CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Health Transitions of Care

Final Learning Collaborative Meeting | October 22, 2024

Care Transformation Collaborative of RI

Agenda

Time	Topic	Presenter
7:30 – 7:35	Welcome and Review of Agenda	Susanne Campbell, CTC-RI
7:35 - 8:00	Practice Activities and Updates	**Practices and Providers:** Dr. Richard Ohnmacht & Dr. Chad Lamendola East Greenwich Pediatrics / University Family Medicine Atlantic Pediatrics / Dr. Matt Rocheleau Anchor Pediatrics / Anchor Medical Concilio Pediatrics / RIPCPC Referral Hub **Practice Facilitator:** Sue Dettling, CTC-RI
8:00 - 8:10	Survey Results	Carolyn Karner, CTC-RI
8:10 - 8:25	RIPIN Self-Directed Support Program	Sharon Kochan, BS, CCHW
8:25 – 8:30	Closing Remarks	Patricia Flanagan, MD, CTC-RI

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Dyad Team: *Dr. Ohnmacht & Dr. Lamendola*

Healthcare Transfer of Care | October 22, 2024

Dr. Ohnmacht & Dr. Lamendola – 10/22/24

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Successes:

- 10 complex young adults have been transferred
- Dr. L took additional transfers (and is still taking others ongoing)
- Dr. Ohnmacht retired July 1st – thank you for your service as an outstanding Pediatrician!

Challenges/opportunities:

- Specialists are more difficult to engage in transfer process
- Limited space in Family Physician practice to accept large volume of new patients
- Lack of adult PCPs in Rhode Island (often 10 calls a day from patients looking for PCP)

Ideas for sustainability:

- Encourage law makers to consider increased reimbursement rates (on par w/ other NE states)
- Outreach to other RIPCPC providers taking new patients:(Matt Rocheleau)
- Encourage more collegial relationships between Pediatricians and Adult Care Providers to engage dyads in a more structured transfer of care paradigm
- Engage Specialists in the transfer of care process

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Dyad Team: E. Greenwich Peds & University Family Medicine

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E. Greenwich Peds & University Family Medicine – 10/22/24

Successes:

- 6 YA seen, 1 pending; 5 additional YA have been scheduled at UFM
- Improved communication/enhanced workflow between pediatric/adult FM practice
- Oct. meeting – face to face at E. Greenwich Pediatrics (Dr. McMillan)

Challenges/opportunities:

- Lack of access to adult primary care
- Would be helpful to have another practice to partner with
- Census of patients that will be "aging out" of pediatric care (aged 18/19) ~ 312 patients
- Special needs patients may stay in practice a little past age 19

How are other pediatricians handling the lack of access to family/adult primary care?

- For YA - suggest to talk to family members re: their PCPS, give list of providers with open access – list is compiled by referral coordinator (Deb calls offices to see if they are accepting new patients – very labor intensive)
- Transition discussed early – age of 16, letters sent to YA

Ideas for sustainability:

- UFM may be hiring a new provider
- Dr. Matthew Rocheleau – may have access

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Dyad Team: Atlantic Pediatrics/Dr. Matt Rocheleau

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Atlantic Pediatrics/Dr. Matt Rocheleau – 10/22/24

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Successes:

- YA are being independent and making their own appointments (not recently dealing with over-bearing parents)
- YA were encouraged to make their own appointments (Ruth kept track of status, reminded YA to make appointment with Dr. R when necessary, Ruth served as "peer" or role model for YA)
- 10 YA successfully transferred (as part of this project)
- Other YA have been referred to Dr. Rocheleau as well
- Dr. Rocheleau started project when new to practice, patients will "grow" with practice, over 600 patients now

Challenges/opportunities:

- YA need to understand that they have to make the call to adult provider
- YA may adopt NHP which may limit access to certain providers
    - **How are other pediatricians handling the lack of access to family/adult primary care?**
- Atlantic Peds receiving many calls for adult medicine provider, so referring to the RIPCPC referral hub

Ideas for sustainability:

- Consider education/handouts regarding life skills (ie. Learn to fish) and YA taking charge of their healthcare

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Dyad Team: *Anchor Pediatrics/Anchor Medical*

