ADVANCING INTEGRATED HEALTHCARE

Welcome
Healthcare Transfer of Care Kickoff Meeting

Healthcare Transfer of Care Learning Collaborative | November 29, 2023

Care Transformation Collaborative of RI

Agenda

Topic Presenter(s)	Duration
Welcome, Thank you RIDOH and UnitedHealthcare & Getting to Know each other Deborah Garneau, MA, Maternal and Child Health Director, RIDOH Colleen Polselli, Special Needs Program Manager Office of Special Needs, RIDOH Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Director Carolyn Karner, MBA, CTC-RI Program Coordinator	30 minutes
Got Transitions Overview Patience White, MD, MA, FAAP, MACP, Co-Project Director Got Transitions, The National Alliance to Advance Adolescent Health	45 minutes
Review of Objectives & Video Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Director	5 minutes
Review of Deliverables and Timing Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Program Director	10 minutes

Getting to Know

Rhode Island Department of Health (RIDOH) Team & Family Voice

Colleen Polselli,
Special Needs Program Manager
Office of Special Needs
RI Department of Health

Deborah Garneau, MA
Maternal and Child Health Director
RI Department of Health

Tara Hayes,
Family Voices Manager, RIPIN

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Getting to Know the CTC-RI / PCMH Kids Team

Patricia Flanagan,
MD, FAAP,
PCMH Kids
Co-chair

Elizabeth Lange,
MD, FAAP,
PCMH Kids
Co-chair

Pano Yeracaris,
MD, MPH,
CTC-RI Chief
Clinical
Strategist

Susanne Campbell,
RN, MS,
PCMH CCE,
Senior
Project
Director

Carolyn Karner
MBA, Project
Management
& Evaluation

Getting to Know your Practice Facilitators

Susan Dettling, BS, PCMH CCE

Anchor Pediatrics

Christiane Bloodworth, Practice Manager
Judith Westrick, MD
Cathleen Tager, NCM
Stacey Timperley, Practice Coordinator

Anchor Medical - Lincoln

Mary Carol McMahon, Practice Manager
Laura Runyan, PA
Sandra Mann, NCM
Donna Mack, Practice Coordinator

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Anchor Peds: Aide our patients in feeling confident in the hand-off of their medical care from one trusted group of providers to another and how to effective do so without any loss in care for the patients.

Anchor Pediatrics		Anchor Medical - Lincoln	
Patient Age	#	Patient Age	#
Age 12-13	285	Age 18-22	59
Age 14-15	362	Age 23-26	224
Age 16-17	397		
Age 18+	338		
Total	1382	Total	283
% Medicaid	54.5%	% Medicaid	55.5%

Share something about your practice that others may not know

Anchor Peds: Our group of providers are some of the medical professionals who originally where part of RIGHA and then Harvard Pilgrim Healthcare, for those local Rhode Islanders, who created the new group known as Anchor Medical and now consists of three locations caring for the diverse communities of Rhode Island.

Atlantic Pediatrics

John Concannon, MD
Colleen Vitale, MD
Esteisy Ramirez, MA

Matt Rocheleau, MD

Matt Rocheleau, MD

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Atlantic Peds: Transitioned patients have definite name of an adult practice that will accept them for primary care needs. If there are specialist needs, we can suggest adult specialists, but ultimately that will be up to the new PCP

Rocheleau: Success will be developing and implementing a transition and care policy that is thorough yet streamlined and not static. The policy and resources will be designed with functionality and a collaborative approach in mind to ensure partnership between the physician and patient. The practice will be deliberate in seeking out constructive feedback and input from the young adults for ways to improve. Additionally, project success includes establishing and fostering a working relationship between Atlantic Pediatrics and my practice - which includes an open dialogue between physicians and staff in order to meet the needs of this unique patient population.

Atlantic Pediatrics		Matt Rocheleau, MD	
Patient Age	#	Patient Age	#
Age 12-13	285	Age 18-22	59
Age 14-15	362	Age 23-26	224
Age 16-17	397		
Age 18+	338		
Total	1382	Total	283
% Medicaid	54.5%	% Medicaid	55.5%

Share something about your practice that others may not know

Atlantic Peds: We are a later onset transition than many practices. We transition at either 1.) when they are fully employed with their own health insurance, or 2.) reach the age of 22 so as to allow us to be their PCP when home during breaks from college.

Rocheleau: The practice is brand new. Since finishing my internal medicine residency this past June, I established the practice and have been learning the ins and outs of starting a small business.

Hello

East Greenwich Pediatrics

Missy Zinni, Office Manager
Heather Tirpaeck, MD
Nelson Medina, Office Manager

University Family Medicine

Gina Andrade, Office Manager
Ellen Hight, MD

EGP Pediatrics		UFM Practice	
Patient Age	#	Patient Age	#
Age 12-13	440	Age 18-22	238
Age 14-15	400	Age 23-26	271
Age 16-17	373		
Age 18+	390		
Total	7500	Total	5457
% Medicaid	13%	% Medicaid	18%

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

UFM: **Because we have so many children that we have seen here since they were newborns, these children already "transition" to adult care with us upon the age of 18. So, our success for the practice would be to implement a process & track all of the Six Core Elements upon the transition of care for young adults that are joining the practice from other pediatric care.**

Share something about your practice that others may not know

UFM: **Our practice has multi-generations of patients that continue to grow and that we provide care for. We have families that include, grandparents, parents, children and now great-grand children. We always want to keep the family together to provide the best care for all.**

Concilio Pediatrics QI Team

Gerald Concilio, MD
Amalia, Office Manager

Focus: Testing RIPCPC's Transition of Care process with intentional transition of 7 youth, 3 with special needs to adult care.

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Share something about your practice that others may not know

Pediatric Practice 2023 Data	
Patient Age	#
Age 12-13	80
Age 14-15	46
Age 16-17	51
Age 18+	30
Total	207
% Medicaid	65%

Hello

Richard Ohnmacht QI Team

Richard Ohnmacht, MD
Maureen Coletta, Nurse

Chad Lamendola QI Team

Chad Lamendola, MD
Ozevette DiLorenzo, NCM
Pamela Laramee, Practice Manager

Focus: Transfer of youth with special needs and include the specialist.

What does success look like for your practice for the Health Transfer of Care Quality Improvement project?

