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| **New Pediatric Practice Transfer of Care Quality Improvement Milestone Summary** | | | |
| The timeframe to accomplish the transfer is brief. In months, 5-7, the last pediatric visit with each patient will be completed. An optional joint communication/telehealth call  between sending and receiving PCPs with transferring patient will happen before the initial adult visit, which will start in months 8-11. If joint communication/telehealth call is not completed, practice will plan for other youth/young adult engagement activity. | | | |
| **Component** | **Deliverable** | **Timeframe Due Dates** | **Notes** |
| Form Health Care Transition Quality Improvement Team and Confirm Connection with Adult Practice | * Identify members of the practice quality improvement (QI) team. The team should consist of 3 to 4 staff in different roles such as practice clinical champion, nurse care manager/care coordinator, practice manager, and/or IT representative if available. * Establish connection with adult primary care   practice who will be accepting 7 transferring patients, with at least 3 patients with special health care needs. | Completed as part of submitted application |  |
| Project Start-Up | * Pediatric practice completes Got Transition’s Current Assessment of HCT Activities | November 7, 2023 | Due November 7, 2023  Current [Pediatric Assessment](https://www.surveymonkey.com/r/TOCPedCohort3Pre) of HCT Activities |
| Project Start-Up | * Team champion/team member(s)Participate in kick-off meeting with pediatric and adult awardees to review project plan. * Schedule regular monthly team meetings with Practice Facilitator (PF) | November 14, 2023 | Kickoff meeting  [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09) |
| Identify and Invite Potential Eligible Patients Ready to Transfer | * Identify 7 young adults interested in transferring to adult practice. (3 patients with special health needs) * Invite these 7 patients to participate, explaining time frame and added transition assistance to be provided, e.g.:   + medical summary   + communication between pediatric/adult doctors,   + facilitated integration into adult care (See sample medical summary form)   + integration of youth/family goal * Create a simple tracking sheet (registry) to monitor date of last pediatric visit, joint communication/telehealth call, and initial adult visit and receipt of core elements 4,5, and 6. * Share progress in monthly QI meeting. (see sample registry form) | Months 1-2  Nov. 2023  Dec 2023 | [Transitioning Youth to an Adult Health Care Clinician-Implementation Guide (gottransition.org)](https://www.gottransition.org/6ce/?leaving-ImplGuide-full)  See: Transitioning Youth to an Adult Health Care Clinician Core Element 4 - Transition Planning (update plan of care with youth’s goal) |
| Develop Transfer of Care Improvement Plan for Transferring Patients | * Review Got Transition’s 6 Core Elements, with special attention to Core Elements 4,5,6 * Utilize suggested tools that can be customized by the practice. * Use Plan-Do-Study-Act (PDSA) cycles for Core Elements 4, 5, and 6, summarized in detail below. * Explore billing and coding for transition services. * Share progress in monthly QI meeting. | Months 1-4  Nov. 2023  Dec 2023  Jan 2024  Feb 2024 | Core Element 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)  [**2023 Coding and Payment Tip Sheet for Transition from Pediatric to Adult Health Care**](https://www.ctc-ri.org/sites/default/files/uploads/Final%202023%20Transition%20Coding%20and%20Payment%20Tip%20Sheet.pdf) |
| Develop Content and Process for Transition Planning (Core Element 4), with PDSA Cycle | * Customize content and process for Transition Planning (Core Element 4), including:   + preparation of medical summary to be shared with patient and adult PCP inclusive of what matters to the youth/family (goals/plan of care)   + discussion with patient about plans for timing of transfer to adult care   + changes in privacy at age 18. (See sample check list) * Complete a PDSA on customized content and process for Core Element #4. * Share approach at monthly QI meeting. | Month 2  Dec 2023 | [Six Core Elements Implementation Guide for Transition](https://www.gottransition.org/6ce/?leaving-ImplGuide-planning) [Planning](https://www.gottransition.org/6ce/?leaving-ImplGuide-planning)  [Turning 18: What It Means for Your Health](https://www.gottransition.org/resource/?turning-18-english) |
