Welcome
Healthcare Transfer of Care

December 1, 2021

Agenda

Topic *Presenter(s)*	Duration
Welcome & review of Agenda *Susanne Campbell, CTC-RI Senior Program Director*	5 minutes
Summary of Progress *Susan Dettling & Suzanne Herzberg*	5 minutes
Dyads Report Out *Peggy McManus & Patience White to assist with Q&A*	20 minutes
System-wide Improvements on Transition of Care *Colleen Polselli, Special Needs Program Manager, RIDOH*	5 minutes
Next Steps *Susanne Campbell, CTC-RI Senior Program Director*	5 minutes

Progress To Date

- Tracking sheets are in use
- Workflows are in place for distributing FAQs, welcome letters, and patient packets
- All sites have identified and scheduled patients for their last pediatric visits
- Practices have either scheduled or in the process of scheduling their adult visits
- Workflows are in place to introduce YAs to the adult team
- Surveys have been completed by some of the YAs who have had their adult visits and outreach to those who didn’t complete a survey is underway

DYAD: Hasbro and Center for Primary Care

Medical Summary in place & shared with young adults ? How? If not, why?	***Yes. The summary is being shared at the last pedi visit (intentional transition visit)***
FAQ in place & shared with young adults ? How? If not, why?	***It's shared on arrival to the practice***
# of young adults scheduled to transition to adult practice?	***5***
# of young adults with initial adult visit completed? How did it go?	***3 completed and 2 are scheduled. Nothing specific, but all positive.***
young adults survey completed? How are you ensuring anonymity?	***Front desk is giving the surveys. How are you ensuring anonymity? Only 5 in each dyad and we want to know from them how the process went.***
How are the joint telehealth visits going?	***Not doing them. Would schedule if possible given providers' schedules. Considered it for one complex patient with communication with the NCM, but patient did not view it as needed. NCM's time is limited – she is half time.***
Criteria used for determining patients that might benefit from joint visits?	***None set***
Overall how is the process going? Is it sustainable?	***Not sure if the process of scheduling is sustainable on a large scale. Tracking down people who don't show is also will not be sustainable.***

DYAD: Hasbro and Center for Primary Care

Successes: (anything you want to share that's not covered above?)	Challenges: (anything you want help with from your fellow practices or National Alliance TAs?)
• *It's very helpful to be on the same EMR* • *Secure chat between providers is really beneficial* • *It's great to have practice assistance (PSRs) for handing out FAQs and for scheduling* • *Thrilled that 3/5 have already had their visits*	• *One patient who went to ER instead of coming in to visit.* • *Logistical questions: can you have two annual visits in one year? How do you prevent that happening?* • *How do we make this sustainable? Right now, it's great that we have two PCRs who are available for scheduling. But how do we continue that?* • *What level of handoff does your typical YA need compared to someone who is more medically complex?*

DYAD: Providence Community Health Centers

Medical Summary in place & shared with young adults ? How? If not, why?	***We don't give a printed medical summary unless the patient wants it; it is in the portal. All of the patients are being set up with the portal. We do not create a specific transition summary, but the visit summary has the dx, meds and plan automatically pulled into the note***
FAQ in place & shared with young adults ? How? If not, why?	***We have a letter containing the information that the patient receives before the last appt with the pediatrician.***
# of young adults scheduled to transition to adult practice?	***Capitol has scheduled 5. Randall has scheduled 5. Chafee has 5 scheduled.***
# of young adults with initial adult visit completed? How did it go?	***Capitol has completed 3. Randall has completed 1 and had 3 no-shows. Randall has sent a letter to the ones with no-shows to ask them to reschedule and has also asked team to reach out via phone. Chafee has completed 3 and 2 no-show.***
young adults survey completed? How are you ensuring anonymity?	***3 surveys completed at Capitol. How are you ensuring anonymity? The YAs are not placing their names on the surveys. However, we don't want the surveys to be anonymous – if there is something wrong, we want to address them directly.***
How are the joint telehealth visits going?	***Not doing.***
Criteria used for determining patients that might benefit from joint visits?	***None – if provider has any questions, will directly address other provider. YAs already don't want to go in for a visit – don't want to schedule another meeting.***
Overall how is the process going? Is it sustainable?	***Yes. We didn't have anything in place before. All that we've instituted is good. Some of the feedback on the readiness assessment has been that is isn't relevant. The young adults are familiar with the information already.***