Dr. Ohnmacht's Practice		Dr. Lamendola's Practice	
Patient Age	#	Patient Age	#
Age 12-13	80	Age 18-22	75
Age 14-15	77	Age 23-26	75
Age 16-17	65		
Age 18+	75		
Total	297	Total	150
% Medicaid	15%	% Medicaid	<5%

Ohnmacht: Success looks like a continuation of the successful transition of patients in the last cohort with ease of transfer of records

Lamendola:

- Identify a set of patients to make the transition from the Pediatric to the Adult Primary Care practice
- Patient set should be a cohort of both uncomplicated patients and more complex patients with a higher level of needs/services
- Fine tune the working process of the transition established in last year's project used with uncomplicated patients
- Establish a more comprehensive process to transition the more complex patients – to include greater collaboration between the entire medical team (Pediatrician, Family Physician, Specialists, and supportive Health Care Team) during and after the transition
- Develop, utilize, and respond to a process of patient/family/provider feedback to continue to improve performance

Richard Ohnmacht QI Team

Richard Ohnmacht, MD
Maureen Coletta, Nurse

Chad Lamendola QI Team

Chad Lamendola, MD
Ozevette DiLorenzo, NCM
Pamela Laramee, Practice Manager

What did you learn in year 1?

Ohnmacht: We learned how many patients I had about to age out (many more than I thought) and how many Dr Chad could accept. (More than he realized)

Lamendola:

- A well-planned process is essential to ensure the continuing quality, safety, and satisfaction of patient care in transient from the Pediatric to the Adult practice
- Communication between the collaborating physicians involved in the transfer is the foundation of a sound plan
- Communication between physicians is optimized when they share information directly in person before, during, and after the transition period
- Transfer of records is improved significantly if they share the same EMR
- The establishment of a well planned process creates confidence and comfortability for the patient and family during this right of passage to Adult Care

Richard Ohnmacht QI Team

Richard Ohnmacht, MD
Maureen Coletta, Nurse

Chad Lamendola QI Team

Chad Lamendola, MD
Ozevette DiLorenzo, NCM
Pamela Laramee, Practice Manager

What recommendations do you have for Cohort 3?

Lamendola:

- Be patient and work diligently – the fruits of your labor will enhance your relationship with your Physician colleagues and the Health Care Team
- Be open to feedback in order to adjust the approach to maximize the effect the changes might bring to enhance your practice
- Know that your efforts will establish a foundation of trust with your patients that will positively effect the doctor-patient relationship and rekindle your altruistic intentions for caring for your fellow brothers and sisters

Ohnmacht: As we look to transition more medically complex patients, there will be more work necessary in preparing both the patients and family and ensuring that the medical record is fully up to date

Getting to Know the National Alliance to Advance Adolescent Health Team

MARGARET McMANUS, MHS, *Co-Project Director Got Transitions*

Ms. McManus is the President of The National Alliance to Advance Adolescent Health, a nonprofit organization dedicated to improving access to comprehensive health care and insurance coverage for adolescents. Since 2013, with Dr. White, she has overseen project management for Got Transition, a program of The National Alliance. Ms. McManus has over 35 years of experience directing national, state, and private foundation projects on child and adolescent health. These projects have addressed health care transition, youth with special health care needs, health care financing, insurance coverage and benefits, mental/behavioral health workforce, and preventive care. Ms. McManus has a Masters in Health Sciences from the Johns Hopkins Bloomberg School of Public Health.

PATIENCE WHITE, MD, MA, FAAP, MACP, *Co-Project Director Got Transitions*

Dr. Patience White is an adult and pediatric rheumatologist who for over 30 years has been involved in transition issues for children with special health care needs. With Ms. McManus, she is responsible for overall project management for Got Transition and provides technical assistance to health plans, Title V agencies, pediatric and adult primary and specialty care practices and professional societies, and health professional training programs. Over her career, she has been active in academic medicine, clinical care, research, public health and advocacy and is the lead author of the 2018 AAP/AAFP/ACP Clinical Report, “Supporting HCT from Adolescence to Adulthood in the Medical Home”. Dr. White completed a doctor of medicine degree from Harvard Medical School, a Robert Wood Johnson Health Policy fellowship in the US Senate, and a master’s in Education from George Washington University Graduate School of Education and Human Development.

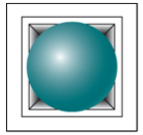
ANNIE SCHMIDT, MPH, *Health Research/Policy Analyst Got Transitions*

Annie Schmidt is responsible for assisting with research and policy analysis related to adolescent health and the development of transition payment options. Ms. Schmidt has been the lead staff person on a number of transition efforts related to Medicaid managed care, value-based payment, a new family transition toolkit, and a clinician toolkit for incorporating transition into adolescent and young adult preventive care. She received her master’s degree in Public Health from the University of North Carolina-Chapel Hill.

Health Care Transition (HCT) Process Improvement: Pediatric to Adult Transition

November 14, 2023

Patience White, MD, MA, FAAP, MACP
Peggy McManus, MHS
Got Transition
The National Alliance to Advance Adolescent Health
Washington DC



The National Alliance To Advance Adolescent Health

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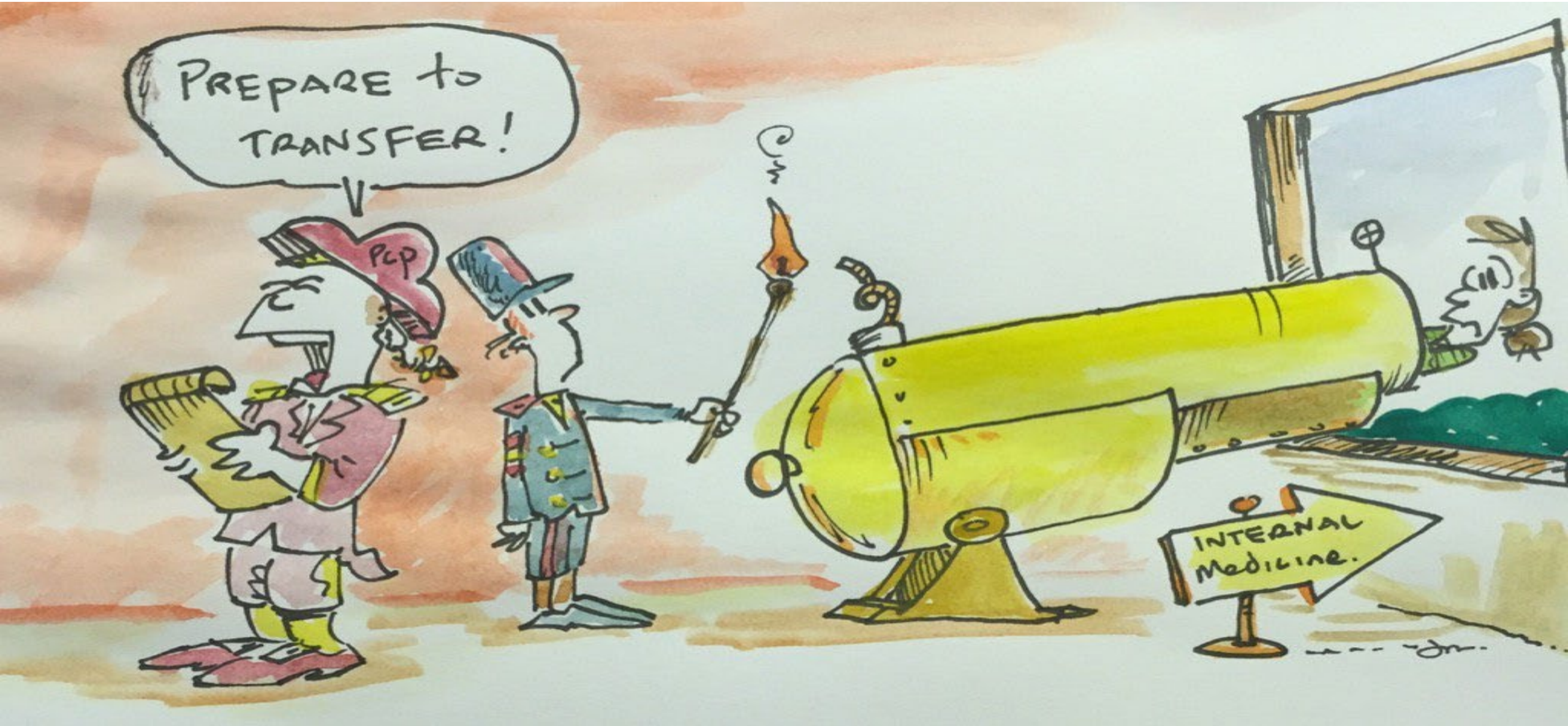
Disclosures

