CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Health Transitions of Care

Quarterly Learning Collaborative

May 25, 2023

Care Transformation Collaborative of RI

Agenda

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Topic	Presenter	Time
Welcome	Kim Nguyen-Leite, MHA, CPHQ, PCMH CCE CTC-RI Pat Flanagan, MD CTC-RI	7:30am – 7:35am
Family Voice and Care Coordination ECHO	Stephanie Trafka RIPIN	7:35am-7:40am
Current Assessment of Activities	Kim Nguyen-Leite	7:40am – 7:45am
Practice Updates	Hasbro & CPC Dr. Ohnmacht & Dr. Lamendola Children's Choice Pediatrics & Greenwich Medical Associates Dr. Nevola	7:45am – 8:20am
Young Adult Feedback Survey Results	Kim Nguyen-Leite	8:20am – 8:25am
Closing	Kim Nguyen-Leite Pat Flanagan	8:25am – 8:30am

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Family Voice and Care Coordination ECHO

Care Coordination ECHO Series

Session #1 – Entitlement to Eligibility
May 31, 2023 @ 7:30am

Objectives

- Case presentation will highlight a family's real-life experience and challenges with the transition from pediatric to adult healthcare services for their child with complex healthcare needs.
- Facilitate an open discussion around the process of transition from pediatric to adult healthcare services and supports (entitlement to eligibility), what's involved, opportunities for improvement, and what both families and professionals need to know.
- Identify key priorities for many families as well as barriers to obtaining the necessary supports throughout and after this transition.
- Outline how developing a partnership with RIPIN can help families and professionals navigate these systems together, providing continuity of care for all individuals in need.

Register Today! https://www.surveymonkey.com/r/CCECHO2023

Summary of Six Core Elements of Transition Approach

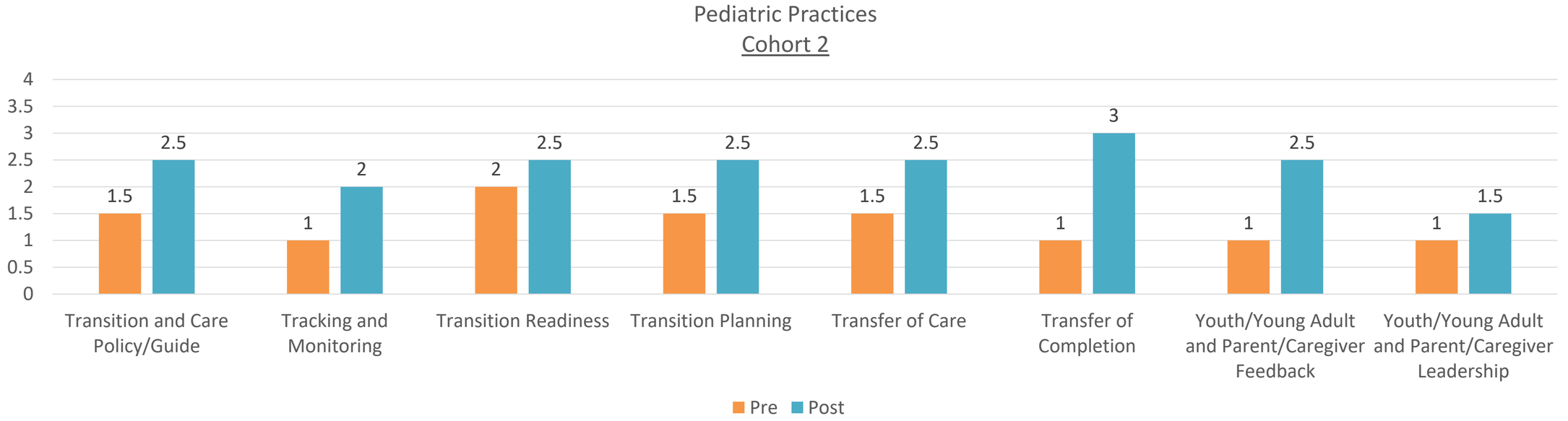
*Roles for Pediatric and Adult Practices**

