CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Health Care Transitions

June 25, 2024

Care Transformation Collaborative of RI

Agenda

Time	Topic	Presenter
7:30am – 7:35am	Welcome and Review of Agenda	Susanne Campbell, CTC-RI
7:35am-8:10am	Practice Activities and Updates	**Practices and Providers:** Dr. Richard Ohnmacht & Dr. Chad Lamendola East Greenwich Pediatrics / University Family Medicine Concilio Pediatrics / RIPCPC Referral Hub Atlantic Pediatrics / Dr. Matt Rocheleau Anchor Pediatrics / Anchor Medical **Practice Facilitator:** Sue Dettling
8:10am-8:25am	RIPIN Cedar Family Program	Jackelyn Aldana, Sheila Santos
8:25am – 8:30am	Next Steps	Susanne Campbell, CTC-RI

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Dyad Team: Dr. Ohnmacht & Dr. Lamendola

Healthcare Transfer of Care | June 25, 2024

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Dr. Ohnmacht & Dr. Lamendola – June 25

How are Adult-Family practices engaging young adults to prevent "no shows"

Dr. Lamendola' s practice does phone reminders until established patient; once established patient and signed up in person for MyChart, then text reminders may be sent. For those complex patients who are not able to manage MyChart alone, a "parent proxy" is set up – a bit more complicated with paper forms – then those signed proxy forms are uploaded to CNE.

How are Adult-Family practice providers using the youth perspective/ identified priorities/goals in your new encounters with young adults?

Dr. Lamendola has an extensive "first visit" with new patients; Another important discussion to have with parents of complex YA is "planning" where child will live as everyone ages; RIPCPC can offer NCM/social worker to help parents with considerations, such as group home.

Dr. Ohnmacht & Dr. Lamendola – June 25

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Successes:

- All 7 complex young adults have been transferred; Dr. L will take additional transfers as able
- Prioritization of communication between physician dyad to ensure seamless transfer and ease patient anxiety
- Shared EMR enables comprehensive transfer of medical information/records

Barriers:

- Specialists are more difficult to engage in transfer process
- Limited space in Family Physician practice to accept large volume of new patients

Patient Story (if available)

Ideas for sustainability:

- 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 – 6/25/24

How are Adult-Family practices engaging young adults to prevent "no shows"

- UFM has auto system calling patient 2 days prior to appointment
- Gina will personally call the YA a week before their appointment

How are Adult-Family providers using the youth perspective/identified priorities/goals in your new encounters with young adults?

- The transfer of care letter with YA goal will be printed out and included for each encounter for adult provider to discuss

E. Greenwich Peds & University Family Medicine – 6/25/24

Successes:

- Dr. Hight/April visited EG Pediatric office for face-to-face meeting re: complex patients; have EGP go to UFM for office visit as well;
- 4 complex patients were discussed at in person meeting; very helpful to review these YA medical charts in advance of patient being seen

Barriers:

- Getting patients to come into office to complete forms (personally explained to YA by Missy)
- Having available adult medicine provider to transfer YA

Patient Story (if available)

Ideas for sustainability:

- Discussion of number of patients that UFM could take in order to plan ahead
- Plan for transfer while YA is at last visit with EGP

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Dr. Concilio/ RIPCPC Referral Hub

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Dr. Concilio/ RIPCPC Referral Hub – 6/25/24

Successes:

- 2 YA have located new adult provider (however, one of these YA informed Dr. C that they didn't care for the adult provider so would find another one)
- Trying new workflows – next PDSA cycle – Dr. C will try 6 new YA to transfer and will test entering the patient information on the RIPCPC "Find a Doctor" website with specific RIPCPC follow up

Barriers:

- RIPCPC referral hub – will call patients just one time / difficult for referral hub to track specific patients
- One YA didn't care for adult provider
- Access – one YA couldn't get appointment until October

Ideas for sustainability:

- May be helpful for Dr. C to enter information into the website hub so that YA get outreach from hub
- Chacha to check on status of these new 6 YA
- Dr. C to check back with new 6 YA to see status

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ADVANCING INTEGRATED HEALTHCARE

Dyad Team: Atlantic Pediatrics/Dr. Matt Rocheleau

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Atlantic Pediatrics/Dr. Matt Rocheleau

How are Adult-Family practices engaging young adults to prevent "no shows"

- Patients typically call to schedule initial appointment
- 3 days before – text or phone reminder
- 5 YA who scheduled arrived for their appointments no problem

How are Adult-Family providers using the youth perspective/identified priorities/goals in your new encounters with young adults?