Patience White has no disclosures for this presentation.

Presentation Objectives

1. To understand the current context of health care transition, HCT outcome evidence and the AAP/AAFP/ACP recommended structured HCT interventions-the Six Core Elements
2. Review tools and resources available through www.gottransition.org
3. Describe key lessons learned from implementing HCT performance improvement program in 7 RI primary care practices


PREPARE to TRANSFER!
PCP
INTERNAL MEDICINE.

Evidence of Health Safety/Adverse Effects for YSHCN Associated with Lack of a HCT Process*

- Medical complications, increased mortality
- Lower self-reported health and wellbeing
- Problems with treatment and medication adherence
- Discontinuity of care
- Youth/young adult/family dissatisfaction
- Poor communications between systems of care and clinicians
- Increased hospitalizations and ER use

*White PH, Cooley WC, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018; 142:85-104.

Receipt of Transition Planning Guidance from Health Care Providers (HCPs)

*National US Survey of Children's Health, 2022**

- 23.2% of RI youth with special health care needs (YSHCN) received transition planning guidance from HCPs (23% US)
- National Performance Measure on Transition is based on whether:
    1. Doctor spoke with child privately without an adult in the room during last preventive check-up;
    2. If a discussion about transitioning to adult care happened;
    3. Doctors actively worked with child to gain skills and understand changes in their health care.

***Data source:** Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 9/2023 from www.childhealthdata.org.*

Outcome Evidence for a Structured Transition Process
Statistically significant improvement in:

Population Health

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

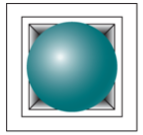
Experience of Care

- 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

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.



The National Alliance
To Advance Adolescent Health

got transition

Clinician Experience Survey in 6 Health Systems

- Target Population: All clinicians and staff (n=855) involved in incorporating HCT (6CE) in their practice in the 6 participating systems.
  - 62% pediatric clinicians, 38% adult providers
  - 62% subspecialty care, 32% provide primary care
  - Clinical roles: 33% MD/DO, 26% RN, 14% NP/PA, 5% SW
- Timeline*:* Electronic distribution over 6 weeks from August - Sept 2022.
- Response rate: 31% (n=272 completed surveys).
- Results:
  - Clinicians agree having a **HCT process** in place **improves:**
    - **Patient experience (91%)**
    - **Clinician experience (87%).**
    - This was true regardless of clinical role, experience with HCT process, specialty or role in the HCT process.

Thus, a structured HCT process statistically improves clinician experience along with patient experience, population health and utilization.

Source: Presentation Baylor HCT Conference Oct 2022

Pediatric to Adult Health Care Transition Definition

- **Definition:** Health care transition is the process of moving from a child to an adult model of health care with or without a transfer to a new clinician
- **Transition Goals for Youth/Young Adults and Clinicians:**
  - To improve the ability of youth and YAs to manage their own health and effectively use health services
  - To have an organized clinical process in pediatric and adult practices to facilitate transition preparation, transfer of care, and integration into adult-centered care

Pediatric to Adult Health Care Transition

- The 2018 AAP, AAFP, ACP Clinical Report Recommendations clarify:
  - TRANSITION ≠ TRANSFER or PLANNING alone
  - TRANSITION = planning, transfer and integration into adult care

Medical Professional Societies' Guidance 2023

- 2011 joint AAP/AAFP/ACP Report Clinical Report (CR) on HCT*
- AAP/AAFP/ACP updated CR in **2018** with guidance on evidence informed processes**
- Both CRs target all youth, beginning at age 12
- Algorithmic structure with emphasis on planning:
  - Branching for YSHCN
  - Application to primary and specialty practices
- Extends through transfer of care to adult medical home and adult specialists
- **Recommendations: Focus on all three aspects of transition: planning, transfer and integration into adult care using a QI approach utilizing the Six Core Elements**

Age 12	Youth and family aware of transition policy
Age 14	Health care transition planning initiated
Age 16	Preparation of youth and parents for adult approach to care and discussion of preferences and timing for transfer to adult health care
Age 18	Transition to adult approach to care
Age 18-22	Transfer of care to adult medical home and specialists with transfer package

**Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home(Pediatrics, July 2011)*

***White PH, Cooley WC, Transitions Clinical Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. Pediatrics. 2018; 142:85-104.*

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 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.

*Published articles available at www.GotTransition.org

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.

