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| CTC/PCMH Kids Pilot Primary Care Learning Collaborative:  Pediatric/Adult Primary Care Health Care Transfer of Care  Quality Improvement Initiative (HC-TOC-QII) | | |
| **Adult (HC-TOC-QII) Project Plan** – v6 | | |
| *NOTE: Deliverables are indicated in the milestone document and in this Project Plan; relevant information may be completed with your practice facilitator; and submitted to* [*deliverables@ctc-ri.org*](mailto:deliverables@ctc-ri.org)*(project plans are due at the end of start-up and pilot phases). Use as much space as needed to complete each section* | | |
| **Adult Practice Name:** | | |
| **Practice Sites:** | | |
| **Practice Facilitator Name:** | | |
| **Pediatric Primary Care Practice Name:**  (connected practice who will be transferring 5 patients) | | |
| **Quality Improvement Team**  Original QI team identified as part of application; team should consist of 3 to 4 staff in different roles and include a clinical champion, nurse care manager/care coordinator, practice manager (PF) and IT/EHR and behavioral health staff (if applicable); *Inform your practice facilitator of any changes in staff on QI team.* | | |
| Name | Title | Role in Project |
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| Adult team completed: [Adult/Family Current Assessment of Health Care Transitions Activity](https://www.ctc-ri.org/sites/default/files/uploads/Appendix%20A%20-%20GT-6CE-Integrating-Current-Assessment-Customizable.pdf) (due May 14, 2021) |

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| **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; | | | | |
| Month 1: | May 19 – May 31, 2021 | 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  **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 | Customize transfer/receive tools | | | | |
| Month 4: | August 2021 | Customize transfer completion process; customize process for initial visit; PDSA cycles on Core Elements 3,4,5 | | | | |
| **Pilot Phase (months 5-12)** | | **Putting it in place :** team meets with PF monthly**,** Peer Learning Mtg. month 5 | | | | |
| Month 5: | September 2021 | **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 (Months 6-8) | | | | |
| Month 7: | November 2021 | **“ “** | | | | |
| Month 8: | December 2021 | **“ “** | | | | |
| Month 8: | December 2021 | 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** | | | | |
| Month 12: | April 2022 | Complete assessment of HCT activities, share/discuss pre/post improvement, plan for sustainability and spread | | | | |
| **Start-Up Phase (months 1-4) : May 19 – September 30, 2021** | | | | | |
| 1. **Create Simple Tracking Sheet for 5 Transferring Patients –** Due by June 30, 2021 | | | | | |
| **Action Items** | | | Owner | Completed (yes/no) | Notes |
| 1. 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* (links below) | | |  |  |  |
| 1. Share progress in monthly QI meeting | | |  |  |  |
| **Documents/links:**  **Sample transition registry form**: <https://www.gottransition.org/6ce/?leaving-registry>  [Telehealth Toolkit (gottransition.org)](https://www.gottransition.org/resource/?telehealth-toolkit-joint-visit-pediatric-adult-clinicians)  **NOTE**: 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 including the transferring patient will happen before the initial adult visit, which will start in months 8-11. | | | | | |
| **Additional Notes:** | | | | | |
| 1. **Develop Transfer of Care Improvement Plan for Integrating New Patients into Adult Care –** Due by Sept. 30, 2021 | | | | | |
| **Action Items** | | | Owner | Completed (yes/no) | Notes |
| 1. 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 | | |  |  |  |
| 1. Use Plan-Do-Study-Act (PDSA) cycles for Core Elements 3, 4, and 5, summarized in greater detail below | | |  |  |  |
| 1. Share progress in monthly QI meeting | | |  |  |  |
| **Documents/links:**  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) | | | | | |
| **Additional Notes:** | | | | | |
| 1. **Develop Content and Process for Orientation to Adult Practice (Core Element 3), with PDSA Cycle** – Due by June 30, 2021 | | | | | |
| **Action Items** | | | Owner | Completed (yes/no) | Notes |
| 1. 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, FAQs* | | |  |  |  |
| 1. Complete a PDSA on customized content and process for Core Element 3 | | |  |  |  |
| 1. Share approach at monthly QI meeting | | |  |  |  |
| **Documents/links:**  **Core Element 3:** [Six Core Elements Implementation Guide for Orientation to Adult Care](https://www.gottransition.org/6ce/?integrating-ImplGuide-orientation-adult-practice)  [Sample Welcome and Orientation of New Young Adults (gottransition.org)](https://www.gottransition.org/6ce/?integrating-welcome-orientation)  [Got Transition® - Parents & Caregivers - Frequently Asked Questions](https://gottransition.org/parents-caregivers/frequently-asked-questions.cfm)  [Got Transition® - Youth & Young Adults - Frequently Asked Questions](https://gottransition.org/youth-and-young-adults/frequently-asked-questions.cfm) | | | | | |
| **Additional Notes:** | | | | | |
| 1. **Develop Content/Process for Integration into Adult Practice (Core Element 4), with PDSA Cycle –** Due by July 31, 2021 | | | | | |
| **Action Items** | | | Owner | Completed (yes/no) | Notes |
| 1. 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* | | |  |  |  |
| 1. Complete a PDSA on customized content and process for Core Element 5 | | |  |  |  |
| 1. Share approach at monthly QI meeting | | |  |  |  |
| **Documents/links:**  **Core Element 4:** [Six Core Elements Implementation Guide for Integration into Adult Practice](https://www.gottransition.org/6ce/?integrating-ImplGuide-integration-adult-practice)  Telehealth Toolkit (gottransition.org)  **Sample Joint Telehealth Call Script** *(to be sent when finalized)* | | | | | |
| **Additional Notes:** | | | | | |
| 1. **Develop Content and Process for Initial Visit (Core Element 5), with PDSA Cycle –** Due by Sept. 30, 2021 | | | | | |
| **Action Items** | | | Owner | Completed (yes/no) | Notes |
| 1. Customize content and process for Initial Visit (Core Element 5), including deciding on common content for initial visits | | |  |  |  |
| 1. Complete a PDSA on customized content and process for Core Element 5 | | |  |  |  |
| 1. Share approach at monthly QI meeting | | |  |  |  |
| **Documents/links:**  **Core Element 5:** [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) | | | | | |
| **Additional Notes:** | | | | | |
| **Learning Collaborative Joint Meeting – October 2021 (Date TBD)** | | | | | |
| **Pilot Phase (months 5 - 12) - September 2021 – April 2022** | | | | | |
| 1. **(Pediatric PCPs) Start Transfer Pilot with 5 Pediatric Patients –** September – November 2021 | | | | | |
| **Action Items** | | | Owner | Completed (yes/no) | Notes |
| 1. Pediatric PCPs will complete final visits | | |  |  |  |
| 1. Pediatric PCPs will complete and share transfer package with patients and new adult PCP | | |  |  |  |
| **Additional Notes:** | | | | | |

