Welcome Healthcare Transfer of Care

April 6, 2022

Care Transformation Collaborative of RI

Agenda

Topic *Presenter(s)*	Duration
Welcome & review of Agenda *Susanne Campbell, CTC-RI Senior Program Director*	5 minutes
Dyads Report Out *Patience White & Peggy McManus to assist with Q&A*	40 minutes
Tips for increasing show rates and engagement *Patience White and Peggy McManus to assist with Q&A*	15 minutes
Survey Results (Patient and Practice feedback) *Patricia Flanagan, MD, FAAP & Beth Lange, MD, FAAP*	15 minutes
Transition of Care Payment Advocacy Efforts *The National Alliance of Adolescent Health*	15 minutes

of patients transferred

Dyad	Transferred	Scheduled to be Transferred	# of surveys received
PCHC – Randall	5	0	5
PCHC – Chafee	6	0	5
PCHC - Capitol	4	3	4
Hasbro PPC / CPC	4	1	3
Nevola/Grande	1	4	0
Coastal Waterman/East Providence	5	3	5
Coastal NBP / EGPC	4	1	0
Total	**29**	**12**	**22**

DYAD: Providence Community Health Centers

What did we learn? The tools were helpful. We modified them to meet the needs of our practice and we were able to develop an organizational practice guideline. The tracking mechanism was helpful with hopes that at some point we can automate it. There were mixed feeling across the sites related to the readiness survey.

Did the adult practice find it helpful to receive a summary? We have a shared EMR. The note from the last pediatric transition visit serves as the summary, and providers can refer to it, but not all do.

What did we learn from youth feedback? Positive feedback based on the surveys.

2 things your practices/team will commit to continue doing:

1. We will continue to use this process and make modifications as we move to the new EMR.
2. We will make sure that workflows are optimized within the new system.
3. We piloted this program at three sites and developed organizational guidelines. We will be rolling it out to all the sites for PCHC.

How are you going to measure success? Implementation of this process at all the sites and movement on our annual well visit measure for youth 18-21.

What recommendations do you have for the next cohort? Have someone from the care teams participate as part of the meetings with the practice facilitator.

DYAD: Hasbro Pediatric PC / Center for PC

What did we learn? That this is a smoother process and builds on the work that we have already in place in working with families about transitions at the earlier adolescent visits. We also learned that a crucial step is the young adult keeping that first appointment with the adult provider. An opportunity for improvement will be to work on supporting the YA to attend that first adult visit.

Did the adult practice find it helpful to receive a summary of the pediatric transition visit? Yes, it was nice to see the YA as a human and connect to the Peds PCP - easy to reach out and ask a question after this.

What did we learn from youth feedback? They seemed ready to transition. Many of the YA did not feel that a joint visit would be helpful.

2 things your practices/team will commit to continue doing:

Hasbro: we will broaden this process to include other faculty and resident providers up to 35 patients. we will work on strategies to encourage young adult attendance at the first adult provider visit.

CPC: facilitate expanding to residents in pediatrics and internal med and add a site at The Miriam Hospital/Fain.

How are you going to measure success: We will measure the number of YA patients who successfully have their first visits with adult provider

What recommendations do you have for the next cohort 1) start the discussion of transition at earlier adolescent visits 2) look at strategies to encourage YA attendance at first appointment with adult provider

DYAD: Nevola / Grande

ADVANCING INTEGRATED HEALTHCARE

What did we learn? Transitions are complicated and require far more preparation, organization, policy development and review, and teamwork than previously thought.

Did the adult practice find it helpful to receive a summary? I hope so. We will be integrating our automated summary/problem list/care team list/comment document into CNE's version of Epic.

What did we learn from youth feedback? Those patients invested in their care are very particular about where they will transition; those that are not present the challenges of self-investment in their care and appropriate follow-up with any clinician.

2 things your practices/team will commit to continue doing?

1. Organized comprehensive Medical Summaries with commentary and communication for the adult provider
2. Reviewing our transition policy with all eligible young adults in-office together with/without parents present as visit dictates.

How are you going to measure success? A successful transition/first visit to the adult practice with a brief follow-up with patient after their first visit.

What recommendations do you have for the next cohort? Start implementing strategies early! Patients will likely need time and multiple discussions to feel reassured enough to participate and proceed.

