CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Nurse Care Manager Meeting
Health Transfer of Care

6.21.2022

Care Transformation Collaborative of RI

Agenda

Topic Presenter(s)	Duration
Welcome and Review of Agenda Susanne Campbell, RN, MS, PCMH CCE, Senior Program Director CTC-RI	5 Minutes
Transfer of Care Background and Year 1 Learning Collaborative Susanne Campbell, RN, MS, PCMH CCE, Senior Program Director CTC-RI	10 Minutes
Practice Highlights and Discussion Hasbro Children's Hospital Pediatric Primary Care Suzanne Herzberg, PhD, MS, OTR/L, CTC-RI Practice Facilitator Carol Lewis, MD, Medical Director Hasbro Pediatric Primary Care Coastal Medical: Waterman Pediatrics and East Providence Internal Medicine Sue Dettling, BS, PCMH CCE, Practice Facilitator, CTC-RI	20 Minutes
Got Transition Resources, Position Statements, and Discussion Patience White, MD, MA, FAAP, MACP, The National Alliance to Advance Adolescent Health	20 Minutes
Next Steps Susanne Campbell, RN, MS, PCMH CCE, Senior Program Director CTC-RI	5 Minutes
NCM/CC Core Curriculum Training Program / application / discussion *Jayne Daylor*	30 minutes

RHODE ISLAND DEPARTMENT OF HEALTH

TUFTS Health Plan

got transition®

Coastal Medical
Lifespan. Delivering health with care.®

East Greenwich Internal Medicine
Narragansett Bay Pediatrics
Waterman Pediatrics
East Providence Internal Medicine

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
A Lifespan Partner
All for one.

Hasbro Pediatric Primary Care

Rhode Island Hospital
Lifespan. Delivering health with care.®

Center for Primary Care

CharterCARE HEALTH PARTNERS

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PCHC
PROVIDENCE COMMUNITY HEALTH CENTERS

Capitol Hill
Randall Square
Chafee

Transfer of Care Background

- AAP/AAFP/ACP recommend that health care transition be part of routine primary, specialty, and behavioral health care for all youth with and without special health care needs
- 2019/2020 National Survey of Children's Health finds:
  - 80% of RI YSHCN and 84% of RI non-YSHCN do NOT receive transition preparation from their health care providers (compared to 76% and 82%, respectively, in US)
  - Among adolescents, ages 12-17, RI has a higher prevalence of special needs (29%) compared to the US (26%)
- ED Utilization
- Gaps in care
- An estimated 22% of children in Rhode Island (compared with estimated 19% of children in US) have at least one special health care need (Child and Adolescent Health Measurement Initative (3/16/22)

Why Health Care Transition (HCT)?

Population Health

- Adherence to care, self-care skills, quality of life, self-reported health

Experience of Care

- Increased satisfaction
- Reduction in barriers to care

Utilization

- Decrease in time between last pediatric and 1st adult visit
- Increase in adult visits
- Decrease hospital admissions and length of stay

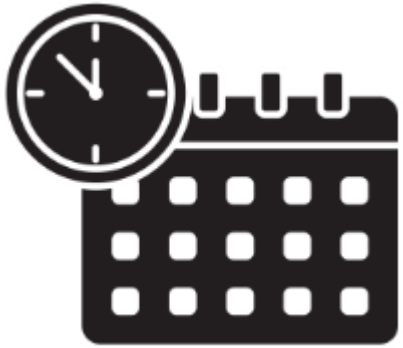
Modified from "Health Care Transition Process Improvement: Pediatric to Adult Transition" 5/19/2021 Got Transition The National Alliance to Advance Adolecent Health Washington DC Presentation. The Sources: *Gabriel et al., Outcome evidence for structured pediatric to adult health care transition interventions: A systematic review. Journal of Pediatrics. 2017;188:263-269. **Schmidt, A., Ilango, S., McManus, M., Rogers, K., & White, P. (2019). Outcomes of Pediatric to Adult Health Care Transition Interventions: An Updated Systematic Review. J. Pediatr Nurs 2020: 51: 92-107.

