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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) |
| **Pediatric (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**(project plans are due at the end of start-up and pilot phases). Use as much space as needed to complete each section* |
| **Pediatric Practice Name:**  |
| **Practice Sites:**  |
| **Practice Facilitator Name:**  |
| **Adult Primary Care Practice Name:** (connected practice who will be accepting 5 transferring 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 and IT/EHR and behavioral health staff (if applicable); *Inform your practice facilitator (PF) of any changes in staff on QI team.*  |
| Name  | Title  | Role in Project  |
|  |  |  |
|  |  |  |
|  |  |  |
| Pediatric team completed: [Pediatric Current Assessment of Health Care Transitions Activity](https://www.ctc-ri.org/sites/default/files/uploads/Appendix%20A%20-%20GT-6CE-Leaving-Current-Assessment-Customizable.pdf) (due 5/14/21) |
| **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 scheduled |
| Month 2:  | June 2021 | Transition planning - customize tools and process**Pediatric**: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation; **Adult**: plan for tracking of patients;  |
| Month 3:  | July 2021 | Customize transfer/receive tools  |
| Month 4: | August 2021 | Customize transfer completion process; PDSA cycles on Core Elements 4, 5, 6 |
| **Pilot Phase (months 5-12)**  | **Putting it in place :** team meets with PF monthly**,** Peer Learning Meeting month 5 |
| Month 5:  | September 2021 | Start to test HCT Transfer Pilot with 5 Pediatric Patients (Mo.5-7) |
| Month 6:  | October 2021 | Joint Communication/Telehealth Call for Each Transferring Patient (Mo. 6-8) |
| Month 7:  | November 2021 | **“ “** |
| Month 8:  | December 2021 | **“ “** |
| Month 8: | December 2021 | **Adult**: Integration into Adult Care: Completion of Initial Adult Visit and HCT patient feedback survey (Mo. 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, analyzed pre/post improvement, plan for sustainability and spread  |
| **Start-Up Phase (months 1-4) : May 19 – September 30, 2021** |
| 1. **Identify and Invite Potential Eligible Patients Ready to Transfer –** Due by June 30, 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Identify 5 youth/young adults interested in transferring to participating adult practice (*at least one patient should have complex needs)*
 |  |  |  |
| 1. Invite pilot patients, explaining time frame and added transition assistance to be provided (e.g., medical summary, communication between pediatric/adult doctors, and facilitated integration into adult care). *See sample medical summary and emergency care form (link below)*
 |  |  |  |
| 1. Create a simple tracking sheet (registry) to monitor pilot group’s receipt of last pediatric visit, joint communication/telehealth call, and initial adult PCP visit and receipt of Core Elements 4, 5, and 6. *SEE sample registry form*
 |  |  |  |
| 1. Share progress in monthly QI meeting
 |  |  |  |
| **Documents/links:** **Sample medical summary and emergency care form**: <https://gottransition.org/6ce/?leaving-medical-summary-emergency-plan>**Sample transition registry form**: <https://www.gottransition.org/6ce/?leaving-registry> |
| **Additional Notes:**  |
| 1. **Develop Transfer of Care Improvement Plan for Transferring Patients –** May through Sept. 30, 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Review and customize a 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 4, 5, and 6, summarized in 3. below; *See Appx A. PDSA template*
 |  |  |  |
| 1. Share progress in monthly QI meeting
 |  |  |  |
| **Documents/links:** Core Element 4- [Transition Planning](https://www.gottransition.org/six-core-elements/transitioning-youth-to-adult/transition-planning.cfm) Core Element 5- [Transfer of Care](https://www.gottransition.org/six-core-elements/transitioning-youth-to-adult/transfer-of-care.cfm)Core Element 6 – [Transfer Completion](https://www.gottransition.org/six-core-elements/transitioning-youth-to-adult/transfer-completion.cfm) |
| **Additional Notes:**  |
| 1. **Develop Content/Process for Transition Planning (Core Element 4), with PDSA Cycle**– Due by June 30, 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Customize content and process for Transition Planning (Core Element 4), including preparation of medical summary to be shared with transferring patient and adult PCP and discussion with patient about plans for timing of transfer to adult care and changes in privacy at age 18. *See sample transfer check list, sample letter, sample HCT plan of care, sample welcome and orientation, FAQs, and Telehealth Toolkit*
 |  |  |  |
| 1. Complete a PDSA on customized content and process for Core Element 4 – Transition Planning
 |  |  |  |
| 1. Share approach at monthly QI meeting