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| 1. **Schedule Joint Communication/Telehealth Call for Each Transferring Patient** – October – December 2021 | | | |
| **Action Items** | Owner | Completed (yes/no) | Notes |
| 1. Coordinate with pediatric practice and patient to schedule a joint communication/telehealth call following last pediatric visit and before initial adult visit |  |  |  |
| 1. Share progress in monthly QI meeting |  |  |  |
| **Documents/links:**  [Telehealth Toolkit (gottransition.org)](https://www.gottransition.org/resource/?telehealth-toolkit-joint-visit-pediatric-adult-clinicians) | | | |
| **Additional Notes:** | | | |
| 1. **Confirm Completion of Initial Adult Visit and HCT Feedback Survey** – December 2021 – March 2022 | | | |
| **Action Items** | Owner | Completed (yes/no) | Notes |
| 1. Complete initial adult PCP visits with 5 transferring patients |  |  |  |
| 1. Communicate with pediatric practice to confirm initial appointment made |  |  |  |
| 1. Request completion of HCT Feedback Survey by young adult at initial visit. *See link below* |  |  |  |
| 1. Share progress in monthly QI meeting |  |  |  |
| **Documents/links:**  **Sample survey:** [Sample Health Care Transition Feedback Survey for Young Adults (gottransition.org)](https://gottransition.org/6ce/?integrating-feedback-survey-young-adults) | | | |
| **Additional Notes:** | | | |
| 1. **Final Transfer of Care Improvement Collaborative – April 2022** | | | |
| **Action Items** | Owner | Completed (yes/no) | Notes |
| 1. Complete Current Assessment of HCT Activities, allowing for analysis of pre/post improvement in Core Elements - 3,4, and 5 |  |  |  |
| 1. Review lessons learned and plans for sustainability and spread |  |  |  |
| 1. Share progress in monthly QI meeting |  |  |  |
| **Documents/links:**  **Final Assessment:** [Current Assessment of HCT Activities](https://www.gottransition.org/6ce/?integrating-current-assessment) | | | |
| **Additional Notes:** | | | |

Appendix A – PDSA Template

PDSA (Plan-Do-Study-Act) Worksheet for Testing Change

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| **Title**: | | | |
| **Background/Goal of Project:** (briefly describe the problem you are having or area that needs improvement, note background information and target population) | | | |
|  | | | |
| **Aim:** (overall goal you wish to achieve) (**S**pecific, **M**easurable, **A**ttainable, **R**elevant, **T**ime-bound) | | | |
|  | | | |
| **Baseline Data:** | | | |
|  | | | |
| **Outline your patient engagement strategy:** | | | |
|  | | | |
| *Every goal will require multiple smaller tests of change* | | | |
| **Describe your first (or next) test of change:** | **Person responsible** | **When to be done** | **Where to be done** |
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| **Plan:** | | | |
| **List the tasks needed to set up this test of change** | **Person responsible** | **When to be done** | **Where to be done** |
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| **Predict what will happen when the test is carried out** | | | |
|  | | | |
|  | | | |
| **Measures to determine if prediction succeeds** | | | |
|  | | | |
| **Do:** | | | |
| Describe what actually happened when you ran the test | | | |
|  | | | |
| **Study:** | | | |
| Describe the measured results and how they compared to the predictions | | | |
|  | | | |
| **Act:** | | | |
| Describe what modifications to the plan will be made for the next cycle from what you learned | | | |
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|  | | | |
|  | | | |
| **New Test of Change** | | | |
|  | | | |
| **Describe your next test of change:** | **Person responsible** | **When to be done** | **Where to be done** |
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|  |  |  |  |
|  |  |  |  |
| **List the tasks needed to set up this test of change** | **Person responsible** | **When to be done** | **Where to be done** |
|  |  |  |  |
|  |  |  |  |
| **Predict what will happen when the test is carried out** | | | |
|  | | | |
|  | | | |
| **Measures to determine if prediction succeeds** | | | |
|  | | | |
| **Do:** | | | |
| Describe what actually happened when you ran the test | | | |
|  | | | |
| **Study:** | | | |
| Describe the measured results and how they compared to the predictions | | | |
|  | | | |
| **Act:** | | | |
| Describe what modifications to the plan will be made for the next cycle from what you learned | | | |
|  | | | |
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| Describe your sustainability plan: | | | |
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