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Anchor Pediatrics/Anchor Medical – 10/22/24

Successes:

- Complex YA – had meet/greet first (May); just had physical recently – reduced anxiety of patient/family
- All 7 YA transferred
- Able to transfer patients to PVD site as well
- Communication workflow (info exchange back / forth) has been helpful

Challenges/opportunities:

- Patients sometimes told practice was closed, Chris was point of contact to trouble shoot any issues (i.e. approved Pedi transfer patients need to be accepted)
- Adolescents are “invincible” and not worried about healthcare
- Some patients do not wish to see a provider in PVD if live farther away

How are other pediatricians handling the lack of access to family/adult primary care?

- Recommend RIPCPC referral hub

Ideas for sustainability:

- Continue partnership of Anchor Pedi/Anchor Medical (access permitting)
- Thinking about ways to keep reminding YA of upcoming appointments

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Dr. Concilio/ RIPCPC Referral Hub

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Dr. Concilio/ RIPCPC Referral Hub – 10/22/24

Successes:

- At least 5 YA have located new adult provider
- Dr. C has continued to work with RIPCPC referral hub with ~15 new YA being sent to referral hub with specific RIPCPC follow up
- Some patients followed thru to find new provider with the assistance of RIPCPC referral hub

Challenges/opportunities:

- RIPCPC referral hub – will call patients just one time/difficult for referral hub to track specific patients
- Patients – YA must take responsibility and make their appointments; ensure that correct PCP is listed w/ insurance (Medicaid and Commercial mandates)
- Geographic limitations when transferring to providers with open access

How are other pediatricians handling the lack of access to family/adult primary care?

- Many patients continue to be referred to Dr. Rocheleau who has open access as of now

Ideas for sustainability:

- Practice continues to discharge YA; females are discharged at age 16 and encouraged to find an OB/GYN, males are discharged 17/18 yrs. Old
- All patients at age 18 are given medical release form and encouraged to find PCP/ use RIPCPC referral hub

Sample handout for youths transitioning

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ADVANCING INTEGRATED HEALTHCARE

Next Stage – Turning 18

Like all childhood stages, transitioning from childhood to adulthood is exciting and challenging. Your Waterman Pediatrics team is here to shepherd the journey, moving from parent-led to young adult-led care. Each youth and parent/caregiver will travel this process at their own pace, especially for youth with special healthcare needs where the healthcare transition may be different.

Before you turn 18 and become a legal adult, figure out if you will need help making health care decisions. If so, ask for assistance from the Nurse Care Manager at Waterman Pediatrics or RI Parent Information Network (https://ripin.org).

At age 18 you are a legal adult, which means that you are legally responsible for your care.
Your doctor talks to **you**, not your parents, about your health. If there is a question about your health, or need for a prescription refill, Waterman Pediatrics asks that you, not your parents, call the office to request this care.
It is up to you to make decisions for your own health care, although you can always ask others for help. If you need help making decisions, talk to your family, your support team and your doctor about who needs to be involved and what you need to do to make sure they can be a part of the conversation.
Your health information and medical records are private (or confidential) and can't be shared unless you give the OK. If you want to share medical information with others, your doctor may ask you to fill out a form that allows them to see your medical record and be with you during the visit.
The confidentiality between you and your doctor is legally known as the Health Insurance Portability and Accessibility Act, or HIPAA. This law gives privacy rights to minors (people who are under age 18) for reproductive and sexual health, mental health and substance abuse services.
At Waterman Pediatrics, young adults are welcome to transition to an adult physician at any time. However, young adults are welcome to remain as Waterman Pediatrics patients until after graduating from college, as long as they do not develop complicated adult-level medical conditions which require more adult medicine-centric care.

For the parents of a new 18-year-old: Your child is now transitioning to adult life! They will still look to you for support and guidance but will be more on their own when it comes to decision making. Support their autonomy but let them know that you will always be there for them. Hold them accountable for their actions by allowing consequences to happen, but in a loving, non-judgmental manner. During the teen years, we provide the opportunity for your teen to have at least a portion of the visit with the parent out of the room.