DYAD: Coastal Medical E Providence IM/Waterman Peds

What did we learn? When YA's are involved in their goals of care, their engagement and appointment outcomes are successful

Did the adult practice find it helpful to receive a summary? Yes

What did we learn from youth feedback? YA's scored high scores as a result of confidence in the preparation and dialogue between both the pediatric and adult offices upon the initial transition

2 things your practices/team will commit to continue doing

1. Continue warm handoff between pediatric and adult offices
2. Continue to encourage transition of care within the Coastal Medical network of practices

How are you going to measure success? Strongly consider feedback survey at completion of visit; involve various departments to initiate process

What recommendations do you have for the next cohort? Ensure open lines of communication and processes are defined and followed through with both pediatric and adult practices so that transition is smooth and organized. This approach was very successful with our team!

DYAD: Coastal Medical NBP/EGPC

What did we learn? Learned a lot, communication with pedi/adult office has been very helpful, ya know what to expect; telehealth very helpful (especially those with anxiety) give ya expectations of adult practice; pedi office can reassure patients transferring that they will continue with same level of care

Did the adult practice find it helpful to receive a summary? Yes, shared eCW;NBP includes specific info on cover pg.

What did we learn from youth feedback? They don't like doing surveys (MA called 4 ya, ended up talking to mother of special needs patient, other patients – no answers – will try to call again)

2 things your practices/team will commit to continue doing?

1. EG doing better job of finding/retaining referred patients (possibly send a letter); be creative with communication; call patient first to confirm phone number belongs to ya;
2. pedi practice will also make efforts to ensure correct contact info is up to date; efforts to keep problem list up to date with subspecialist indicated; continue to use cover sheet, problem list, immunization, most recent appointments listed – makes it easier for adult practice

How are you going to measure success? Patient shows up for first appointment; have patients continue to show up and use process with patients going forward; Pedi – keep track of transition to adult provider (note where they are going when making patient "inactive" – keep this via a telephone encounter – name it "transition"); increased awareness and communication

What recommendations do you have for the next cohort? Think about script before doing Telehealth visit; and expectations of roles; work on policy for payment for both providers for telehealth; Pedi – starting communication with patients at a younger age;

Tips for increasing show rates and engagement

Discussion: What other strategies are being used to increase show rates?

From the practices

- Text messages/reminder calls. We would be interested in finding out if other practices have used incentives for this purpose.
- 1) we have added to the Transition Template a discussion of importance of keeping first appointment 2) reminder call of adult appointment by pediatric practice 3) NHP has incentives for kept well visits for patients (gift cards) will look in to this as being a possibility to encourage keeping the first appointment.
- Consistent reach-out to patients and families. Sadly, there is only so much a smaller practice can do in these circumstances.
- All YA's were seen for their appointments; there were zero no shows. We believe YA's kept their scheduled appointments as a result of initial outreach and engagement between offices and YA.
- EG is under 4% for no show rates; EG is reaching out in person to patients; consider using text messages for reminders (google voice); encourage portal reminders

Other suggestions shared

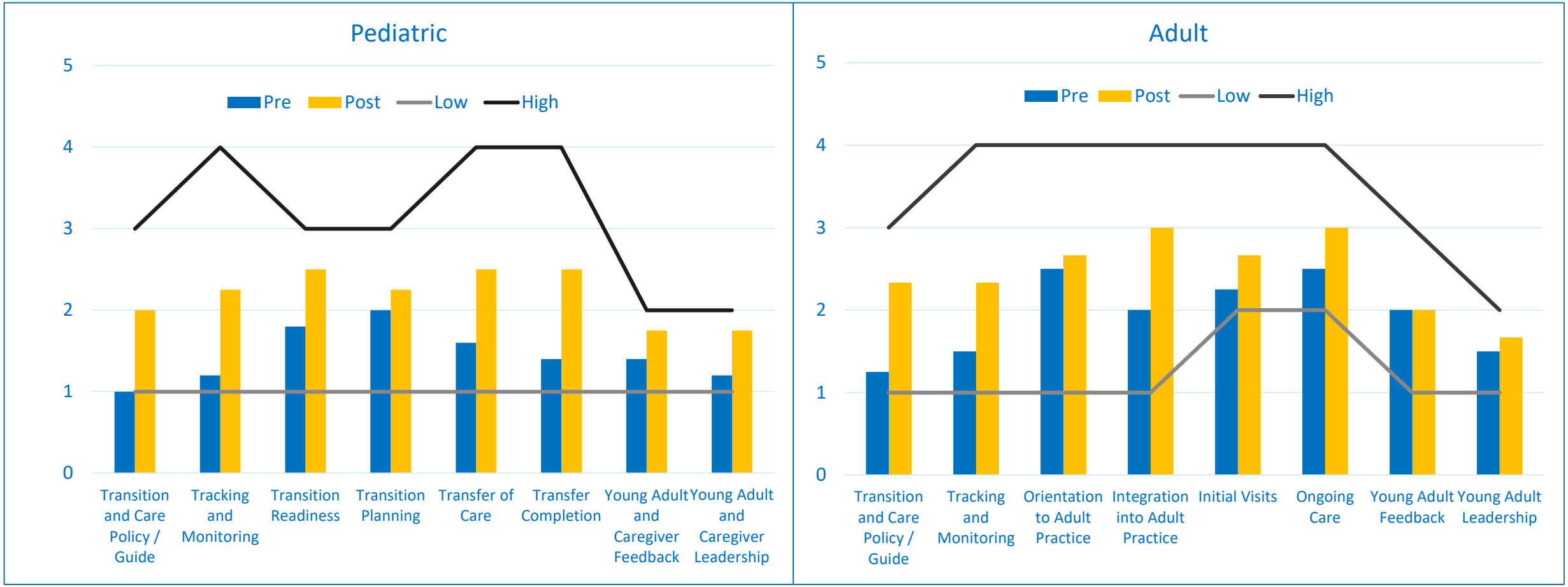
- Suggesting youths take pictures of their appointments
- Suggesting Youths use alarms