| Develop Content and Process for Transfer of Care (Core Element 5), including goals for care for the youth and/or families with PDSA Cycle | * Customize content and process for Transfer of Care (Core Element 5), deciding on what should be included in the transfer package. Work with adult PCP about content for joint communication/ telehealth call transferring patient. * Decide on residual role of pediatric PCP before initial adult visit (eg, refills, taking care of acute needs). * Complete a PDSA on customized content and process for Core Element #5. * **S**hare approach at monthly QI meeting. | Month 3  Jan 2024 | [Six Core Elements Implementation Guide for Transfer of Care](https://www.gottransition.org/6ce/?leaving-ImplGuide-transfer-care)  [Transition Readiness Assessmen](https://www.gottransition.org/6ce/?leaving-readiness-assessment-youth)t (not required, for reference only)  Sample Joint Telehealth Visit Script |
| Develop Content and Process for Transfer Completion (Core Element 6), with PDSA Cycle | * Customize content and process for Transfer Completion (Core Element 6), including plan for confirming completion of initial adult visit, offering time-limited consultation to adult PCP (if needed). * Complete a PDSA on customized content and process for Core Element #6. * **S**hare approach at monthly QI meeting. | Month 4  Feb 2024 | [Six Core Elements Implementation Guide for Transfer](https://www.gottransition.org/6ce/?leaving-ImplGuide-completion) [Completion](https://www.gottransition.org/6ce/?leaving-ImplGuide-completion)  Submit PDSA (including goals for care for the youth) to [deliverables@ctc-ri.org](mailto:deliverables@ctc-ri.org) by March 12, 2024. |
| **Learning collaborative Joint meetings\*** | Team champion/designee/team members actively participate in Learning Collaborative Joint Meetings (3 total) | March 26, 2024 | Learning Collaborative meeting [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09)  Provider champion or team member to present on experience with program to date, PDSA and status of transitions |
| Start transfer process with 7 Pediatric Patients, 3 must have special health care needs | * Schedule and complete final pediatric visits. * Following final pediatric visits, complete transfer package and share with patient and adult PCP. * Coordinate with adult practice and patient to schedule a joint communication/telehealth call following last pediatric visit and before initial adult visit. * Share progress in monthly QI meeting. | Months 5-8  March 2024  April 2024  May 2024  June 2024 | Sample Telehealth Toolkit Link to be provided  Submit PPT to [deliverables@ctc-ri.org](mailto:deliverables@ctc-ri.org) by June 11, 2024 |
| **Learning collaborative Joint meetings\*** | Team champion/designee/team members actively participate in Learning Collaborative Joint Meetings (3 total) | June 25, 2024 | Learning Collaborative meeting [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09)  Provider champion or team member to present on experience with program to date, PDSA and status of transitions |
| (Adult PCPs) Start Integration into Adult Care | * Schedule and complete initial adult visits – discuss who is responsible for scheduling visit (patient, adult practice, pediatric practice?) * Pediatric practice communicates with adult practice to confirm initial appointment made. * Intentionally reviews and discusses youth goal/plan of care * Adult practice administers anonymous HCT Feedback Survey to young adults at initial visit. * Pediatric practice communicates with adult practice to confirm completion of HCT Feedback Survey by young adult, following the initial adult visit. * Share progress in monthly QI meeting. | Months 9-12  July 2024  August 2024  September 2024  October 2024 | [Young Adult HCT Feedback Survey](https://www.gottransition.org/6ce/leaving-feedback-survey-youth) as patients are seen.  Submit final PDSA with PPT to [deliverables@ctc-ri.org](mailto:deliverables@ctc-ri.org) by October 9, 2024  Submit current [Pediatric Assessment](https://www.surveymonkey.com/r/TOCPedCohort3Pre) of HCT Activities by October 9, 2024 |
| **Learning collaborative Joint meetings\*** | Learning Collaborative Joint Meetings (final)   * Complete Current Assessment of HCT Activities * Review lessons learned and plans for sustainability and spread. * Share progress in monthly QI meeting. | October 22, 2024 | Learning Collaborative meeting [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09)  Provider champion or team member to present on experience with program to date, PDSA and status of transitions |
| Learning Collaborative Project Evaluation | * Complete Project and Practice Facilitation Evaluation | November 2024 | <https://www.surveymonkey.com/r/TOC2023Cohort3> |
| Learning Collaborative Dates | * **Kickoff** – Introductions * **March** – PDSA (Aim & Plan) * **June** – PDSA update (Do, Study, Act) * **October** – Lessons Learned, Plans for Sustainability and Spread, Youth Feedback | November 14, 2023  7:30-9:00AM  March 26, 2024  June 25, 2024  October 22, 2024  7:30-8:30AM | [Zoom](https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09) |

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