SIX CORE ELEMENTS™ APPROACH AND TIMELINE FOR YOUTH TRANSITIONING FROM PEDIATRIC TO ADULT HEALTH CARE

Summary of Six Core Elements of Transition Approach

*Roles for Pediatric and Adult Practices**

Practice/ Provider	#1 Transition Policy	#2 Tracking and Monitoring	#3 Transition Readiness/ Orientation to Adult Practice	#4 Transition Planning/ Integration into Adult Care	#5 Transfer of Care/Initial Visit	#6 Transition Completion/ Ongoing Care
Pediatric*	Create and discuss with youth/family	Track progress of youth/family readiness for transition	Transition readiness assessment (RA)	Develop transition plan including needed RA skills	Transfer of care with information and communication to adult clinician	Obtain feedback on the transition process
Adult*	Create and discuss with young adult (YA)/ guardian, if needed	Track progress to increase YA's knowledge of health and adult health care system	Share/discuss Welcome and FAQs letter with YA and guardian, if needed	Update transition plan with additional skills required	Communication with pediatric clinician/ Agree on content of the 1-2 initial adult visits/Self-care assessment	Ongoing care/referrals, as needed, with continued self-care skill building

**Providers that care for youth/young adults throughout the life span would complete both sets of core elements without the transfer process*

Transitioning Youth to an Adult Health Care Clinician

Core Element 1 - Welcome and Care Policy/Guide

Purpose

- ✓ Formalize the practice's approach, reduce clinician variability, offer a transparent approach to youth and their families and friends

Content

- ✓ Define practice approach supports offered around HCT youth and family planning, transfer and information on future clinician choice
- ✓ Clarify adult approach to care and legal changes at age 18
- ✓ Reading level should be appropriate
- ✓ Communicate it to all involved early and continually in the process

Core Element 2 - Tracking and Monitoring

Purpose

- ✓ Facilitate systematic data collection to improve quality of care

Content

- ✓ Date of receipt of each core element (e.g., policy shared, transition readiness assessments administered)

Transitioning Youth to an Adult Health Care Clinician

Core Element 3 - Transition Readiness

Purpose

Assess the patient's skills to manage their health and effectively use health care (especially in the new practice setting)

Content

- ✓ Assesses self-care skills related to own health and using health care services
- ✓ Several tools available, some disease specific
- ✓ Got Transition readiness assessment tool has both youth and parental assessments available and includes motivational interviewing questions:
  - Ranks importance of managing their own health
  - Ranks confidence about ability to manage their own health and the new system

Use

- ✓ Completed several times during the preparation process
- ✓ Used as a **discussion tool** to plan skill-building education
- ✓ Does **not predict** transition success
- ✓ Customized to meet the needs of the practice's population

Integrating Young Adults into Adult Health Care

Core Element 3 – Orientation to Adult Practice

Purpose

To engage young adults moving from pediatrics to practices caring for adults

Content

- ✓ Identify adult providers within practices interested in caring for YAs and YAs with SHCN
  - ✓ Establish a process within the practice to welcome and orient new YAs to the practice
  - ✓ **Develop welcome and orientation materials for the practice with FAQs**
    - **How can YA contact the practice for questions?**
    - **Can they access their medical information?**
    - **What are the missed appointment/cancelation policies?**
  - ✓ Share both the practice policy and welcome letter with pediatric practices for distribution to their transitioning YAs
  - ✓ Share before the joint telehealth visit

Transitioning Youth to an Adult Health Care Clinician

Core Element 4 - Transition Planning

Purpose

Establish agreement between youth/family/caregiver and clinicians about set of actions to address priorities and access to current medical information

Content

- ✓ Identify what matters most to the youth beyond health goals
- ✓ Define how learning about health and health care supports patient's overall goals (add assessment skill needs to the plan)
- ✓ **Complete portable medical summary and emergency care plan with "special information"** – non-medical or specifics on how to make office visit easier- for adolescent/young adult (AYA) and the next clinical team, consider adding photo

Integrating Young Adults into Adult Health Care

Core Element 4 – Integration Into Adult Practice

Purpose

To obtain the YA's medical and other information and communicate with the prior clinician

Content

✓ Prior to first visit ask the pediatric practice for a transfer package with:

1. A complete portable medical summary and emergency care plan with "special information" (non medical) about the new YA – if not available, create this with the YA

2. Decision making documents for youth with IDD (if needed):
   - Review supported decision making plan
   - Review the YA's unique communication needs

✓ Review the key next steps in plan of care that need to be attended to in the first visit (This can be covered in a joint telehealth visit)

Transitioning Youth to an Adult Health Care Clinician

Core Element 5 – Transfer of Care

Purpose

Ensure completion and sharing of transfer package with new provider and support engagement of the patient with a new team

Content / Transfer Checklist

- ✓ Transfer *letter*
- ✓ Medical summary and emergency care plan: key medical and non medical info, including latest RA
- ✓ *Communicate directly* with the new clinician(s), use of telemedicine with joint telehealth visit-see example from Got Transition
- ✓ *Clarify roles* of each provider going forward and clearly communicate the plan to the youth/family/caregiver (e.g. different roles of PCP and subspecialists in adult medicine)
- ✓ *Transfer* when chronic disease is *stable* and *stagger transitions* if many clinicians involved
- ✓ Transfer to PCP medical home first

Integrating Young Adults into Adult Health Care

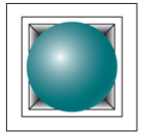
Core Element 5 – Initial 1-2 visits at Adult Practice

Purpose

Ensure completion and sharing of transfer package with new provider and support engagement of the patient with a new adult clinician/ team

Content

- ✓ Consider pre-visit call/text/nurse visit to welcome YA to the practice (this can be accomplished in a joint telehealth visit)
- ✓ Agreement on topics to be covered in first 1-2 visits among the adult clinicians seeing YA in the practice
- ✓ Review, update, and share medical summary and emergency care plan
- ✓ Review transition readiness assessment and/or administer self-care assessment to address unmet self-care skill needs
- ✓ Review and update plan of care, if needed



Transitioning Youth to an Adult Health Care Clinician

Core Element 6 – Transfer Completion

Purpose

- ✓ Confirms the beginning of care by the new clinician, starting of the new role of referring clinician and clarity of both clinicians'/teams' roles

Content:

- ✓ Communicate with new practice confirming completion of transfer (patient came to appointment with all the needed information)
- ✓ Confirm roles going forward of the referring and accepting clinicians (Pediatric specialists as a consultants as needed, adult PCP and adult specialist roles)
- ✓ **Obtain young adult and pediatric provider feedback anonymously after last referring clinician visit**
  - Customizable HCT feedback surveys available at GotTransition.org

Integrating Young Adults into Adult Health Care

Core Element 6 – Transfer Completion/Ongoing Care

Purpose

To close the loop on the "warm handoff"; communication to ensure a smooth transfer of care; complete skill building to manage health/health care

Content

- ✓ Confirm transfer completion with pediatric clinician
- ✓ Complete self-care assessments
- ✓ Offer/refer to self-care skill building education, as needed
- ✓ Ask for consultation with pediatric provider, as needed
- ✓ Assist YA to connect with adult specialists or primary care or other support services, as needed
- ✓ Elicit **feedback** from YAs about their transition and assess experience with adult care

Current Assessment of Health Care Transition Activities

for Transitioning Youth to an Adult Health Care Clinician

Instructions: Each of the Six Core Elements, Youth/Young Adult and Parent/Caregiver Feedback, and Youth/Young Adult and Parent/Caregiver Leadership sections should be scored as Level 1, 2, 3, or 4. To be scored at a certain level, all of the criteria must be met. (No partial scores.)