Results from Youth Surveys: 17 received from 3 dyads

DID YOUR PAST PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Explain the transition process in a way that you could understand?	**100% Yes**
Give you a chance to speak with them alone during visits?	**100% Yes**
Explain the changes that happen in health care starting at age 18 (e.g., changes in privacy, consent, access to health records, or making decisions)?	**100% Yes**
Create and share your medical summary with you?	**82.4%Yes**
Help you find a new adult doctor or other health care provider to move to?	**100% Yes**
DID YOUR NEW ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Address any of your concerns about your move to a new practice/doctor?	**88.24% Yes**
Give you guidance about their approach to accepting & partnering with new young adults?	**88.24% Yes**
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	**94.1% Yes**

- **Overall, how ready did you feel to move to a new adult doctor? 88.24% "Very"; 11.76% "Somewhat"**

Practice Assessments



Making Your Case to Your System Billers/Payors

- Data and stories are key:
  - How many transition-aged youth and young adults, ages 14-25, do you serve?
    - Who are their major payers?
  - Obtain stories from parents and young adults about their concerns and experiences around HCT, including the positive feedback you have received.
  - Figure out exactly what HCT services you offer:
    - Transition readiness assessment, self-care skill building, prep/updating of medical summary and emergency care plan, preparation of transfer package, identification of adult PCPs and specialists, outreach to reduce loss to follow-up, joint telehealth transition visit, consultation with adult clinicians
  - Is your practice/system billing for these services; are payers reimbursing for them?
  - Advocate with your state AAP/AAFP/ACP chapters.

Crosswalk to Codes

- **Transition readiness assessment** annually – Use health risk assessment code (96160).
- **Self-care skill-building** as part of routine preventive and chronic care – Use E/M codes (99202-99205, 99211-99215); no other option (unless using a standardized curriculum). For patients with chronic conditions, E/M codes work. For those without chronic condition, no options exist.
- Preparation/update of **transition plan of care** – A few options: care plan oversight (99339, 99340), non-face-to-face prolonged services (99358, 99359), care management services (99490, 99439, 99491, 99487, 99489, G2064, G2065)
- Preparation/update of **medical summary and emergency care plan** - Same as above
- **Outreach** so transition-aged youth/young adults not lost to follow-up – Care management services (99490, 99439, 99491, 99487, 99489)
- **Identification of adult clinicians** – No options
- Preparation of **transfer package** – A few options: care plan oversight (99339, 99340), non-face-to-face prolonged services (99358, 99359), care management services (99490, 99439, 99491, 99487, 99489, G2064, G2065)
- **Communication/consultation** with adult clinician(s) – interprofessional telephone/internet code (99446-99449, 99451, 99452) (Note: joint telehealth example in DC)

got transition

1

PAS Pediatric Academic Societies

You've made it through the program; now what? Ideas for celebrating and sustaining efforts

- Opportunity for practices to continue transfer efforts and expand
  - Quick Blurb for the patients involved in HTOC pilot – showing the value of their efforts
  - System of Care wide expansion
  - Video?
  - Other?
- Launch another Call for Applications for next cohort
- Communicate more broadly to state agencies the success
- Work with health plans and Medicaid to discuss payment for HCT-related services and for providing more specificity about EPSDT transition anticipatory guidance.
- Other?

Stay Safe and Healthy