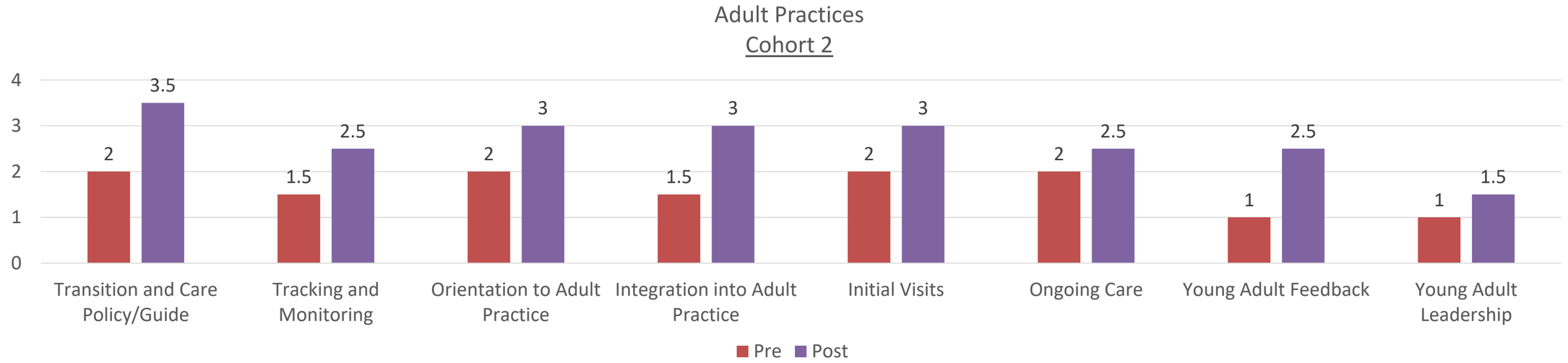
Practice/ Provider	#1 Transition Policy	#2 Tracking and Monitoring	#3 Transition Readiness/ Orientation to Adult Practice	#4 Transition Planning/ Integration into Adult Care	#5 Transfer of Care/Initial Visit	#6 Transition Completion/ Ongoing Care
Pediatric*	Create and discuss with youth/family	Track 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