DYAD: Providence Community Health Centers

Successes: (anything you want to share that's not covered above?)	Challenges: (anything you want help with from your fellow practices or National Alliance TAs?)
	• ***We would appreciate guidance around how to handle no-shows. We are confirming the day before the appt, but they are still not showing.***

DYAD: Dr. Nevola/Dr. Grande (Pilgrim Park)

Medical Summary in place & shared with young adults ? How? If not, why?	***Each patient's medical summary is discussed during course of visit, and is available on the patient portal. A physical print out is not shared.***
FAQ in place & shared with young adults ? How? If not, why?	***Yes, the FAQ for adult practice is shared, and a "Healthcare Goals" sheet is reviewed – this is opportunity for young adult (YA) to voice concerns medically/ non-medically; then share with Dr. Grande, anything complicated – doc to doc conversation always welcome***
# of young adults scheduled to transition to adult practice?	***6 YA have agreed to transition, with information sent to Dr. Grande; it is up to the YA to schedule their appointment with adult provider ; additional 2 YA are ready for appointments next year***
# of young adults with initial adult visit completed? How did it go?	***No YA have completed their initial visit, Dr. Grande has the YA feedback survey for use***
young adults survey completed? How are you ensuring anonymity?	
How are the joint telehealth visits going?	***Trying to schedule one visit with 23 yr. old YA***
Criteria used for determining patients that might benefit from joint visits?	
Overall how is the process going? Is it sustainable?	***Haven't completed the cycle yet – patients due for visits in November; hopefully the information being shared is everything that Dr. Grande needs;***

DYAD: Dr. Nevola/Dr. Grande (Pilgrim Park)

Successes: (anything you want to share that's not covered above?)	Challenges: (anything you want help with from your fellow practices or National Alliance TAs?)
Dr. Nevola built a resource in EPIC – embedded transition page that includes patient care team and problem list, leaves room for comment section provider to provider, typically one pager; this page gets emailed securely outside of EPIC, (to adult provider); also IN Communications within EPIC/patient's chart; adult provider can access the Communications section and look at cover letter .	• *Dr. Nevoa has experienced staffing challenges, down to just an office manager and one MA; staff has checked with 5 pending patients – calls have been made to ensure that they have followed up and booked appointment;* • *Look at possibility of establishing a "referral hub" from ACO; have help of a care manager or other ACO help for referrals within the system of care.*

DYAD: Coastal Narragansett Bay Pediatrics (NBP) / E. Greenwich Adult

Medical Summary in place & shared with young adults ? How? If not, why?	***E. Greenwich:*** ***Patients are encouraged to access their medical summary on the patient portal, medical summary not printed/ never was; Tell via the hub if a patient is signed up; patients will use messaging (both YA seen thus far were on the portal)*** ***NB Pedi:*** ***YA are encouraged to access the portal; information in the medical summary is discussed with all patients***
FAQ in place & shared with young adults ? How? If not, why?	***Yes, FAQ is in the patient packet provided by NBP***
# of young adults scheduled to transition to adult practice?	***1 complex patient in progress of being scheduled, including the joint telehealth visit; 2 remaining YA not due for visits until the summer***
# of young adults with initial adult visit completed? How did it go?	***2 YA have completed their visits; visits went very well, the warm handoff very helpful. Another one booked January 2022. (3) total transferred.***
young adults survey completed? How are you ensuring anonymity?	***EG will send them the YA patient satisfaction survey as they didn't have the tool at the time of their visits; EG will communicate that the survey is anonymous***
How are the joint telehealth visits going?	***visits went very well, the warm handoff very helpful.***
Criteria used for determining patients that might benefit from joint visits?	***Not practical for every patient; may look at complexity (medical/social); and look to pediatrician / NCM to determine if telehealth visit is needed.***
Overall how is the process going? Is it sustainable?	***Process is going very well thus far. Transitions of care have been more organized as part of this process; improved communication has been extremely helpful; transfers spread out over time helps sustainability, not large volume. Benefit is that all of the pilot YA are on eCW; organized in same fashion – system of care – very helpful; transfers from outside of Coastal – process is helpful; (EPIC / Care connect / "bridge" medical records outside of practices); yes, think this is sustainable.***