Sample handout for youths transitioning

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Transition to Adult Care

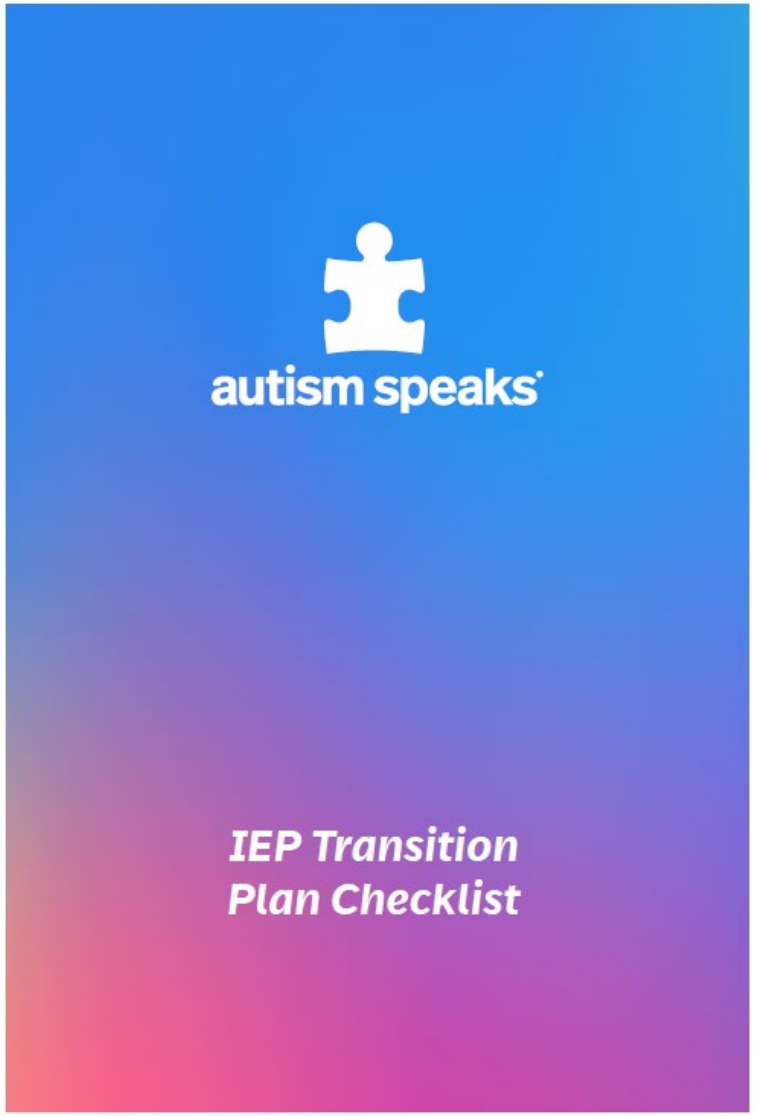
Health care services for adults are generally managed in a different style and with different expectations than services for children. Teens and young adults who have been used to a pediatricians and specialists who they have known for a long time may have a period of adjustment after switching to adult providers. Planning ahead can help ease this transition.

Make the Appointment - what kind of an appointment is needed?
New patient appointment – the first time you see the doctor. Takes longer and you may have to wait until a slot is available
Annual Exam – also takes longer. Let the office staff know if you have health forms that need to be filled out at the appointment
Illness or injury – is this an emergency or can you wait for a day or so? Office staff can help you decide. Don't ask for an urgent appointment if it is not really an emergency. If the condition is life-threatening, go to the nearest emergency room.
Follow-up or return appointment – this is an appointment to see if the treatment is working or needs to be changed. It will be fairly short so if you have new problems to ask about, tell the office staff so they can give you more time.

