Welcome
Healthcare Transfer of Care

September 1, 2021

Agenda

Topic *Presenter(s)*	Duration
Welcome & review of Agenda *Susanne Campbell, CTC-RI Senior Program Director*	5 minutes
Summary of Progress *Susan Dettling & Suzanne Herzberg*	10 minutes
Dyads Report Out – Successes, Challenges, Plans Peggy McManus & Patience White to assist with Q&A	60 minutes
Next Steps *Susanne Campbell, CTC-RI Senior Program Director*	15 minutes

Progress Made

- Tracking sheets have been revised to meet the practices' needs.
- Patients have been identified for the transition.
- Practices are in the process of reaching out to patients
- Practices have completed their FAQs
- New Patient Packets are being formed.
- Joint telehealth visits are being discussed
- Practices are meeting with practice facilitators

- Rhode Island HCT from Pediatric to Adult Health Care is partnering with other states: Massachusetts and Arizona

COASTAL: Waterman Pediatrics & E. Providence Internal Medicine Successes, Challenges & Plans

Successes:

Incorporating the voice of YA and families in the process of being transitioned:

Asking YA about provider gender and location preference

Use of Healthcare Transition Readiness Assessment:

Waterman Pedi uses own tool and conversations starting at age 13; NCM also assists YA with HCT

Guardianship:

Address with high-risk patients/families

Joint telehealth visit:

Planned approach: use NCM to NCM/Care Navigator, packet mailed to young adult first, Doximity will be offered; FAQ will be reviewed with YA as well as the "new patient packet"; remind YA reminder about new PCP appointment (follow up email reminders as well)

Healthcare transition within/out of System of Care:

Have YA fill out ROI

Customization of Registry:

Update Patient Portal to YA email information

Use of FAQ Documents:

FAQ Document is part of the welcome packet to later discuss in joint telehealth visit with NCMs

Challenges:

- YA has a lot of paperwork to fill out
- Need to ensure that small PDSAs are conducted at each step of the process
- Limitations when doing transfers outside of Coastal, need to wait for release before moving forward

Plans:

Enhanced partnership and communication between pediatric and adult practices:

Talking thru workflow has been very positive; new process in eCW for "telephone encounter" to do the ToC; goal is to inform Coastal to help improve ToC across the system

What can your fellow practices assist you with in developing a sustainable HCT process in your practice?

COASTAL: Narragansett Bay Pediatrics & E. Greenwich Primary Care - Successes, Challenges & Plans

Successes:

Incorporating the voice of YA and families in the process of being transitioned:

NBP is using a transition cover letter, care plan document and HCT readiness assessment – shared with 3 of 5 patients thus far

Use of Healthcare Transition Readiness Assessment:

2 young adults have completed the HCT readiness assessment

Guardianship:

NBP has located resources to share with parents of complex patients

Joint telehealth visit:

NBP & EGPC have completed one joint telehealth visit, with actual in person visit scheduled 3 months out

Process for transition within eClinicalWorks

Using electronic telephone encounter to initiate the transfer of care

All 4 Coastal practices will meet to leverage effective workflows within eCW

Challenges:

Joint telehealth visit:

Working out process for better scheduling; determine who has responsibility for patient care after the joint telehealth visit (adult practice)

Keeping the patient engaged:

We want to make sure patient stays engaged with us and interacts going forward in the new office (no-shows are typically aged 25 and under)

Plans:

Joint telehealth visit – need to have a more defined script (pediatrician/ adult)

Evaluating the first adult visit/ transition process – examine tool and process to use to survey patient after first adult visit

Educate patient – make YA aware of th adult programs that may be of benefit to them, use FAQ in transition packet and new patient packet

What can your fellow practices assist you with in developing a sustainable HCT process in your practice?

Dr. Chad Nevola / Pilgrim Park Physicians
Successes, Challenges & Plans

Successes:

- Dr. Nevola has engaged 6 young adults (YA), 2 have committed to follow up with Dr. Grande. One YA is complex (ADHD), and will schedule with adult practice in 3 mos. The other YA will schedule PE in 10 mos.
- Dr. Grande has used the integrated KRAMES patient education that can be customized and printed from EPIC.

Challenges:

- Dr. Nevola - Trying to get YA to commit to transition. Staffing at pediatric practice has been difficult this summer, staff out on medical leave and need to use temp staff.
- Dr. Grande – the YA is not interested in accessing healthcare. Not a lot of need for healthy YA, except school physicals, or ADHD medication refills.

Plans:

- ***Incorporating the voice of the youth and families in the process of being transitioned -*** Dr. Nevola has modified the "Care Plan" template for the young adult to complete their healthcare goals, priorities and concerns.
- ***Use of FAQ document*** - Dr. Nevola has tested the adult FAQ with YA who are engaged. One idea was to send "transfer packet" to YA via patient portal prior to last visit. Developing workflows in EPIC, once tested will consider spreading to system of care. Dr. Grande willing to adjust this document once it is tested.

What can your fellow practices assist you with in developing a sustainable HCT process in your practice?