DYAD: Coastal Narragansett Bay Pediatrics (NBP) / E. Greenwich Adult

Successes: (anything you want to share that's not covered above?)	Challenges: (anything you want help with from your fellow practices or National Alliance TAs?)
• *process/workflow thus far has been going well* • *Process within eCW is working well* • *NBP: the practice has looked at the whole process, not just the "end" - where we are now in identifying young adults who are due or overdue to transition to an adult provider; practice will have more consistent policy around what gets communicated to patients at age 16, age 18, release of info and transition plan; also it has been helpful to connect to resources on legal aspects.*	• *No show rates; young adults – getting them in during school breaks, etc.;* • *scheduling telehealth visits is a challenge,* • *lack of ability to bill for pediatrician / adult provider time* • *NBP – some YA identified are not due for visits until after the pilot is over.*

DYAD: Coastal Waterman Pediatrics/ E. Providence

Medical Summary in place & shared with young adults ? How? If not, why?	***E. Providence:*** ***Patients are encouraged to access their medical summary on the patient portal*** ***Waterman Pedi:*** ***Medical summary is not printed, portal is encouraged. The medical summary is reviewed with patient; checked for accuracy – patient gives input – updates on new address, email address, portal sign on, etc.*** ***The medical summary is discussed during NCM mtg.; NCM asks – "is there anything you wish to share with new adult doctor?"***
FAQ in place & shared with young adults ? How? If not, why?	***Yes, the FAQ is shared during the joint telehealth visit and in patient packet***
# of young adults scheduled to transition to adult practice?	***1 was officially scheduled/visit completed 11/11/21; 2 young adults have had all of their information sent as of 11/16, E. Providence continues to do outreach to schedule these YA; may need assistance of Waterman NCM; 2 additional patients will need to be scheduled for a "follow-up" visit as they are not due to be seen for a wellness visit until August 2022 (after the pilot).***
# of young adults with initial adult visit completed? How did it go?	***1 patient completed their adult visit, and it was a very successful visit; the patient was very prepared and understood the differences between the pediatric and adult practice. This patient was able to outreach to adult practice ahead of visit, spoke to patient navigator and was able to get missing patient packet ahead of visit.***

DYAD: Coastal Waterman Pediatrics/ E. Providence

young adults survey completed? How are you ensuring anonymity?	***1 patient completed survey – he sat in waiting room, completed the paper survey and submitted it to front desk, he was not aware ahead of time that he would fill out a survey, and patient didn't know that this pilot only has a few patients***
How are the joint telehealth visits going?	***These visits include the NCM from Waterman and NCM and patient navigator from E. Providence. So far, the one joint telehealth visit went very well and resulted in a successful transition for 1 YA. Amy, NCM asked additional questions about patient needs before transition; Telehealth visit is short (20 – 30 min). Challenge is finding common time to be on joint call;***
Criteria used for determining patients that might benefit from joint visits?	***As part of the pilot, attempt is being made to do telehealth with all 5 patients***
Overall how is the process going? Is it sustainable?	***Process is going very well thus far. Using tracking grid for this pilot, but also in eCW, serves as a reminder of steps (because telephone encounter goes away); Worked well up to this point with the 5 patients (small number is working)*** ***Too soon to determine sustainability; one sample thus far – looking forward to seeing how it goes with other patients; re: sustainability – if significant (unbillable) time is required, this is not sustainable;***

DYAD: Coastal Waterman Pediatrics/ E. Providence

Successes: (anything you want to share that's not covered above?)	Challenges: (anything you want help with from your fellow practices or National Alliance TAs?)
• *process/workflow set for Waterman to EPIM transitions went smoothly for first young adult (11/11)* • *Process within eCW is working well.*	• *Finding common time for joint telehealth* • *Billing for wellness visit if under 12 months* • *Billing for joint telehealth visit* • *Process for transitioning outside of Coastal… release of record can be an issue; Waterman offers NCM services; (one provider did reach out)*