Pilot Goals

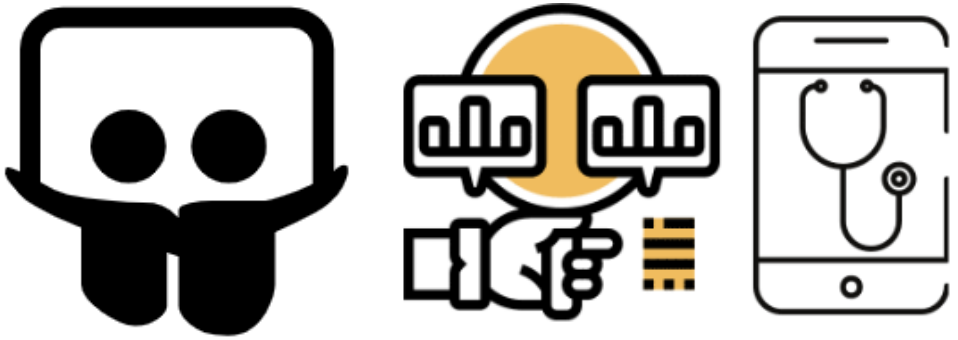
- Created standardized process for transfer from pediatric to adult care with youth, with and without special needs, and families
- Use nationally recognized HCT approach and quality improvement methods to implement practice improvements in both pediatric and adult care
- Strengthen engagement with youth and collaboration between pediatric and adult primary care sites
- Measure HCT practice improvements and consumer experience with HCT process
- Encourage sustainable HCT process through improvements in payment and infrastructure support

Overview of HCT Pilot

7 Dyads
Transitioning youth
with and without SHCN



12 Months
May 2021 – April 2022



Peer Learning
Tools for Tracking/Assessments
Joint Communication and Visits
Youth Feedback

Pilot Summary - What was asked of practices?

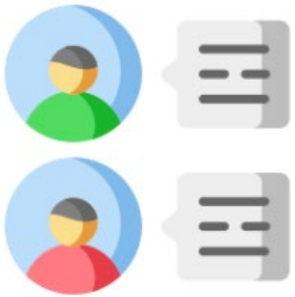
- Pediatric and Adult practices applied together
- Team based care approach
- Transfer of 5 Youths over 12-month period
- Joint transition telehealth visit with pediatric and adult PCPs and transferring youth (option)
- Preparation and sharing of medical summary
- Quality Improvement and Practice Facilitation