ADVANCING INTEGRATED HEALTHCARE



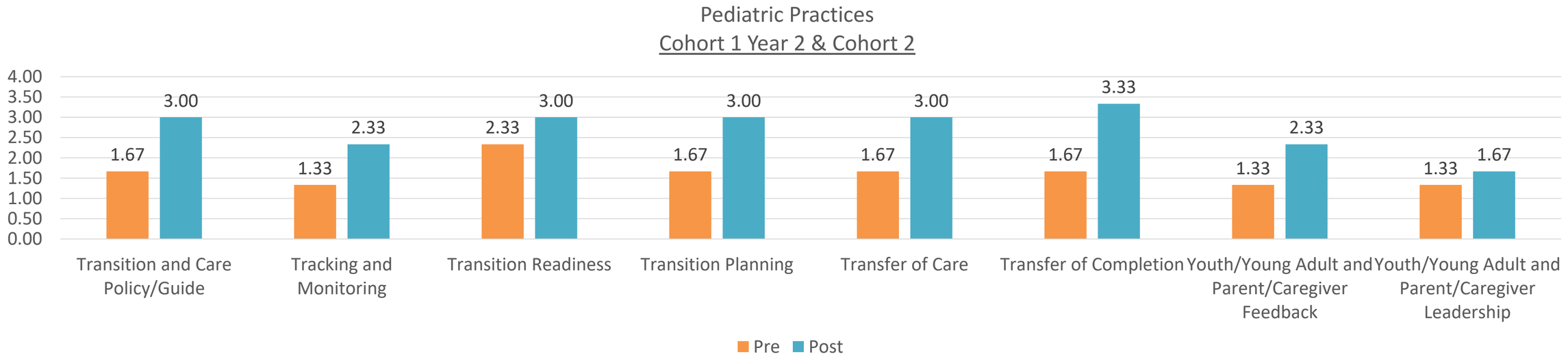


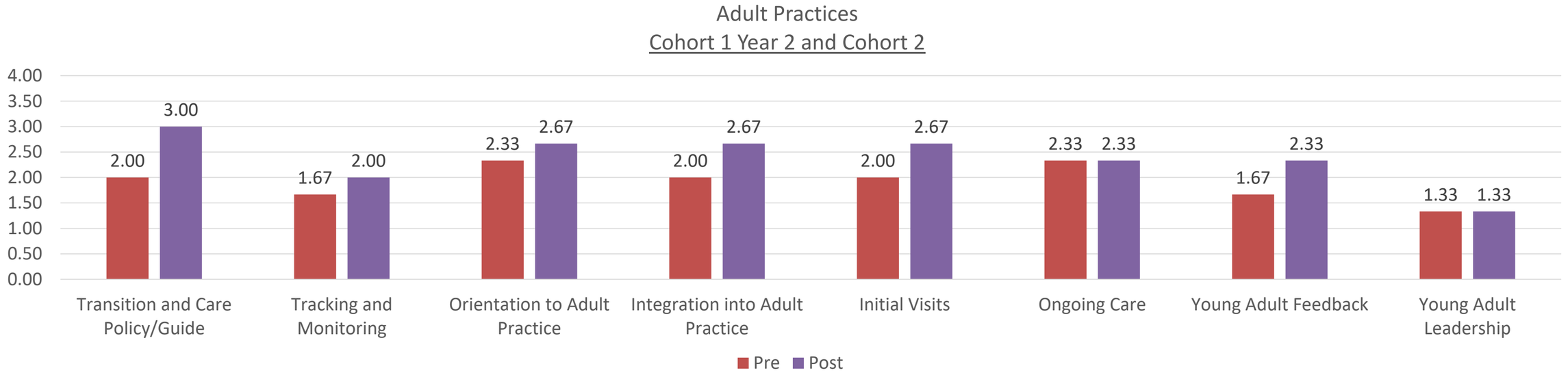
Practice Assessments

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE





Practice Assessments

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Assessment Links

Pediatric: https://www.gottransition.org/6ce/?leaving-current-assessment
Adult: https://www.gottransition.org/6ce/?integrating-current-assessment

Practice Team Updates

ADVANCING INTEGRATED HEALTHCARE

Hasbro (Dr. Carol Lewis) & CPC (Dr. Meghan Geary)

Data
Total # of Patients Identified for Transfer: 24
Total # of Patients Successfully Transferred: 19
Total # of Patients with upcoming appointment scheduled: 3

What area of focus did you work on?
Identifying patients for transfer, creating a shared list for easy communication within EMR, scheduling specific transition visits for young adults at Hasbro, updating the template for transition visit to include specific questions
How did you make improvements? We used a team-based approach. Providers worked on the templates and took responsibility for creating the shared list, care manager identified patients for transfer and tracked appointments kept
What additional changes would you like to make, if any. Increase the spread of the program to other areas, such as specialty care

What tools or EHR enhancements did you feel were most helpful for the process?
Shared list within EMR, transition-specific template

Describe your process and success with collecting patient feedback: This has been difficult for us. We haven't been able to find a good workflow for this process.

Patient/Family Success Story: Drs. Geary and Lewis were able to collaborate on a patient, bringing in the pediatric cardiologist as well. The process was much more interconnected and collaborative than it would have been without this program.

What transition activities will you continue to do?
Hasbro will continue to identify patients for transition, conduct a transition visit, and schedule those patients with the CPC.

What advice would you give other practices looking to do this work?
It has significantly improved our transition process and enabled us to provide better care.

Practice Team Updates

Dr. Richard Ohnmacht and Dr. Chad Lamendola

Data
Total # of Patients Identified for Transfer 10
Total # of Patients Successfully Transferred 7

What area of focus did you work on? Communication around coordination between providers, introducing a new patient to the practice
How did you make improvements? Through Epic, we were able to see shared records, which allowed us to communicate well. Dr. L. created and improved introduction letter for new YA adult patients, which will now be used with all patients. He also created introductory visit for new patients.
What additional changes would you like to make, if any. –We would like to continue process of working together

What tools or EHR enhancements did you feel were most helpful for the process. – Sharing the same EMR made the process much easier and allowed for seamless communication between providers. The introduction letter was key to helping new patients understand basic information about the practice, expectations of them, and confidentiality. We are using the letter for all new patients.