Measurement Option:
Current Assessment of HCT Activities

TRANSITION AND CARE POLICY/GUIDE				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Score**
Clinicians vary in their approach to HCT, including the age of transfer to adult clinicians.	Clinicians follow a uniform but not a written transition and care policy/guide about the age of transfer to adult clinicians.	The practice has a written transition and care policy/guide.	The practice has a written transition and care policy/guide.	_____ (out of 4)
		The transition and care policy/guide includes privacy and consent information, a description of the practice's approach to HCT, and age of transfer.	The transition and care policy/guide includes privacy and consent information, a description of the practice's approach to HCT, and age of transfer.	
		Clinicians sometimes discuss/share the transition and care policy/guide with youth and parents/caregivers.	Clinicians consistently discuss/share the transition and care policy/guide with youth and parents/caregivers, beginning at ages 12 to 14.	
		The transition and care policy/guide is familiar to some staff.	The transition and care policy/guide is publicly displayed and familiar to all staff.	
			The transition and care policy/guide was developed with input from youth and parents/caregivers.	

TRACKING AND MONITORING				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Score**
Clinicians vary in their process of identifying transition-aged youth, but most wait until close to the age of transfer to identify them.	Clinicians follow a uniform process to identify transition-aged youth.	The practice has an individual transition flow sheet or registry for identifying and tracking transition-aged youth, or a subgroup of youth with chronic conditions, close to the time of transfer.	The practice has an individual transition flow sheet or registry for identifying and tracking transition-aged youth, or a subgroup of youth with chronic conditions, starting between the ages of 12 and 14.	_____ (out of 4)
	Clinicians use youths' medical records to document relevant HCT information (e.g., discussed transition, future clinician name).	The practice tracks youths' receipt of some but not all of the Six Core Elements.	The practice tracks youths' receipt of all of the Six Core Elements.	

HCT - health care transition, Y/YA - youth/young adult

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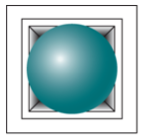
Measurement Option:

Youth/parent/caregiver feedback survey

- Includes summary questions on the Youth/Young Adult Feedback survey:
  - How ready did you feel to move to an adult doctor or other health care provider?
  - Answer: Very, Somewhat, Not at all
  - Do you have any ideas for your past doctor or other health care provider about making the move to an adult health care easier?



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Sample Health Care Transition Feedback Survey for Youth/Young Adults

This is a survey about what it was like for you to move from pediatric to adult health care. Your answers will help us improve our health care transition process. Your name will not be linked to your answers.

DID YOUR PAST DOCTOR OR OTHER HEALTH CARE PROVIDER... *Please check the answer that best fits at this time.*	YES	NO
Explain the transition process in a way that you could understand?	☐	☐
Give you guidance about the age you would need to move to a new adult doctor or other health care provider?	☐	☐
Give you a chance to speak with them alone during visits?	☐	☐
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)?	☐	☐
Help you gain skills to manage your own health and health care (e.g., understanding current health needs, knowing what to do in a medical emergency, taking medicines)?	☐	☐
Help you make a plan to meet your transition and health goals?	☐	☐
Create and share your medical summary with you?	☐	☐
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	☐	☐
Advise you to keep your emergency contact and medical information with you at all times (e.g., in your phone or wallet)?	☐	☐
Help you find a new adult doctor or other health care provider to move to?	☐	☐
Talk to you about the need to have health insurance as you become an adult?	☐	☐

Overall, how ready did you feel to move to an adult doctor or other health care provider?

☐ Very ☐ Somewhat ☐ Not at all

Do you have any ideas for your past doctor or other health care provider about making the move to adult health care easier?

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Measurement Options:
HCT Feedback Surveys

- Clinician survey adapted from the Medical Home Feedback Survey
  - Example questions:
    - "In Your Practice" section offers 4 answer choices that range from "strongly disagree" to "strongly agree" or "don't know"

Sample Health Care Transition Feedback Survey for Clinicians

This survey can be completed individually or by a group of clinicians/care team members. This survey allows a more robust look at your practice's culture/style and health care transition (HCT) processes.

IN YOUR PRACTICE *Please check the answer that best applies now.*	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	DON'T KNOW
Our practice takes time to consider ways to improve the HCT process.	☐	☐	☐	☐	☐
Our practice encourages everyone (front office and clinical staff) to share ideas about their role in the HCT process.	☐	☐	☐	☐	☐
Our practice has successfully gained senior leadership buy-in for our HCT quality improvement effort.	☐	☐	☐	☐	☐
Our practice leadership makes sure that we have the time and resources to plan for and implement changes to improve the HCT process.	☐	☐	☐	☐	☐
Our practice has incorporated a structured HCT process into our workflow.	☐	☐	☐	☐	☐
Front office and clinical staff operate as a team to implement the HCT process.	☐	☐	☐	☐	☐
Youth/Young adults and parents/caregivers are valued partners in our HCT planning and quality improvement efforts.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice improves safety and quality of care.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice improves youth/young adult and parent/caregiver experience.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice improves clinician experience.	☐	☐	☐	☐	☐
The HCT process we are currently using works for our practice.	☐	☐	☐	☐	☐
Having an HCT process in place in our practice saves time for our clinicians.	☐	☐	☐	☐	☐
Our practice has been successful in obtaining payment for HCT services.	☐	☐	☐	☐	☐
Our practice has been successful in modifying our electronic medical records to incorporate HCT.	☐	☐	☐	☐	☐

Do you have any ideas to better implement HCT into the clinic process?

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***.

Implementation Guides Customized to HCT are Available at GotTransition.org

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

TRANSITIONING YOUTH TO AN ADULT HEALTH CARE CLINICIAN

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

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Transition Readiness
Guide | Examples

Transition Planning
Guide | Examples

Transfer of Care
Guide | Examples

Transfer Completion
Guide | Examples

TRANSITIONING TO AN ADULT APPROACH TO HEALTH CARE WITHOUT CHANGING CLINICIANS

For use by Family Medicine and Med-Peds Clinicians

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Transition Readiness
Guide | Examples

Transition Planning
Guide | Examples

Transition to Adult Approach to Care
Guide | Examples

Ongoing Care
Guide | Examples

INTEGRATING YOUNG ADULTS INTO ADULT HEALTH CARE

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

Download Full Implementation Guide

Transition and Care Policy/Guide
Guide | Examples

Tracking and Monitoring
Guide | Examples

Orientation to Adult Practice
Guide | Examples

Integration into Adult Practice
Guide | Examples

Initial Visits
Guide | Examples

Ongoing Care
Guide | Examples

Six Core Elements of Health Care Transition™ 3.0

An Implementation Guide

Transitioning Youth to an Adult Health Care Clinician

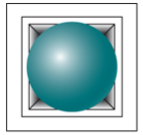
Core Element 1 - Transition and Care Policy/Guide

I. Purpose, Objectives, and Considerations

II. Quality Improvement Considerations, Tools, and Measurement

III. Sample Transition and Care Policies/Guides

IV. Additional Resources



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https://www.gottransition.org/6ce/?leaving-ImplGuide-policy

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Considerations: Sample Questions

Content

What should be included in the transition and care policy/guide?