Data Summary

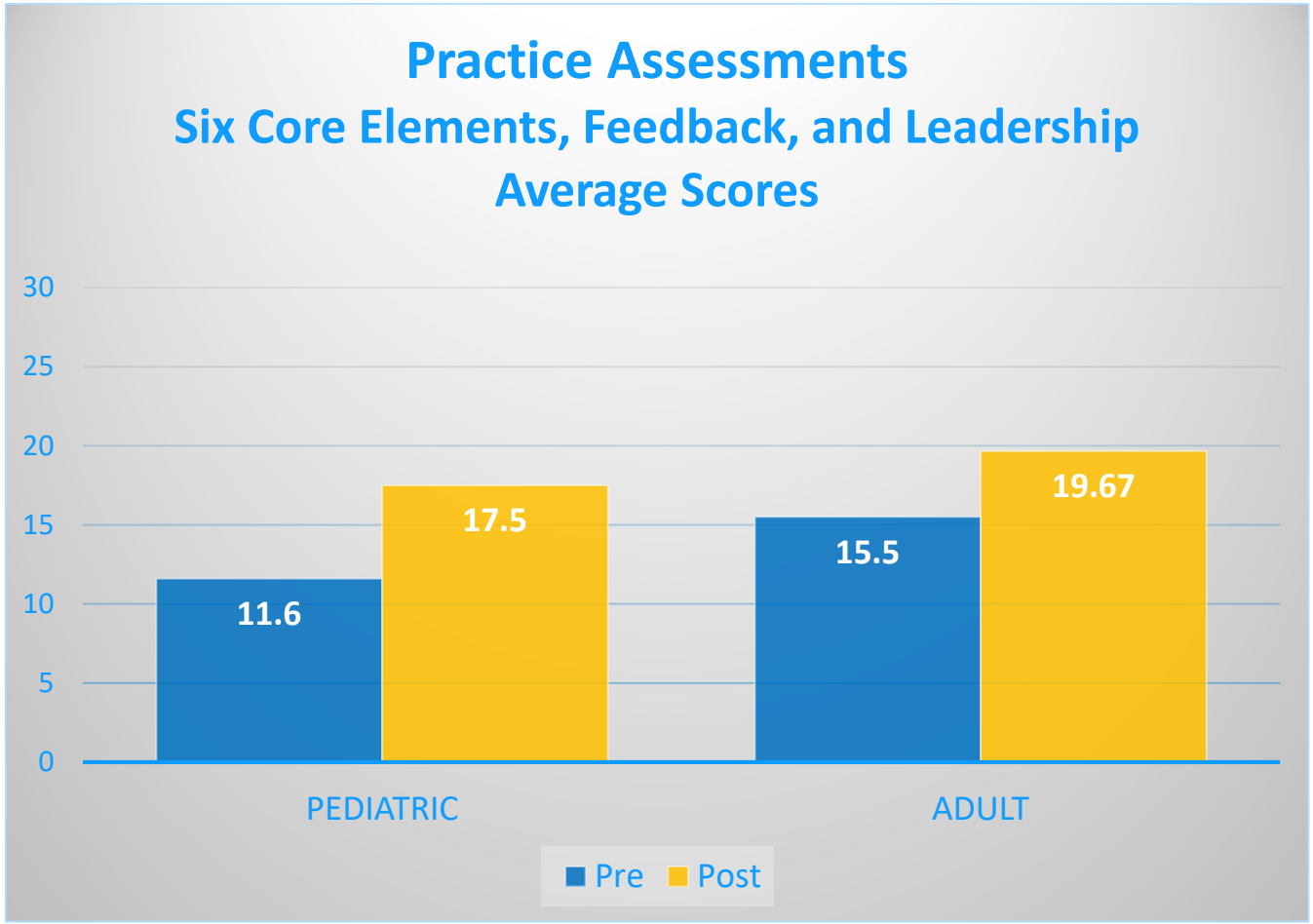
Learning Collaborative May 2021 – April 2022

Total # of patients transferred = 29

Total # of patients awaiting transfer = 12



Total # of youth surveys received = 17



Results from Youth Surveys: 17 received

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 Highlights

Process:

- Pediatric provider identified young adult (YA) for transition
- Sent message to adult provider and two administrative supports
- Sent message to pediatric PCMH project manager
- Provided information on patient's strengths and needs and time frame of next visit
- Adult practice reached out to patient to schedule appt
- Adult practice sent message to pediatric practice via secure chat

Documentation

- **Transition template:**
  - HCH pediatric team scheduled a transition visit using a specific transition template.
  - The template was given to the patient and available in the shared EMR.
- **Transition note:**
  - Brief
  - Included a medical summary, information on readiness skills, and goals.

Hasbro Primary Care and the Center for Primary Care

Lessons learned – shared at April 2022 wrap up meeting:

- **What did we learn?** 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 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:** Broaden this process to include other faculty and resident providers to transfer 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

Role of Nurse Care Managers & Patient Navigator

- Integral part of each practice's quality improvement team
- Waterman Pedi – NCM /E. Prov. – NCM and patient navigator

Process:

1. Pediatric NCM reviews medical summary w/ young adult
   - "anything you wish to share with new adult doctor?"
2. Joint transition telehealth visit
   - Included transferring young adult, pedi NCM & adult NCM
   - Review differences between pediatric and adult practices
   - Reviews adult practice "FAQ"
   - Asks about any special patient needs that may have not yet been identified
   - Review process for making an appointment with adult practice

Process (continued):

3. Patient Navigator (adult practice)
   - Ensures patient schedules appointment with adult provider
   - Ensures patient completes paperwork ("New Patient Packet")

Successes:

- Transferring patients very prepared; understand differences between pedi and adult practice
- Collaboration between pedi & adult NCM/patient navigator = successful visits

Challenges:

- Finding common time for joint telehealth
- Billing for wellness visit if under 12 months, billing for joint telehealth visit
- Transfers out of Coastal Medical – release of record barriers

Dyad: Coastal Medical: Waterman Pediatrics/ E. Providence Internal Medicine Lessons learned – shared at April 2022 wrap up meeting:

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

- Continue warm handoff between pediatric and adult offices
- 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!

