in the past 30 days) alcohol misuse, cannabis use and use of other illegal drugs; violent behavior and antisocial behavior at least once in the past 12 months). In a second step, a multinomial logistic regression was conducted including all variables significant at the .05 level. Results are given as Relative Risk Ratios (RRR) with 95% confidence intervals. As it is often argued that the lack of

differences observed in risk behaviors between CC and health youths may be due to the fact that respiratory diseases (mainly asthma) are the commonest CC in this age group, we subsequently repeated all the analyses without these cases (CCWL: N=275, 61.4% females; CCLDA: N=76, 55.6% females).

Results: At the bivariate level, as the degree of limitation increased, participants were significantly more likely to be female, living in a non-intact family, reporting poorer health and emotional well-being, and lower socioeconomic status. As the degree of limitation increased, students were significantly more likely to have used illegal drugs or to have engaged in violent behaviors. When controlling for potential confounders, CCWL reported poorer health (RRR: 3.70 [2.55:5.36]) and emotional wellbeing (RRR: 1.30 [1.03:1.65]) and higher cannabis use (RRR: 1.38 [1.03:1.85]) while CCLDA reported poorer health (RRR: 18.37 [11.15:30.27]) and emotional wellbeing (RRR: 2.02 [1.27:3.22]) and higher odds of violent behavior (RRR: 1.89 [1.08:3.29]). When respiratory diseases were excluded, the only additional difference at the bivariate level was that alcohol misuse significantly increased along with the degree of limitation. At the multivariate level, CCWL were more likely to be female (RRR: 1.71 [1.27:2.30]) to report poorer health (RRR: 5.01 [3.24:7.73]) and emotional wellbeing (RRR: 1.35 [1.00:1.82]) but no differences were found for risky behaviors. CCLDA reported poorer health (RRR: 19.74 [10.93:35.67]) and emotional wellbeing (RRR: 1.84 [1.07:3.17]) and engaging in violent behaviors (RRR: 2.38 [1.25:4.54]).

Conclusions: Youths living with a CC are at least as likely as their healthy peers to engage in risky behaviors, independently of the degree of limitation. Whether this fact is due to their desire to be normal or to live on the fast-track remains to be studied. Health professionals dealing with youths with a CC must be aware of it and make sure they receive the same prevention, counseling and guidance that they offer to any young person. Living with a CC is not a protective factor.

Sources of Support: The Programme Intercantonal de Lutte contre la Dépendance au Jeu (PILDJ) and the canton of Fribourg.

73.

END OF LIFE IN ADOLESCENTS AND YOUNG ADULTS WITH CANCER



Anne Watson, PhD, RN, Shana Jacobs, MD, Meaghann Weaver, MD, MPH, Maureen Lyon, PhD, FSAHM.

Children's National Health System.

Purpose: Participation in a facilitated advance care planning (ACP) program is associated with having end-of-life wishes known and followed, and their families indicate less stress, anxiety and depression, compared to those who do not participate. ACP is also associated with decreased numbers of Intensive Care Unit (ICU) admissions and length of stay. Dying in the setting of full support predicts lower quality of death and dying, while the presence of a living will, discussion of the patient's wish to withdraw life support during a family conference, and assessment of pain is associated with higher quality of death and dying. Advance directives and documentation of wishes to restrict medical interventions are associated with less use of life-sustaining treatments. The purpose of the present study is to examine some of these metrics at end of life in a population of teens and young adults with cancer who had participated in either the intervention or control arm of a study on facilitated pediatric advance care planning (pACP).