PROVIDENCE COMMUNITY HEALTH CENTERS

PEDIATRIC TO ADULT - TRANSITION OF CARE

PEDIATRIC TO ADULT - TRANSITION OF CARE SUCCESSES

- Completed Full Presentation to the Care Teams Involved
- Full Commitment From all the Care Teams Involved
- Use of Healthcare Transition Readiness Assessment and Transition Tracking Tool – Got Transitions
- PDSA Created
  - Modified the HCT Readiness Assessment – Got Transitions
    - To be Completed by Pedi RN at Last Pedi Visit
    - Tested this Assessment Tool with Pediatric Sample and Identified Areas for Additional Educational Needs
  - Modified Transition of Care Letter Focusing on the Patient Versus Patient and Parents
- Number (8) of Pedi Patients Scheduled with their New Adult Provider
  - Completed a Meet and Greet with the Adult Care Team

PEDIATRIC TO ADULT - TRANSITION OF CARE CHALLENGES

- Clinicians Hesitant to Have Transition of Care Conversations Starting at Early Age (13 yr)
- Patients with Special Needs Having Difficulty with Readiness Assessment Questions
  - Requiring Help from Parent or Guardian
  - After 18 yr patients with Special Needs require Power of Attorney (for parent to help)
- Identified one Patient in Pilot who Decided not to Participate due to Relocation
- Something to Think About
  - Expand Approach for Transition at age 18

PEDIATRIC TO ADULT - TRANSITION OF CARE

- Next Steps
  - Continue with New Transition Letter that Targets the Patient Versus the Patient and Parent
    - PDSA Complete
  - Develop Process for Surveying the Young Adult After the First Visit with New Provider

What can your fellow practices assist you with in developing a sustainable HCT process in your practice?

PROVIDENCE COMMUNITY HEALTH CENTERS

Michael Leighton HCD	Randall Square
Michael Spoerri HCD	Chafee
Patricia Terceira HCD	Capitol

Hasbro Pediatric Primary Care / Center for Primary Care
Successes, Challenges & Plans

Successes:

- Having a visit labelled specifically as a transition visit made it easier to focus on the transition. It also helped with the scheduling and content of 1st adult visit. Secure chat helped provide information on past hx to set up for success of adult visit.
- Helped families realize the need to have guardianship issues worked out officially and feel comfortable with that.
- Interesting that patients chose in-person care over video for last visit.

Challenges:

- We have a good process for the pilot. Translating that going forward is something that needs to be discussed in the future.
- The average person doesn't understand insurance – need to explain that can't have two physicals in one year. Has to be scheduled as establishing care.

Plans: For the next cycle, we will change the way in which the appts are made. The pediatric providers will contact Damarys Garcia at the CPC via secure chat, providing some personal information about the patient as appropriate. Damarys will then contact the YA to schedule the visit and communicate back to the provider regarding the upcoming appt schedule.

What can your fellow practices assist you with in developing a sustainable HCT process in your practice?

Timeline

Pediatric Timeline at a glance		Adult Timeline at a glance
Start-Up Phase (months 1-4)	**Process Deliverables/ Workflows:** Practice meets monthly with PF during months 1, 2 and 3; Adult and pediatric team meets with PF during month 4;	**Process Deliverables/ Workflows:** Practice meets monthly with PF during months 1, 2 and 3; Adult and pediatric team meets with PF during month 4;
Month 1:	May 19 – May 31, 2021 Pediatric/Adult practices connected, QI team completes Got Transitions HCT assessment, monthly meetings scheduled	Pediatric/Adult practices connected, QI team completes Got Transitions HCT assessment, monthly meetings with QI team and facilitator scheduled
Month 2:	June 2021 Transition planning - customize tools and process **Pediatric**: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation; **Adult**: plan for tracking of patients;	Transition planning - customize tools and process **Adult**: plan for tracking of patients; **Pediatric**: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation;
Month 3:	July 2021 Cust	Customize transfer/receive tools
Month 4:	August 2021 Cu rocess; PDSA cycles on Core Elements 4, 5, 6	Customize transfer completion process; customize process for initial visit; PDSA cycles on Core Elements 3,4,5
Pilot Phase (months 5-12)	**tting it in place** : team meets with PF monthly, Peer Learning Meeting onth 5	**Putting it in place :** team meets with PF monthly**,** Peer Learning Mtg. month 5
Month 5:	September 2021 tart to test HCT Transfer Pilot with 5 Pediatric Patients (Mo.5-7)	**Pediatric**: Start to test HCT Transfer Pilot with 5 Pediatric Patients (Months 5-7) **Adult**: receive and review transfer packet
Month 6:	October 2021 Joint Communication/Telehealth Call for Each Transferring Patient (Mo. 6-8)	Joint Communication/Telehealth Call for Each Transferring Patient (Months 6-8)
Month 7:	November 2021 " "	" "
Month 8:	December 2021 " "	" "
Month 8:	December 2021 **Adult**: Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey (Mo. 8-11)	Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey (Months 8-11)
Month 9:	January 2022 " "	" "
Month 10:	February 2022 " "	" "
Month 11:	March 2022 " "	" "
	Wrapping it up : Peer Learning Collaborative Meeting	**Wrapping it up:** Peer Learning Collaborative Meeting
Month 12:	April 2022 Complete assessment of HCT activities, analyzed pre/post improvement, plan for sustainability and spread	Complete assessment of HCT activities, share/discuss pre/post improvement, plan for sustainability and spread

You are here

Next Steps

- **Start to test HCT Transfer Pilot with 5 Pediatric Patients (Mo.5-7)**
- **Conduct Joint Communication/Telehealth Calls for Each Transferring Patient (Mo. 6-8)**
- **Completion of Initial Adult Visit and HCT patient feedback survey (Mo. 8-11)**

Next & final meeting on April 6, 2022

Would having another debriefing session like we did today be helpful to assist you in making progress on your HCT improvement process (Dec 7th)?

Stay Tuned…

In consultation with the National Alliance, looking to develop plan to identify costs associated with Transfer of Care work. This will help us work with health plans in discussions for payment on transition of care codes that are part of the EPSTD.

Milestone Document Pediatric & Adult

Pediatric and Adult Transfer of Care QI Milestone Summaries

Pediatric and Adult Transfer of Care Work Plans

Stay Safe and Healthy