- At what age will your practice start the HCT planning process?
- When are youth expected to leave your practice?
- What will your practice offer youth and parents/caregivers to assist them in transition—e.g., a readiness assessment, plan of care that includes transition, medical summary, transfer package?
- What will your practice do to prepare youth for changes in privacy and consent that happen at age 18?

Considerations: Sample Questions

Process

What is the process to develop the transition and care policy/guide?

- Does it describe the practice's approach to transition, including privacy and consent information?
- Is the reading level appropriate for your youth and parents/caregivers?
- How to engage youth and parents/caregivers in the development process?

What is the process to implement the transition and care policy/guide? (Consider creating a process Flow diagram)

- Whose job is it to share and discuss the HCT policy/guide with the youth and parent/caregiver?
- Whose job is it to ask if the youth and parent/caregiver have any questions?
- Review the process with youth and family and create a written document to describe the clinic approach to implement the process outlined above.
- Educate all team members/staff about the process.

Sample Transition and Care Policies/Guides

As you develop your transition policy, you should strive for a 6th grade reading level using common words with a concise message, plenty of white space, and an easily readable format.

Please see the QI Primer for information about health literacy, including strategies for implementation https://www.gottransition.org/6ce/?quality-improvement-primer

Examples from other programs are available for each Six Core Element:

Transition and Care Policies/Guides:

- Sample Transition and Care Policies/Guides at Different Reading Levels
- Sample Transition and Care Policies/Guides in Different Clinical Settings
- Sample Transition and Care Policies/Guides for Youth with Specific Conditions
- Sample Transition and Care Policies/Guides in Video Format

QI Primer: Using Quality Improvement to Improve the Health Care Transition Process

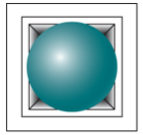
A companion piece to use with the Six Core Elements of Health Care Transition™

Intended to help practices understand quality improvement (QI) and apply it to their work

Gives breakdown of Quality Improvement's:

- History
- Relationship to research
- Benefit to health care teams and patients

I. What is Quality Improvement?
II. Selecting Improvement Projects
III. Successful Teams
IV. The Model for Improvement
V. Measuring for Improvement
VI. Tools for Improvement
VII. Sustaining Improvement
VIII. Spreading Improvement
IX. Health Literacy
X. Co-Production
XI. Resources and References



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Key Features of Successful Transition Efforts

- Involvement of senior leadership and clinic/institution support
- Engagement of key players, including youth & families and adult clinicians, from outset
- Identify champion(s) to guide process
- Use of QI methods, with measurable aims, clarity on "what success looks like" and
- Measure the clinic process changes following tests of change and hard wire the changes that work into clinic process
- Aligning EHR
- Utilizing resources at Got Transition's Six Core Elements, which are free and can be customized with your own logos
- Sharing successes and lessons learned to maintain traction and spread

Sustainability: Key Strategies

- Assign ownership of sustaining to an individual
- Hardwire sustainability into your systems
- Continue measuring to monitor sustainability
- Continue involving senior leadership

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

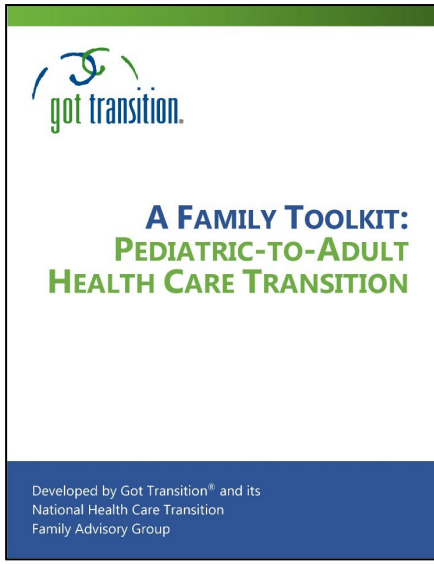
Setting up the "Medical ID" Feature on Apple's Health App and on Android Phones [En Español]

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

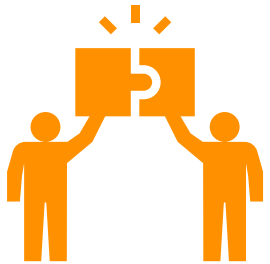
Questions to Ask Your Doctor About Transitioning to Adult Health Care (for Youth and Young Adults) [En Español]

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?*



Healthcare Transfer of Care QI Objectives for New Dyads



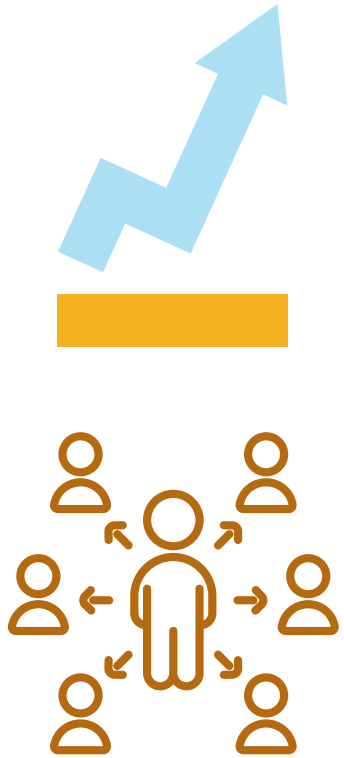
Pediatric and adult team partners will work together to improve transition of care for youth as they transition from pediatric to adult care.

New teams will be asked to test the transfer of care concept on a small sample (7, at least 3 with special needs) of identified “transfer of care” young adults. The first 4 months will be “start-up” with customization of content and process followed by an 8-month pilot period for the 4-5 transferring patients, including a final pediatric visit, a joint communication telehealth visit with pediatric and adult primary care providers and transferring patient, and an initial adult visit.

Teams will apply selected Core Elements from Got Transition’s approach, using the performance improvement process, and develop and implement a more intentional and structured approach to the transfer of care process.