- New patient form from Dr. Rocheleau – what do you do for fun/hobbies? In addition to information from Atlantic Pediatrics.
- Good ice breaker/ patients like this

Atlantic Pediatrics/Dr. Matt Rocheleau

Successes:

- Very useful to move YA along, healthcare transition policy working – starting at age 5,6 (increasing skills in young children), age 10, then 16, etc.
- Ripple effect for Dr. R – YA see the opportunity to have new PCP, invite extended family to choose Dr. R as PCP – trust factor
- Atlantic Pedi also referring family members to referral hub

Barriers/opportunities:

- "Tiger" mothers – need to educate patients about engaging in their own healthcare
- Atlantic Pediatrics trying to prevent this; one situation with "girlfriend" calling on behalf of patient

Ideas for sustainability:

- Atlantic Pediatrics will continue with this process; using FAQ has been helpful
- Dr. Rocheleau will consider YA survey moving forward, gathering goals from patients
- RIPCPC – care management approach/measures

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Dyad Team: *Anchor Pediatrics/Anchor Medical*

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Anchor Pediatrics/Anchor Medical – 6/25/24

How are Adult-Family practices engaging young adults to prevent "no shows"

- After 2 no-shows there is a warning letter to YA
- Text messages, auto phone call – multiple reminders before each appointment
- Communication with pediatric practice for additional outreach

How are Adult-Family providers using the youth perspective/identified priorities/goals in your new encounters with young adults?

- Information in Athena with YA goal has been very helpful (reviewed ahead of appointment – enhanced awareness)
- Helps to build trust;
- Warm hand off is appreciated by patients/families

Anchor Pediatrics/Anchor Medical – 6/25/24

Successes:

- Pediatric practice has specific educational info (age based) to help with ToC
- Trust with patient/ mom based on collaboration of pedi/adult providers; knowing clinical supports
- Dr. W has been trying to nudge YA for a long time and now they have transitioned!
- Special outreach to encourage patients to make appointments

Barriers:

- Not hearing any barriers from patients, also have done follow up appointments/sick visits
- A couple have been no-shows
- Lack of availability in adult medicine (providers leaving)

Patient Story: 23 yr. old YA with mental health issues was very reluctant to leave pediatrics; now is being seen in adult care - PCP and behavioral health adult care

Ideas for sustainability:

- Number of patients to transfer is limited to adult availability; some patients sent to Anchor Medical (PVD Internal Medicine)
- Workflows developed as part of this project will continue

Youth Survey Results - 13 responses, so far

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?	92.3% 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?	92.3% Very 7.7% 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!

RIPIN

RIPIN: Supporting Families who have Children with Special Needs

PERSONAL SUPPORT BUILT ON PERSONAL EXPERIENCE

Who are we?

- RIPIN is a 501(c)(3), charitable, nonprofit organization established in 1991 by a passionate group of parents of children with special needs. These parents recognized that together they could provide support through sharing essential information and helping to find the resources they needed for their loved ones. This peer model continues to be at the heart of our work and has lead RIPIN's network to expand statewide. Today we have over 110 employees, most of whom have personal experience caring for a loved one with special health care or educational needs.

RIPIN Programs

RIPIN

What is Cedar?

EXECUTIVE OFFICE O
Health & Human Service
State of Rhode Island

Cedar Family Centers provide intensive care coordination for families with children, ages 3 – 21, who have special healthcare needs.

*Ages 0-3 should be enrolled in Early Intervention!

- Locating clinical services (medical and behavioral)
- Referrals to community and social supports
- Health education and prevention
- Screenings for physical and mental health
- Assistance with changes between levels of service
- Supporting families
- http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/CSHCN/Cedar%20Fact%20Sheet%208.19.pdf

RIPIN

Eligibility for Cedar Support

Who is Eligible for Intensive Care Coordination?