Successes to Carry Forward - Practices

- Policy
- Workflows, Documentation and Systems
- Communication Youths provided feedback on the process using assessments
- Spread

The National Alliance to Advance Adolescent Health

Got Transition

Professional Association Policy Statements on HCT

- **NAPNAP** Position Statement on Supporting the Transition from Pediatric to Adult-Focused Health Care. Journal of Pediatric Health Care 2020 34:390
- **American Association of Nurse Practitioners**. (2015). Quality of Nurse Practitioner Practice. Retrieved from https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice
- Betz, C. L. (2017)**. SPN position statement**: Transition of pediatric patients into adult care. Journal of Pediatric Nursing,35 :160
- **American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians,**. (2018). Supporting the health care transition from adolescence to adulthood in the medical home.Pediatrics,142, e20182587
- Transition to Adulthood for Youth With Chronic Conditions and Special Health Care Needs **Society for Adolescent Health and Medicine** Position paper| Volume 66, ISSUE 5, P631-634, May 01, 2020

Six Core Elements of HCT Approach

- The Six Core Elements is not a model of care, but a process (road map/clinical pathway) called for in the NAPNAP position statement and AAP/AAFP/ACP Clinical Report recommendations
- Tested in quality improvement (QI) learning collaboratives (LC) using the Institute for Healthcare Improvement breakthrough QI research approach
- Customizable for busy practices with different models of care
- Intensity of intervention can be guided by: medical complexity of youth/YAs, social determinants of health, ACEs and availability of practice resources
- Applied in many different systems/models of care: primary* and subspecialty clinics*, Medicaid managed care*, prof org.*, state title V agencies care coordination services*, children's hospitals*, FQHCs, SBHCs, behavioral health settings. All have incorporated the Six Core Element Process and improved their HCT processes.

Relevant in All Settings

**Published articles available at www.GotTransition.org*


got transition.
Six Core Elements™
Youth & Young Adults
Parents & Caregivers
Resources & Research
About Us
SIX CORE ELEMENTS OF HEALTH CARE TRANSITION™
Got Transition created the Six Core Elements of Health Care Transition™ 3.0 for use by clinicians to assist youth and young adults as they transition to adult health care.
READ & DOWNLOAD

Six Core Elements of Health Care Transition Content

- Overview
- 3 Transition Packages:
  - Transitioning Youth to an Adult Health Care Clinician
  - Transitioning to an Adult Approach to Care without Changing Clinicians
  - Integrating Young Adults into Adult Health Care
- Implementation Guides for each core element in each package
- Measurement for each of the 3 Packages
- Payment
- Frequently Asked Questions about the 6 Core Elements

There are three sets of customizable tools available for different practice settings.

Click below for information and samples of each core element and full Six Core Elements packages.

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN

For use by Pediatric, Family Medicine, and Med-Peds Clinicians

Click for details on each element.

Six Core Elements Package

Six Core Elements Package En Español

Full Implementation Guide

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS

For use by Family Medicine and Med-Peds Clinicians

Click for details on each element.

Six Core Elements Package

Six Core Elements Package En Español

Full Implementation Guide

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE

For use by Internal Medicine, Family Medicine, and Med-Peds Clinicians

Click for details on each element.

Six Core Elements Package

Six Core Elements Package En Español

Full Implementation Guide

Click here to request a customizable version of any tools.

Examples of GT Tools Available

(Developed with Youth and Families, Customizable)

- Transition Care and Policies Guides (pediatric and adult practices)
- Examples of Registries
- HCT Readiness and self care assessments
- Templates for HCT plans of care, medical summaries and emergency care plans
- Transfer check lists and content for transfer packages, guidance on joint telehealth visits
- Welcome and FAQs for young adults joining a new adult practice
- Current Assessment of HCT activity measurement
- 2022 Coding and Payment Tip Sheet

Six Core Elements of Health Care Transition™

IMPLEMENTING THE SIX CORE ELEMENTS

These Implementation Guides are intended to help clinicians/practices/systems carry out and support health care transition (HCT) improvements using the Six Core Elements of HCT 3.0 for their patients transitioning to adult-centered care with or without changing their clinician. Each guide below contains practical guidance, resources, and examples for conducting HCT quality improvement (QI) in a range of health care settings, using the Model for Improvement as its framework. Each guide contains specific QI considerations, tools, and measures for each core element.

