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| **New Adult Practice Transfer of Care Quality Improvement Milestone Summary** | | | |
| The timeframe to accomplish the transfer is brief. In months, 5-7, the last pediatric visit with each patient will be completed. An optional 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. If joint communication/telehealth call is not completed, practice will plan for other youth/young adult engagement activity. | | | |
| **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 7 patients, 3 of   which must have special healthcare needs, to adult care. | Completed as part of submitted application |  |
| Project Start-Up | * Adult practice team completes Got Transition’s Current Assessment of HCT Activities. | November 7, 2023 | Due November 7, 2023  [Current [Adult/Family Assessment](https://www.surveymonkey.com/r/TOCAdultCohort3Pre) of HCT Activities](https://www.gottransition.org/6ce/?integrating-current-assessment) |
| Project Start-Up | * Team champion/team member(s)Participate in kick-off meeting with pediatric and adult awardees to review project plan. * Schedule regular monthly team meetings with Practice Facilitator (PF) | November 14, 2023 | Kickoff meeting  [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09) |
| Create Simple Tracking Sheet for 7 Transferring Patients (3 of which must have special healthcare needs) | * 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. | Month 1-2  Nov. 2023  Dec 2023 |  |
| 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 7 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 detail below. * Explore billing and coding for transition services. * Share progress in monthly QI meeting. | Months 1-4  Nov. 2023  Dec 2023  Jan 2024  Feb 2024 | 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)  [**2023 Coding and Payment Tip Sheet for Transition from Pediatric to Adult Health Care**](https://www.ctc-ri.org/sites/default/files/uploads/Final%202023%20Transition%20Coding%20and%20Payment%20Tip%20Sheet.pdf) |
| 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 an FAQ about adult practice to share with pediatric PCPs and transferring patients. (see Welcome letter for FAQ) * Complete a PDSA on customized content and process for Core Element #3. | Month 2  Dec 2023 | [Six Core Elements Implementation Guide for Orientation to](https://www.gottransition.org/6ce/?integrating-ImplGuide-orientation-adult-practice) [Adult Care](https://www.gottransition.org/6ce/?integrating-ImplGuide-orientation-adult-practice) |

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|  | * Share approach at monthly QI meeting. |  |  |
| 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 on 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  Jan 2024 | [Six Core Elements Implementation Guide for Integration into](https://www.gottransition.org/6ce/?integrating-ImplGuide-integration-adult-practice) [Adult Practice](https://www.gottransition.org/6ce/?integrating-ImplGuide-integration-adult-practice)  Sample Joint Telehealth Call Script |
| Develop Content and Process for Initial Visit (Core Element 5), with PDSA Cycle | * Customize content and process for Initial Visit (Core Element 5) * Intentionally review and discuss the youth goal/plan of care * Complete a PDSA on customized content and process for Core Element #5. * **S**hare approach at monthly QI meeting. | Month 4  Feb 2024 | [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) including review of patients stated goals.  Submit PDSA to [deliverables@ctc-ri.org](mailto:deliverables@ctc-ri.org) by March 12, 2024. |
| **Learning collaborative Joint meetings\*** | Learning Collaborative Joint Meetings (3 total) | March 26, 2024 | Learning Collaborative meeting [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09)  Provider champion or team member to present on experience with program to date, PDSA and status of transitions |
| (Pediatric PCPs) Start Transfer Pilot with 7 Pediatric Patients | * Pediatric PCPs complete final visits. * Pediatric PCPs complete and share transfer package with patients and new adult PCP. * 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. * If not done, plan for other youth/young adult engagement activity | Months 5-8  March 2024  April 2024  May 2024  June 2024 | Sample [Telehealth Toolkit](https://gottransition.org/resource/?telehealth-toolkit-joint-visit-pediatric-adult-clinicians)  Submit PPT to [deliverables@ctc-ri.org](mailto:deliverables@ctc-ri.org) by June 11, 2024 |
| **Learning collaborative Joint meetings\*** | Learning Collaborative Joint Meetings (3 total) | June 25, 2024 | Learning Collaborative meeting [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09)  Provider champion or team member to present on experience with program to date, PDSA and status of transitions |
| Confirm Completion of Initial Adult Visit and HCT Feedback Survey | * Complete initial adult PCP visits with 7 transferring patients. * Communicate with pediatric practice to confirm initial appointment was completed. * Request completion of HCT Feedback Survey by young adult at initial visit. * Share progress in monthly QI meeting. | Months 9-12  July 2024  August 2024  September 2024  October 2024 | [HCT Feedback Survey for Young Adults](https://www.gottransition.org/6ce/?leaving-feedback-survey-youth)  Submit final PDSA with PPT to [deliverables@ctc-ri.org](mailto:deliverables@ctc-ri.org) by October 9, 2024  Submit current [Adult/Family Assessment](https://www.surveymonkey.com/r/TOCAdultCohort3Pre) of HCT Activities by October 9, 2024 |
| **Learning collaborative Joint meetings\*** | Learning Collaborative Joint Meetings (3 total)   * Complete Current Assessment of HCT Activities * Review lessons learned and plans for sustainability and spread. * Share progress in monthly QI meeting. | October 22, 2024 | Learning Collaborative meeting [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09)  Provider champion or team member to present on experience with program to date, PDSA and status of transitions |
| Learning Collaborative Project Evaluation | Complete Project and Practice Facilitation Evaluation | November 2024 | <https://www.surveymonkey.com/r/TOC2023Cohort3> |
| Learning Collaborative Dates | * **Kickoff** – Introductions * **March** – PDSA (Aim & Plan) * **June** – PDSA update (Do, Study, Act)   **October** – Lessons Learned, Plans for Sustainability and Spread, Youth Feedback | November 14, 2023  7:30-9:00AM  March 26, 2024  June 25, 2024  October 22, 2024  7:30-8:30AM | [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09) |

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