Describe your process and success with collecting patient feedback: We gave patients the QR code and discussed any questions at the end of the visit. Questions from patients were mostly about transferring records

Practice Team Updates

Dr. Richard Ohnmacht and Dr. Chad Lamendola

Provide an example of a patient transition that went well or one that allowed the practice to learn a lot about the process
We had a seamless transition for a patient who came in with ADHD meds. The initial 45-minute visit allowed Dr. L. to assess her needs and continue writing rx for a stimulant.

Another patient has had a few sick visits following the initial transition visit, preventing urgent care visits. This process points to the utility of having an established relationship with primary care physician.

What transition activities will you continue to do?
Dr. L. will continue to take patients from Dr. O. (plan is for 10 a year). We will continue with the process established during this year and extend the model to non-CTC patients.

What advice would you give other practices looking to do this work?
When you're taking in young adults, for the most part, they are uncomplicated, which should allow adult providers to take on more patients than they had thought they could. Having young adults also adds a new dimension to the practice and keeps it interesting.

Practice Team Updates

ADVANCING INTEGRATED HEALTHCARE

Children's Choice Pediatrics (Dr. Khanbhai) & Greenwich Medical Associates (Dr. Khan)

Data

Total # of Patients Identified for Transfer – 5 patients, with 2 being complex

Total # of Patients Successfully Transferred - 5 patients

Total # of Patients with upcoming appointment scheduled – Dr. Khan, Greenwich Medical Associates (GMA) will continue to accept patients

What area of focus did you work on? Children Choice Pedi (CCP) identified 5 young adults (YA) and facilitated their transfer of care to GMA

How did you make improvements? CCP offered a letter/GMA FAQ to all YA identified; concerted effort was made to ensure YA followed thru and appointments were made; Frequent communication regarding YA occurred between Dr. Khanbhai and Dr. Khan.

What additional changes would you like to make, if any. Looking forward to RIPCPC system-wide approach for transfer of care

What tools or EHR enhancements did you feel were most helpful for the process. CCP uses CareTracker and GMA uses EPIC, so didn't have benefit of shared records; FAQ for YA was very helpful.

Describe your process and success with collecting patient feedback. Tried paper patient surveys at first (pedi version sent to patient with stamped return envelope – didn't work well; GMA tried paper surveys then switched to QR code electronic patient survey – had YA take a picture of QR code at adult visit

Practice Team Updates

Children's Choice Pediatrics (Dr. Khanbhai) & Greenwich Medical Associates (Dr. Khan)

Patient/Family Success Story
In the process of choosing one YA for transfer, there are 4 YA from one family who will be transferring to Dr. Khan, so this is very convenient. Additionally, there was another 21 yr. old who had a bad car accident and had her follow up apt. with Dr. Khan as her new adult provider.

What transition activities will you continue to do?
CCP and GMA will continue to have phone calls regarding YA to transfer; ensure that GMA front desk is expecting this YA to make appointment. Each office will continue with the follow up to ensure that the YA "first" appointment is made.

What advice would you give other practices looking to do this work? For YA to transfer, ask – do you have a PCP in mind (yes or no); If no, decide if YA wishes male/female provider; gives FAQ, phone number, card for GMA – "call now to stay part of the lateral RIPCPC partnership; office may be closed to external patients, but they will take you…"; Get appointment scheduled asap, (especially if special needs patient); but to get "penciled in" for physical.