- Patient centered goals from milestone document (#5)

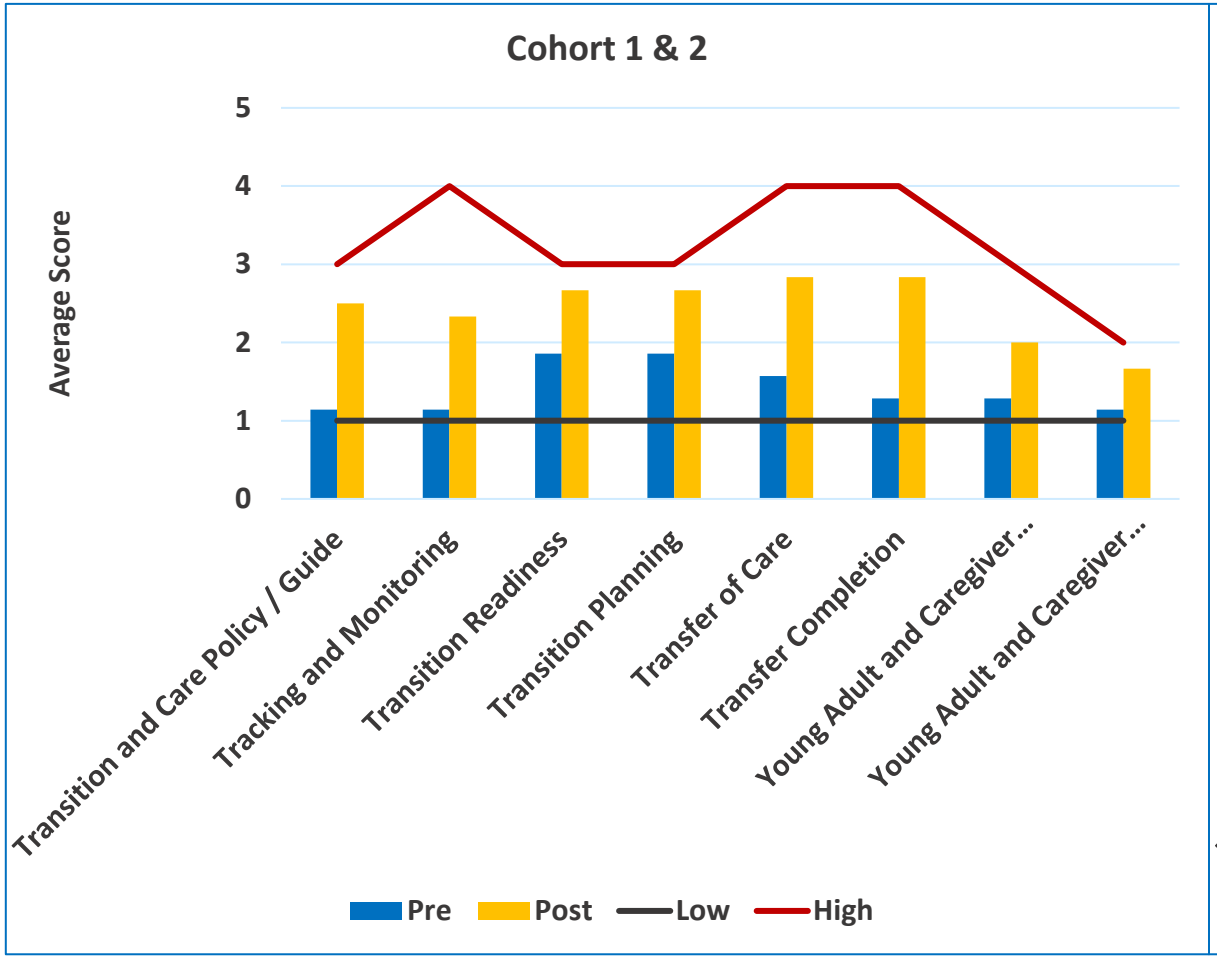
Healthcare Transfer of Care QI Objectives for Extended Participation Practices