Prepare for your First Adult Health Care Appointment –
Put the appointment on your calendar so you won't forget!
If at the last minute you cannot attend this appointment, call the office to cancel or reschedule – missed appointments disrupt the doctor's schedule and are often incur a charge by the office. Some adult offices may refuse to continue having you as a patient if you miss appointments often.
Arrive a few minutes ahead of time and wear clothes that are easy to prepare for the exam
Write down a list of questions and concerns you have before seeing your new doctor
Keep a list of your medications, how much you take and any allergies to medications. You can take a picture of your medicines' label and bring it with you to the visit
Keep your doctor's phone number in your phone or somewhere you can easily find it
Keep your health insurance card with you always, and learn what services and doctors are and are not covered
Keep a record of your medical history, family history, allergies and vaccines to share with your new doctor

During the Appointment –
Introduce yourself and anyone you brought with you, telling the doctor what you want that person's role to be in the appointment
Ask your doctor where to go if you need to get care after office hours or on the weekend
Ask your doctor to explain information you do not understand.
Ask the doctor to write down the instructions, making sure you understand them before leaving
Ask your doctor if there is an online portal or an app you can use to look up your health information, contact information or to make appointments.

IEP Transition Plan Checklist – Pediatrics to Adult Autism checklist



Youth Survey Results – 20 responses

Question: DID YOUR PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER...	Response
Explain the transition process in a way that you could understand?	100% Yes
Give you the 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
Question: **DID YOUR ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER...**	Response
Address any of your concerns about your move to a new practice/doctor?	95% Yes
Give you guidance about their approach to accepting and 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 doctor?	90% Very 10% Somewhat
Do you have any ideas for your past pediatric doctor or new doctor about making the move to adult health care easier?	See next slide

Feedback on "Do you have any ideas for your past pediatric doctor or new doctor about making the move to adult health care easier?" and other comments

- No/None/NA
- Easy switch
- Seamless
- Maybe group chat for kids with high anxiety transitioning to adult doctor.
- This was a very smooth transition
- It was good. Everyone was welcoming and so nice!
- Was a very smooth transition
- More information about other than that one.

Summary of Six Core Elements of Transition Approach

*Roles for Pediatric and Adult Practices**

Practice/ Provider	#1 Transition Policy	#2 Tracking and Monitoring	#3 Transition Readiness/ Orientation to Adult Practice	#4 Transition Planning/ Integration into Adult Care	#5 Transfer of Care/Initial Visit	#6 Transition Completion/ Ongoing Care
Pediatric*	Create and discuss with youth/family	Track progress of youth/family readiness for transition	Transition readiness assessment (RA)	Develop transition plan including needed RA skills	Transfer of care with information and communication to adult clinician	Obtain feedback on the transition process
Adult*	Create and discuss with young adult (YA)/ guardian, if needed	Track progress to increase YA's knowledge of health and adult health care system	Share/discuss Welcome and FAQs letter with YA and guardian, if needed	Update transition plan with additional skills required	Communication with pediatric clinician/ Agree on content of the 1-2 initial adult visits/Self-care assessment	Ongoing care/referrals, as needed, with continued self-care skill building

**Providers that care for youth/young adults throughout the life span would complete both sets of core elements without the transfer process*