Compiled Surveys: 7 received so far

DID YOUR PAST PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Explain the transition process in a way that you could understand?	100% Yes
Give you a chance to speak with them alone during visits?	100% Yes
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)?	100% Yes
Create and share your medical summary with you?	100% Yes
Help you find a new adult doctor or other health care provider to move to?	100% Yes
DID YOUR NEW ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER...	
Address any of your concerns about your move to a new practice/doctor?	100% Yes
Give you guidance about their approach to accepting & partnering with new young adults?	100% Yes
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	100% Yes

Overall, how ready did you feel to move to a new adult doctor? 86% “Very”; 14% “Somewhat”

System-wide Improvements on Transition of Care

In consultation with the National Alliance

- **Develop a plan to identify costs associated with Transfer of Care work**
- **Work with health plans to discuss payment on transition of care codes that are part of the EPSTD.**

Survey Questions for Pediatric Clinicians

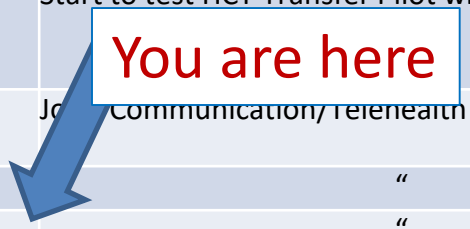
Transition Service	Are you providing the service?	Are you documenting the service?	Are you billing for the service?	Are you receiving payment for the service?
Transition readiness assessment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Education and counseling on self-care skill building using time-based office visits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medical summary	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Joint telehealth visit	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
About how many hours of care coordination time was spent per transferring patient in this pilot on assisting ...				
Youth with medical complexity	____ hours ☐ N/A			
Youth with chronic conditions	____ hours ☐ N/A			
Youth without chronic conditions	____ hours ☐ N/A			
Are any of the pilot participants or their families receiving services from the Cedar Family Center?	☐ Yes ☐ No			

Survey Questions for Adult Clinicians

Transition Service	Are you providing the service?	Are you documenting the service?	Are you billing for the service?	Are you receiving payment for the service?
Self-care skills assessment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Education and counseling on self-care skill building using time-based office visits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medical summary	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Joint telehealth visit	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Consultation of pediatric clinician by adult clinician (if needed)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For what percentage of your medically complex patience would you consider utilizing this consultation service? _____				
About how many hours of care coordination time was spent per transferring patient in this pilot on assisting ...				
Youth with medical complexity	____ hours ☐ N/A			
Youth with chronic conditions	____ hours ☐ N/A			
Youth without chronic conditions	____ hours ☐ N/A			

Timeline

Pediatric Timeline at a glance		Adult 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;	**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	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 **Pediatric**: 5 youth/young adults identified for transfer/participation in adult practice pilot group and agree to participation; **Adult**: plan for tracking of patients;	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	Customize transfer/receive tools
Month 4:	August 2021 Customize transfer completion process; PDSA cycles on Core Elements 4, 5, 6	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 Meeting month 5	**Putting it in place :** team meets with PF monthly**,** Peer Learning Mtg. month 5
Month 5:	September 2021 Start to test HCT Transfer Pilot with 5 Pediatric Patients (Mo.5-7)	**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 (Mo. 6-8)	Joint Communication/Telehealth Call for Each Transferring Patient (Months 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)	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	**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	Complete assessment of HCT activities, share/discuss pre/post improvement, plan for sustainability and spread



Next Steps

- Completion of Initial Adult Visit and HCT patient feedback survey (Mo. 8-11)
- Complete assessment of HCT activities,
- analyze pre/post improvement,
- plan for sustainability and spread

Final meeting on April 6, 2022

Resources

- Pediatric and Adult Transfer of Care QI Milestone Summaries
- Pediatric and Adult Transfer of Care Work Plans
- Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care
- Healthcare Transition Resources - Navigation Checklist for RI Individuals with Developmental Disabilities, developed by RIPIN
- Shared Decision-Making
- Got Transitions 6 Core Elements - Side by side
- Youth Feedback Form
- Care Notebook
- Healthy Transitions and Behavioral Health Guide for Young Adults

Stay Safe and Healthy