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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**(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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **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: |
|  |
|  |