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| Pediatric Practice Transfer of Care Quality Improvement Milestone Summary | | | |
| 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 5 transferring patients. | Describe as part of application |  |
| Project Start-Up | * Participate in initial kick-off meeting with pediatric and adult awardees to review project plan and schedule regular monthly team meetings. * **Pediatric practice team completes Got Transition’s Current Assessment of HCT Activities prior to kick off meeting (due May 7, 2021)** | Month 1 | Got Transition, with RI Team, will offer kick-off training.  [Current Assessment of HCT Activities](https://www.gottransition.org/6ce/?leaving-current-assessment) |
| Identify and Invite Potential Eligible Patients Ready to Transfer | * Identify 5 youth/young adults with and/or without special health needs interested in transferring to participating adult practice. * Invite pilot group, explaining time frame and added transition assistance to be provided (eg, medical summary, communication between pediatric/adult doctors, and facilitated integration into adult care). SEE sample medical summary form * 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. * Share progress in monthly QI meeting. SEE sample registry form) | Months 1-2 | 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 visit between sending and receiving PCPs with transferring patient will happen before the initial adult visit, which will start in months 8-11. |
| Develop Transfer of Care Improvement Plan for Transferring Patients | * 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. * Use Plan-Do-Study-Act (PDSA) cycles for Core Elements 4, 5, and 6, summarized in greater detail below. * Share progress in monthly QI meeting. | Months 1-4 | 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) |
| 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 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 check list * Complete a PDSA on customized content and process for Core Element #4. * Share approach at monthly QI meeting. | Month 2 | [Six Core Elements Implementation Guide for Transition 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), with PDSA Cycle | * 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. * 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 | [Six Core Elements Implementation Guide for Transfer of Care](https://www.gottransition.org/6ce/?leaving-ImplGuide-transfer-care)  [Transition Readiness Assessment](https://www.gottransition.org/6ce/?leaving-readiness-assessment-youth) (not required, for reference only)  Sample Joint Telehealth Visit Script *(to be sent when finalized)* |
| 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 | [Six Core Elements Implementation Guide for Transfer Completion](https://www.gottransition.org/6ce/?leaving-ImplGuide-completion) |
| Learning Collaborative Joint Meeting\* | Learning Collaborative Meeting | Month 5 |  |
| Start HCT Transfer Pilot with  5 Pediatric Patients | * Schedule and complete final pediatric visits. * Following final pediatric visits, complete transfer package and share with patient and adult PCP. * Share progress in monthly QI meeting. (SAMPLE New telehealth tool kit) | Months 5-7 |  |
| Schedule Joint Communication/Telehealth Call for Each Transferring Patient | * Coordinate with adult practice and patient to schedule a joint communication/telehealth call following las pediatric visit and initial adult visit. * Share progress in monthly QI meeting. | Months 6-8 |  |
| (Adult PCPs) Start Integration into Adult Care | * Schedule and complete initial adult visits. * Per transfer of care process, communicate with adult practice to confirm initial appointment made. * Communicate 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 8-11 | [Young Adult HCT Feedback Survey](https://www.gottransition.org/6ce/leaving-feedback-survey-youth) |
| Final Transfer of Care Improvement Collaborative | * Complete Current Assessment of HCT Activities, allowing for analysis of pre/post improvement in Core Elements 4, 5, and 6. * Review lessons learned and plans for sustainability and spread. * Share progress in monthly QI meeting. | Month 12 | [Current Assessment of HCT Activities](https://www.gottransition.org/6ce/?leaving-current-assessment) |

\*additional learning collaborative meeting may be added based on needs team learning needs