 |  |  |  |
| **Documents/links:** **Core Element 4**: [Six Core Elements Implementation Guide for Transition Planning](https://www.gottransition.org/6ce/?leaving-ImplGuide-planning) https://www.gottransition.org/6ce/?leaving-transfer-letterhttps://www.gottransition.org/6ce/?leaving-plan-care**Sample checklist**: <https://www.gottransition.org/6ce/?leaving-transfer-checklist>**Patient Education:** [Turning 18: What It Means for Your Health](https://www.gottransition.org/resource/?turning-18-english)[Telehealth Toolkit (gottransition.org)](https://www.gottransition.org/resource/?telehealth-toolkit-joint-visit-pediatric-adult-clinicians)(Adult): [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)(Adult): [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 Transfer of Care (Core Element 5), with PDSA Cycle –** Due by July 31, 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Customize content and process for Transfer of Care (Core Element 5), deciding on what should be included in the transfer package and working with adult PCP about content for joint communication/telehealth call with pediatric and adult PCP and transferring patient
 |  |  |  |
| 1. Decide on residual role of pediatric PCP before initial adult visit (e.g., refills, taking care of acute needs)
 |  |  |  |
| 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 Transfer of Care](https://www.gottransition.org/6ce/?leaving-ImplGuide-transfer-care) **Sample transition assessment for youth**: [Transition Readiness Assessment](https://www.gottransition.org/6ce/?leaving-readiness-assessment-youth) (not required, for reference only)Sample transfer checklist: https://www.gottransition.org/6ce/?leaving-transfer-checklist |
| **Additional Notes:**  |
| 1. **Develop Content/Process for Transfer Completion (Core Element 6), with PDSA Cycle –** Due by Sept. 30, 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Customize content and process for Transfer Completion (Core Element 6), including plan for communication with adult provider and youth, confirming completion of initial adult visit, offering time-limited consultation to adult PCP (if needed) *See Telehealth Toolkit*
 |  |  |  |
| 1. Complete a PDSA on customized content process for Core Element 6
 |  |  |  |
| 1. Share approach at monthly QI meeting
 |  |  |  |
| **Documents/links:** **Core Element 6:** [Six Core Elements Implementation Guide for Transfer Completion](https://www.gottransition.org/6ce/?leaving-ImplGuide-completion) [Telehealth Toolkit (gottransition.org)](https://www.gottransition.org/resource/?telehealth-toolkit-joint-visit-pediatric-adult-clinicians) |
| **Additional Notes:**  |
| **Learning Collaborative Joint Meeting – October 2021 (Date TBD)**  |
| **Pilot Phase (months 5 - 12) - October 2021 – May 2022** |
| 1. **Start HCT Transfer Pilot with 5 Pediatric Patients –** September – November 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Schedule and complete final pediatric visits
 |  |  |  |
| 1. Following final pediatric visits, complete transfer package and share with patient and adult PCP. *See Telehealth Toolkit*
 |  |  |  |
| 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. **Schedule Joint Communication/Telehealth Call for Each Transferring Patient** – October – December 2021
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Coordinate with adult practice and patient to schedule a joint communication/telehealth call following last pediatric visit and 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. **(Adult PCPs) Start Integration into Adult Care** – December 2021 – March 2022
 |
| **Action Items**  | Owner  | Completed (yes/no)  | Notes  |
| 1. Schedule and complete initial adult visits
 |  |  |  |
| 1. Per transfer of care process, communicate with adult practice to confirm initial appointment made
 |  |  |  |
| 1. Communicate with adult practice to confirm completion of HCT Feedback Survey by young adult, following the initial adult visit
 |  |  |  |
| 1. Share progress in monthly QI meeting
 |  |  |  |
| **Documents/links:** **Sample survey:**  [Young Adult HCT Feedback Survey](https://www.gottransition.org/6ce/leaving-feedback-survey-youth) |
| **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 4, 5, and 6
 |  |  |  |
| 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/?leaving-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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Plan:**  |
| **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  |
|  |
|  |
|  |
| **New Test of Change**  |
|  |
| **Describe your next test of change:** | **Person responsible** | **When to be done** | **Where to be done** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **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  |
|  |
|  |
| Describe your sustainability plan: |
|  |
|  |