How to Implement the Six Core Element of Health Care Transition includes steps that a health care delivery system or individual practice can consider when utilizing a QI process to implement for the Six Core Elements.

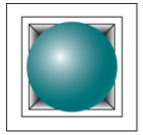
For additional information about the QI framework and methods described in the Implementation Guides, please refer to the ***Quality Improvement Primer***.

How to Implement the Six Core Elements of Health Care Transition™ 3.0

A practical step-by-step supplement to the Six Core Elements

Organized into nine steps that a health care delivery system or individual practice can consider when implementing a quality improvement (QI) process for health care transition (HCT)

Step 1: Secure Senior Leadership Support
Step 2: Form the HCT Quality Improvement Team
Step 3: Develop an HCT Improvement Plan
Step 4: Raise Awareness about HCT Activities
Step 5: Implement the Six Core Elements of HCT
Step 6: Plan for Sustainability
Step 7: Plan for Spread
Step 8: Communicate Successes
Step 9: Tips for Success



Youth and Young Adult Resources at Gottransition.org

TOP RESOURCES

Click into any resource or view all Youth & Family resources here.

Do you want to learn about transitioning to adult health care? (Infographic)

Health Care Transition Timeline for Youth and Young Adults [En Español]

What is Health Care Transition (HCT)? (Animated Video)

More

More

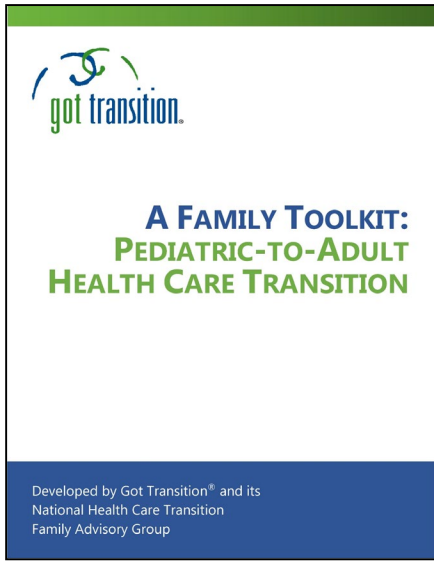
Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones [En Español]

Turning 18: What it Means for Your Health [En Español]

Questions to Ask Your Doctor About Transitioning to Adult Health Care (for Youth and Young Adults) [En Español]

Family Resources at www.gottransition.org
Got Transition's Family HCT Toolkit

- Got Transition and its National Family Advisory Group (10 representatives from National Family groups) have developed a new Family HCT Toolkit to help families throughout the transition process.
- The resource help to answer questions families may have about transition:
  - *When should my child and I start to think and talk about transition?*
  - *What are the recommended HCT services?*
  - *What questions can my child and I ask our doctor about transitioning to adult care?*
  - *How does my role and my child's role change throughout the transition process?*
  - *How can I learn if my child needs help with decision-making?*
  - *What are some of the legal changes in health care that happen at age 18?*
  - *What are the differences between pediatric and adult care?*
  - *How ready is my child to transition to adult care and manage their own health and health care?*



Next Steps

- Learning Collaborative Year 2
  - 7 Practices – 2 New dyads, 3 extended participation practices
    - Dr. Chad Lamendola & Dr. Richard Ohnmacht
    - Children's Choice Pediatrics & Greenwich Medical Associates
    - Hasbro Children's Hospital Pediatric Primary Care & Center for Primary Care
    - Dr. Chad Nevola
- Kickoff Meeting
  - June 29, 2022 @ 7:30am

New name: "Best Practices in Team-Based Care"
formerly "Nurse Care Manager/Coordinator Best Practice"

- Third Tuesday, 8 – 9AM

Applications Open!

Nurse Care Manager/Care Coordinator Standardized Core Curriculum (GLearn) Program

12-15 week program for Nurse Care Managers and Care Coordinators

- Interactive web-based module
- Weekly facilitated collaborated discussions
- Case Study Capstone Presentation
- Earn up to 18.5 RN CEU's and 18.54 CCM credits

Applications due July 22nd.

More details and application materials can be found here:

31

THANK YOU