Practice Assessments

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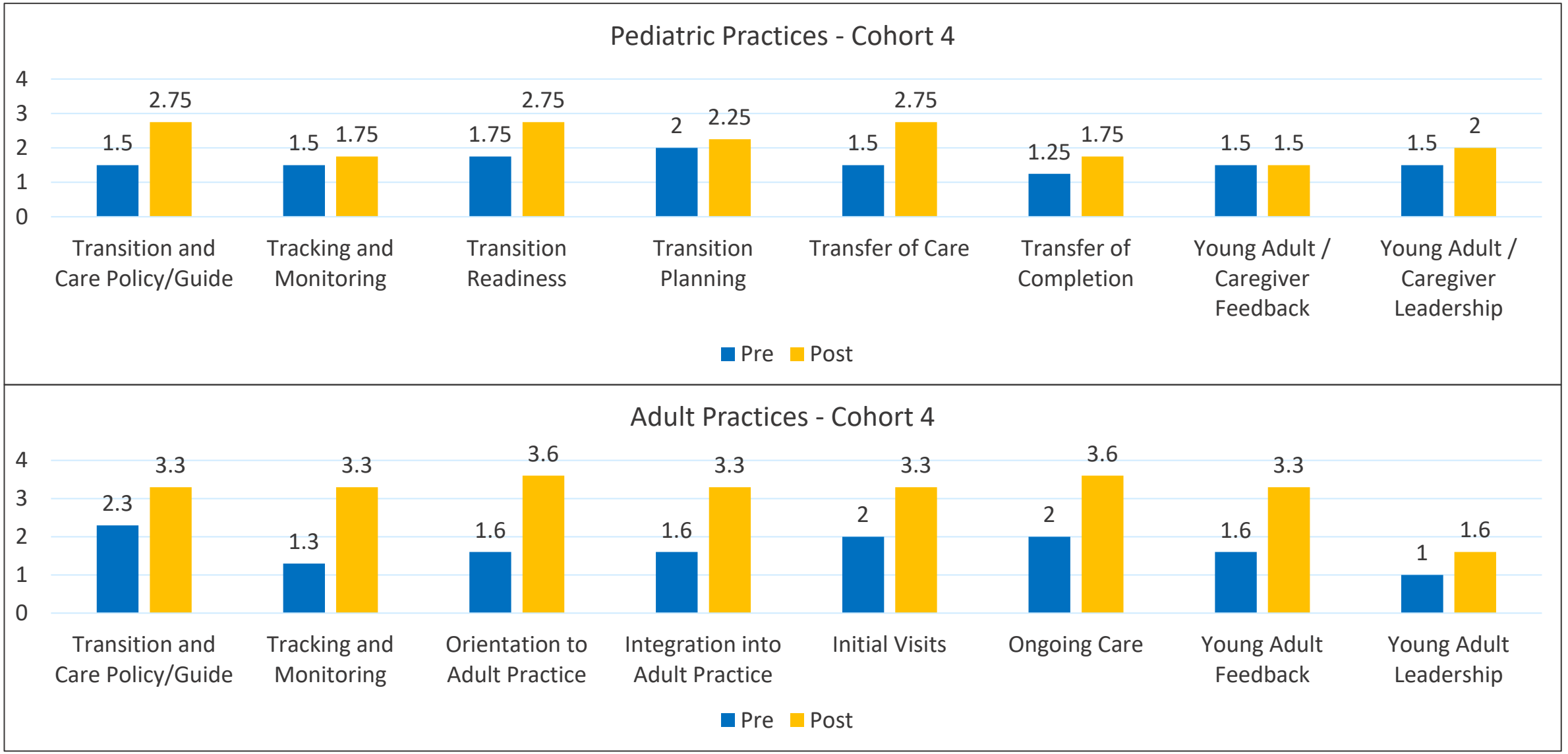

RIPIN

Self-Directed Support Program

RI Care Transformation Collaborative Meeting
10.22.24

PERSONAL SUPPORT BUILT ON PERSONAL EXPERIENCE

ABOUT RIPIN

- Independent 501(c)(3) nonprofit organization
- *Peer Professionals*
- Help Rhode Islanders of all ages, abilities, and backgrounds access and navigate:
  - Health Care
  - Education
  - Healthy Aging
  - Other services/supports/complex systems

RIPIN

What is Self-Direction?

- A service model for adults with intellectual and developmental disabilities (I/DD)
- Must be found eligible for funding from Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
- Allows the person and their family or trusted allies to manage their own budgets, hire their staff, and set their priorities
- Based on the individual's unique support needs and goals

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Differences between choosing Agency Programs & Self- Directed

Provider Agency

- Costs for program administration and management and transportation
- Less hours of direct support
- Set schedule/hours of operation
- Activities are predetermined
- Training is more generalized

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Why Consider Self-Direction?

- Personal choice and control
- Creative scheduling (staff)
- Person Centered planning
- Activities are directly designed around the person and their goals and interests
- Funds go further
- More hours available for personal support (staff)
- You can combine self-directed services with agency programs

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ABOUT RIPIN'S SELF-DIRECTED SUPPORT PROGRAM (SDSP)

The goal of the Self-Directed Support Program at RIPIN is to guide and support families and individuals in navigating the systems and supports available to them when they choose self-direction.

We do this through:

- Training and Education
- Sharing resources
- Peer Support
- Referrals
- Collaborations with other agencies and organizations

View our content on the web!

Our live webinars are recorded and posted within a few days to our website for you to view at any time.

They can be reviewed here:

Under RESOURCES

Click on “Recorded Presentations”
ripin.org/webinars/sdsp

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