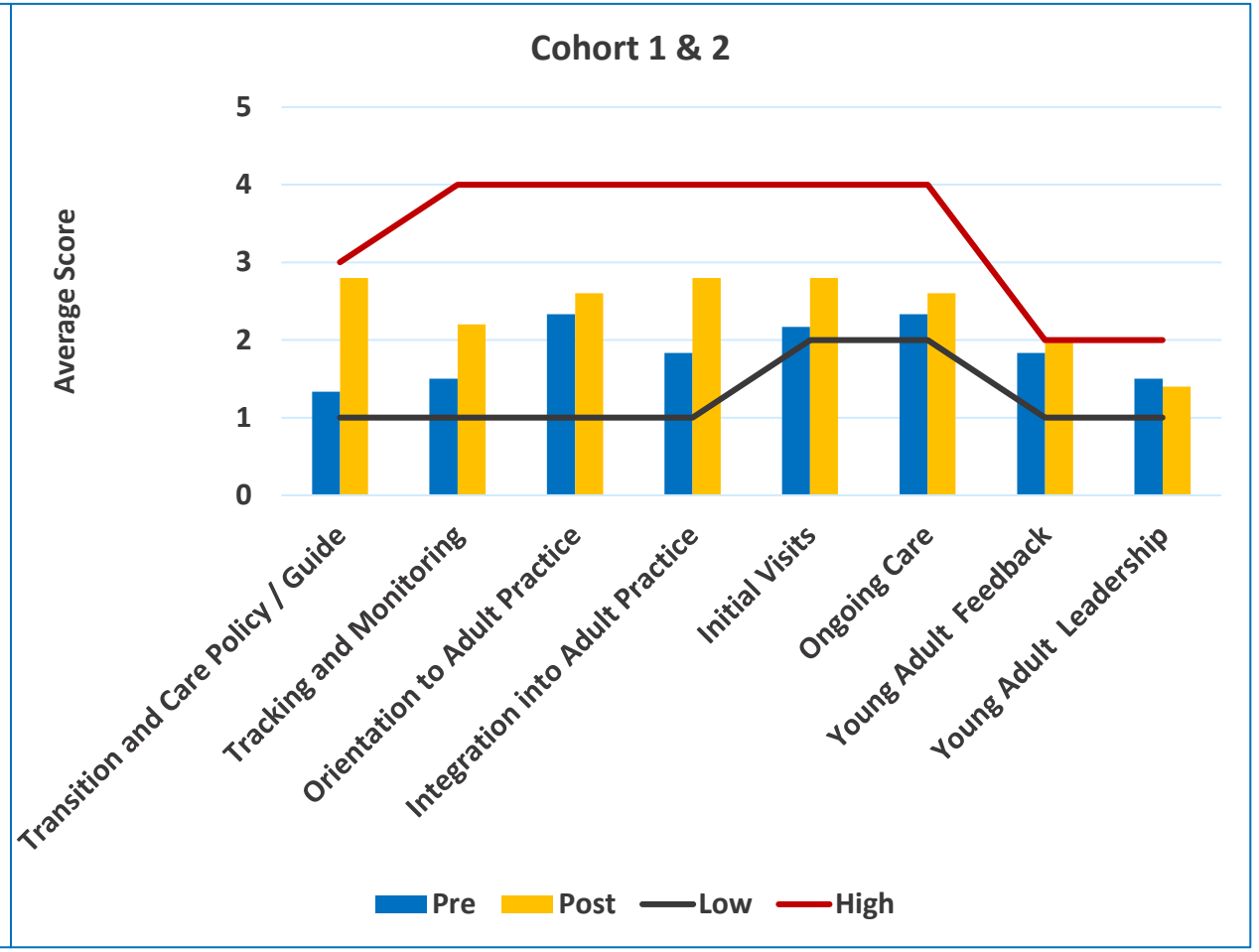


Pediatric and adult team partners will continue to work together to improve transition of care for youth as they transition from pediatric to adult care.

Expand and improve upon existing transition activities to include 7 additional populations of patients, refine policies, and increase knowledge, including 3 youths with special needs, including specialists.

Current Assessment Results from Cohorts 1 & 2





Baseline Survey Results - New Dyads

Pediatric	Average (Range of 1-3)	Adult	Average (Range of 1-2)
Transition and Care Policy / Guide	1.5	Transition and Care Policy / Guide	2.3
Tracking and Monitoring	1.5	Tracking and Monitoring	1.3
Transition Readiness	1.8	Orientation to Adult Practice	1.7
Transition Planning	2	Integration into Adult Practice	1.7
Transfer of Care	1.5	Initial Visits	2
Transfer Completion	1.3	Ongoing Care	2
Youth/Young Adult & Parent/Caregiver Feedback	1.5	Young Adult Feedback	1.7
Youth/Young Adult & Parent/Caregiver Leadership	1.5	Young Adult Leadership	1

Pediatric Current Assessment of Health Care Transition Activities
Adult/Family Current Assessment of Health Care Transition Activities

New Dyad Timeline
Nov 2023 – Oct 2024

1. Project Start-Up
   Kick-off meeting
   Monthly meetings scheduled
2. Transition planning
   Pediatric: 7 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation
   Adult: plan for tracking of patients
3. Customize transfer/receive tools
4. Customize transfer completion process
   Pediatric: PDSA cycles on Core Elements 4, 5, 6
   Adult: Customize process for initial visit; PDSA cycles on Core Elements 3,4,5
5. Start to test HCT Transfer Pilot with 7 Pediatric Patients (Mo.5-7)
   Adult: Receive and review transfer packet
6. Schedule and complete final pediatric visits
   Pediatric: Complete transfer package
7. Continue month 6 activities and plan joint Communication/Telehealth Call for Each Transferring Patient
8. Joint Communication/Telehealth Call for Each Transferring Patient with intentional focus on youth's special talents.
9. Prepare for Initial Adult Visit and confirm initial appointment was completed
10. Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey
11. & 12. Wrapping it up : Peer Learning Collaborative Meeting
    Complete assessment of HCT activities, analyze pre/post improvement, plan for sustainability and spread

Continuing Dyad Timeline Nov 2023 – Oct 2024

1. Project Start-Up
   Kick-off meeting
   Monthly meetings scheduled
2. Set goals, select priority, and set timeline for the project, considering: - Pt. engagement/preventing missed appts - Spread of program - Accommodating large numbers of transferring patients
3. Formalize and begin to implement a performance improvement plan
4. Identify youth with complex needs to transfer.
   Conversation about involvement of specialists.
5. Invite patients/families to partner in transfer process
6. Review elements of final transition visit and initial adult visit, including
7. Schedule and complete final pediatric visits.
   Following final pediatric visits, complete transfer package and share with patient and adult PCP.
8. Start integration into adult care
   Review who is responsible for scheduling visit (patient, adult practice, pediatric practice)
9. Prepare for Initial Adult Visit and confirm initial appointment was completed
10. Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey
11. & 12. Wrapping it up : Peer Learning Collaborative Meeting
    Complete assessment of HCT activities, analyze pre/post improvement, plan for sustainability and spread

Milestone Documents

Pediatric and Adult Transfer of Care QI Milestone Summary

Continuing Practice Transfer of Care QI Milestone Summary

Care Coordination ECHO Recordings & Presentations

November 29, 2023 - *Autism*
- **Presenters: Susan Jewel & Ariana DeAngelis,** Autism Project
- **Case Presenter:**

October 2023 - *Durable Medical Equipment and Medical Services* | Recording | Presentation | 1 Credit
- **Presenters: Carol Musso,** UnitedHealthcare**, Heather Kinsey, MPA,** Office of Health and Human Services, **Tara Hayes, BS, CCHW**: Family Voices Manager, RIPIN, and
- **Case Presenter: Nicole Wharton**, Lifespan

Durable Medical Resources and Services in RI

September 2023 - *Healthcare Transition from Pediatric to Adult Providers for Youth in Foster Care* | Recording | Presentation | 1 Credit
- **Presenters: Lisa Guillette,** Foster Forward, **Sylvia Parrott,** Foster Forward and **Joan Harmon,** DCYF.

August 2023 - *Disability and Accommodations in Higher Education* | Recording | Presentation | 1 Credit | Pending AAFP approval
- **Presenters: Adam Pallant, MD, PhD** and **Karen Andrews, M.Ed.:** Division of Health and Wellness, Brown University

July 2023 - *Understanding BHDDH Developmental Disability and Behavioral Healthcare Transitions of Care* • Recording | Presentation| 1 Credit
- **Presenters: Susan Hayward, MSW, LCSW**: Casework Supervisor, BHDDH| **Denise Achin, M.Ed**: Associate Administrator, BHDDH

June 2023 - *Maximizing Autonomy: Guardianship and Less Restrictive Alternatives* • Recording | Presentation| 1 Credit
- **Presenter: Jeannine Casselman, JD**: Law & Policy Director, MLPB

May 2023 - *Family Voice & Entitlement to Eligibility* • Recording | Presentation| 1.5 Credit
- **Presenters Tara Hayes, BS, CCHW**: Family Voices Manager, RIPIN| **Stephanie Trafka, CCHW**: RIPIN Family Voices

Evaluation & CME Credit

Up Next:

Patient-family Presentation

https://downloads.aap.org/DOCHW/MeganandCarlyLearningSession.mp4

Stay Safe and Healthy