Practice Updates

Dr. Chad Nevola

PDSA/Quality Improvement
What area of focus did you work on? Plan for System of Care Approach to keep nearly 6,000 young adults within RIPCPC system when they transition from pediatric to adult medicine

How did you make improvements? Meetings with RIPCPC leadership (8/18/22) which led to ACO board beginning to build strategies to "retain lives" and fashion some in-roads to seamless transitions within the ACO., “grass roots” informal meeting with 2 adult medicine providers to discuss logic of accepting young adults in practice (9/2022); meetings with Pediatric Steering Committee (10/2022); ACO/POD Annual Meeting Presentation Jan 25, 2023; RIPCPC surveyed pediatricians and adult providers to determine interest and ability to participate in system wide approach for transfer of care; RIPCPC building referral hub call center and website to schedule patients

What additional changes would you like to make, if any. Each pediatrician needs to have a few adult providers to accept patients taking into consideration: 1. Geography, 2. Gender preference, 3. Insurance

Practice Updates

Dr. Chad Nevola

What tools or EHR enhancements did you feel were most helpful for the process. Dr. Nevola built templates in EPIC and shared these; Packet built during participation in Cohort 1 is very useful and still using; Still making referrals to Dr. Grande and others using this process

Success Story
Grass roots discussions with adult providers has convinced them to think about what a practice can handle not just quantitatively, but qualitatively. Considerations: young adults coming from our pedi practices are generally healthy and compliant, less likely to take up more time and space in a provider's overall workload. In addition, most of our special needs patients are already connected with specialists - there is often not a necessity to immediately make new diagnoses and connections. This should make it appealing to establish a structure that would facilitate ACO lives solvency.

What transition activities will you continue to do? Will continue to use patient packet and process for “warm handoffs” ; will continue to help RIPCPC promote this system wide approach by presenting at meetings and speaking with colleagues about benefits.

What advice would you give other practices looking to do this work? Getting the system/partnerships in place make for smooth transitions.

Young Adult Feedback Survey Results

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

16 Surveys Received from 3 dyads

DID YOUR PAST PEDIATRIC DOCTOR OR OTHER HEALTH CARE PROVIDER...		
	Yes	No
Explain the transition process in a way that you could understand?	87.50%	12.50%
Give you a chance to speak with them alone during visits?	100.00%	0.00%
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)?	93.75%	6.25%
Create and share your medical summary with you?	81.25%	18.75%
Help you find a new adult doctor or other health care provider to move to?	87.50%	12.50%
DID YOUR NEW ADULT DOCTOR OR OTHER HEALTH CARE PROVIDER...		
	Yes	No
Address any of your concerns about your move to a new practice/doctor?	93.75%	6.25%
Give you guidance about their approach to accepting & partnering with new young adults?	75.00%	25.00%
Explain how to reach the office online or by phone for medical information, test results, medical records, or appointment information?	87.50%	12.50%
Overall, how ready did you feel to move to a new adult doctor?	87.50%	12.50%

Young Adult Feedback Survey Results

There wasn't anything difficult about the systematic portion, however the mental transition proved to be difficult. Simply saying, it was hard to say goodbye to him as my doctor, but I look forward to our future.

Definitely could've received more information as to what my responsibilities were.

Explain in more detail as to what questions to ask new provider. Such as; Number to call when sick, portal access, and how to use portal

Had a very informative transition. All questions answered.

No. All questions and concerns were answered

Next Steps

Post Learning Collaborative Survey

https://www.surveymonkey.com/r/TOC2022Cohort1Yr2Cohort2

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Care Coordination ECHO

Date	Speaker(s)	Topic
5/31/2023 *7:30am – 9am	Tara Hayes and Stephanie Trafka, RIPIN	Family Voice & Entitlement to Eligibility
6/29/2023 Thursday	Jeannine Casselman, MLPB	Guardianship
7/26/2023	Susan Hayward and Denise Achin, BHDDH	Understanding BHDDH/ Developmental Disability Transitions of Care
8/30/2023	Adam Pallant, Brown University	Care Coordination for Children with Special Healthcare Needs in College
9/27/2023	Lisa Guillette, Foster Forward & Joan Harmon, DCYF	Supporting Youth in Foster Care & DCYF
10/25/2023	Carol Musso, UHC	Durable Medical Equipment & Resources
11/29/2023	Susan Jewel, The Autism Project	Autism
***CEU/CME pending approval**		

Register Today! https://www.surveymonkey.com/r/CCECHO2023

THANK YOU

www.ctc-ri.org

CTC-RI