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| Adult Practice Transfer of Care Quality Improvement Milestone Summary  |
| Component  | **Deliverable**  | **Timeframe Due Dates** | **Notes**  |
| Form Health Care Transition Quality Improvement Team and Confirm Connection with Pediatric Practice | * Identify members of the practice quality improvement (QI) team. The team should consist of 3 to 4 staff in different roles such as practice clinical champion, nurse care manager/care coordinator, practice manager, and/or IT representative if available.
* Establish connection with pediatric primary care practice who will be transferring 5 patients to adult care.
 | Describe as part of application  |  |
| Project Start-Up  | * Participate in initial kick-off meeting with pediatric and adult awardees to review project plan and schedule regular monthly team meetings.
* **Adult practice team completes Got Transition’s Current Assessment of HCT Activities. Due May 7, 2021**
 | Month 1 | Got Transition, with RI Team, will offer kick-off training.[Current Assessment of HCT Activities](https://www.gottransition.org/6ce/?integrating-current-assessment)  |
| Create Simple Tracking Sheet for 5 Transferring Patients | * Create a simple tracking sheet (registry) to monitor dates of joint communication/telehealth visit and initial adult PCP visit and receipt of Core Elements 3,4, and 5 (SEE Sample registry and Telehealth Tool kit
* Share progress in monthly QI meeting.
 | Months 1-2 | The time frame to accomplish the transfer is brief. In months, 5-7, the last pediatric visit with each patient will be completed. A joint communication/telehealth call between sending and receiving PCPs with transferring patient will happen before the initial adult visit, which will start in months 8-11.  |
| Develop Transfer of Care Improvement Plan for Integrating New Patients into Adult Care | * Review and customize the Transfer of Care Improvement Plan to be used for the 5 transferring patients, drawing on Got Transition’s Six Core Elements.
* Use Plan-Do-Study-Act (PDSA) cycles for Core Elements 3, 4, and 5, summarized in greater detail below.
* Share progress in monthly QI meeting.
 | Months 1-4 | Core Element 3- [Orientation to Adult Practice](https://www.gottransition.org/six-core-elements/integrating-young-adults/orientation-to-adult-practice.cfm) Core Element 4 – [Integration into Adult Practice](https://www.gottransition.org/six-core-elements/integrating-young-adults/integration-into-adult-practice.cfm)Core Element 5 – [Initial Visits](https://www.gottransition.org/six-core-elements/integrating-young-adults/initial-visits.cfm) |
| Develop Content and Process for Orientation to Adult Practice (Core Element 3), with PDSA Cycle | * Customize content and process for Orientation to Adult Care (Core Element 3), including preparing a written/online Frequently Asked Questions about the adult practice that will be shared with pediatric PCPs and transferring patients. (SEE Welcome letter for FAQ)
* Complete a PDSA on customized content and process for Core Element #3.
* Share approach at monthly QI meeting.
 | Month 2  | [Six Core Elements Implementation Guide for Orientation to Adult Care](https://www.gottransition.org/6ce/?integrating-ImplGuide-orientation-adult-practice)  |
| Develop Content and Process for Integration into Adult Practice (Core Element 4), with PDSA Cycle | * Customize content and process for Integration into Adult Practice (Core Element 4), including working with pediatric PCP about content for joint communication/telehealth call with transferring patient. (SEE Telehealth Tool kit and Sample Call Script)
* Complete a PDSA on customized content and process for Core Element #5.
* **S**hare approach at monthly QI meeting.
 | Month 3  | [Six Core Elements Implementation Guide for Integration into Adult Practice](https://www.gottransition.org/6ce/?integrating-ImplGuide-integration-adult-practice)Sample Joint Telehealth Call Script *(to be sent when finalized)* |
| Develop Content and Process for Initial Visit (Core Element 5), with PDSA Cycle | * Customize content and process for Initial Visit (Core Element 5), including deciding on content for initial visits.
* Complete a PDSA on customized content and process for Core Element #5.
* **S**hare approach at monthly QI meeting.
 | Month 4  | [Six Core Elements Implementation Guide for Initial Visits](https://www.gottransition.org/6ce/?integrating-ImplGuide-initial-visits)[Sample Content for Initial Visits with Young Adults](https://www.gottransition.org/6ce/?integrating-initial-visits) |
| Learning collaborative Joint meeting\* | Learning Collaborative Joint Meeting  | Month 5  |  |
| (Pediatric PCPs) Start Transfer Pilot with 5 Pediatric Patients | * Pediatric PCPs will complete final visits.
* Pediatric PCPs will complete and share transfer package with patients and new adult PCP.
 | Months 5-7 |  |
| Schedule Joint Communication/Telehealth Calls for Each Transferring Patient | * Coordinate with pediatric practice and patient to schedule a joint communication/telehealth call following last pediatric visit and before initial adult visit.
* Share progress in monthly QI meeting.
 | Months 6-8 |  |
| Confirm Completion of Initial Adult Visit and HCT Feedback Survey | * Complete initial adult PCP visits with 5 transferring patients.
* Communicate with pediatric practice to confirm initial appointment made.
* Request completion of HCT Feedback Survey by young adult at initial visit.
* Share progress in monthly QI meeting.
 | Months 8-11 | [HCT Feedback Survey for Young Adults](https://www.gottransition.org/6ce/?leaving-feedback-survey-youth) |
| Final Transfer of Care Improvement Collaborative  | * Complete Current Assessment of HCT Activities, allowing for analysis of pre/post improvement in Core Elements 3,4, and 5.
* Review lessons learned and plans for sustainability and spread.
* Share progress in monthly QI meeting.
 | Month 12  | [Current Assessment of HCT Activities](https://www.gottransition.org/6ce/?integrating-current-assessment)  |

\*Additional Joint Learning Collaborative may be added based on the team learning needs