- Families of children ages 3 - 21 with two or more chronic conditions or have one chronic condition and are at risk of developing a second
- Children having a severe mental illness or severe emotional disturbance
- Children must be Medicaid-eligible

Neighborhood Health Plan OF RHODE ISLAND™

TUFTS Health Plan

UnitedHealthcare®

EXECUTIVE OFFICE OF Health & Human Services State of Rhode Island

RIPIN

Cedar Triage Tool

Please FAX to RIPIN Cedar Family Center: 401-270-7049
Cedar Referral and Triage Tool

Date of referral:		Is parent/guardian aware of and in full agreement with this referral? ☐ Yes
Referral Source:	Phone:	Email:
Child's First Name:	MI:	Last Name:
DOB:	Current Age:	Gender:
Address:		
City:	State:	Zip:
Parent/Guardian Name:		Email Address:
Home phone number:		Cell phone number:
Interpreter needed? ☐ Yes ☐ No		Language:
Parent/Guardian Name:		Email Address:
Home phone number:		Cell phone number:
Interpreter needed? ☐ Yes ☐ No		Language:
Primary Health Insurance:		Member ID#:
Secondary Health Insurance:		Member ID #:
Primary Care Physician:		Phone:
Child's Social Security #:		
Medicaid ID# (10-digit number found on child's "Anchor" card):		
***** CHILD'S SSN and/or Medicaid ID information MUST be included to submit this form *****		

Chronic Conditions requiring Intensive Care Coordination: (Please check all that apply)

☐ ADD/ADHD	☐ Brain Injury	☐ Down Syndrome	☐ Seizure Disorder
☐ Anxiety	☐ Cerebral Palsy	☐ Epilepsy	☐ Sickle Cell Anemia
☐ Asthma	☐ Depression	☐ Hearing Problems	☐ Speech Problems
☐ Autism, Asperger's, ASD	☐ Developmental Delay	☐ Intellectual Disability	☐ Tourette Syndrome
☐ Behavioral Problems	☐ Diabetes	☐ Learning Disability	☐ Vision Problems
☐ Bone, joint, or muscle problems	☐ Other (please specify):		

Child/Family Risk Factors:	Current Need	Current Services (please specify)	Past services (please specify)	Current Barrier
Current hospitalization/inpatient admission	☐	☐	☐	☐
2+ ED visits related to chronic condition	☐	☐	☐	☐
Inability to follow through (appts/med regimen)	☐	☐	☐	☐
School issues (low performance, absenteeism, behavior)	☐	☐	☐	☐
Difficulties with daily living	☐	☐	☐	☐
Unable to socially interact	☐	☐	☐	☐
Trauma	☐	☐	☐	☐
Parent/Caregiver MH concern or cognitive delay	☐	☐	☐	☐
Domestic Violence	☐	☐	☐	☐
Substance Use ☐ Parent ☐ Caregiver ☐ Child	☐	☐	☐	☐
Food uncertainty	☐	☐	☐	☐
Housing Issues	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐

Does the family require Intensive Care Coordination through Cedar? ☐ Yes ☐ No

Suggested Alternatives

Cedar Staff/Date

CDR-0027 2021.04.01

Envíe un fax al Centro Familiar RIPIN Cedar: 401-270-7049
Herramienta de triaje y derivación de Cedar

Fecha de referido:	¿Los padres o tutores legal están consciente y totalmente de acuerdo con este referido? ☐ Sí	
Origen del referido:	Teléfono:	Correo electronico:
El primer nombre del niño:	Inicial del segundo nombre:	Apellido:
Fecha de nacimiento:	Edad actual:	Género:
Dirección (la calle y el numero):		
Ciudad:	Estado:	Código postal:
Nombre del Padre/Guardián:		ctronico:
Teléfono de casa:		óvil:
¿Necesita intérprete? ☐ Sí ☐ No		interprete, ¿cuál idioma?:
Nombre del Padre/Guardián:		ctronico:
Teléfono de casa:		óvil:
¿Necesita intérprete? ☐ Sí ☐ No		interprete, ¿cuál idioma?:
Seguro médico primario:		#:
Seguro médico secundario:		#:
Nombre del médico de atención primaria:		
Número de seguro social del niño:		
Número de identificación de Medicaid (Número de 10 dígitos, localizado en la tarjeta ancla del niño):		
***** Se DEBE incluir el SSN del NIÑO y / o la información de identificación de Medicaid para enviar este formulario**		

Condiciones crónicas que requieren coordinación de cuidados intensivos: (marque todos los que apliquen)

☐ trastorno por déficit de atención e hiperactividad	☐ Lesión cerebral	☐ Síndrome de Down	☐ Crisis epiléptica
☐ Ansiedad	☐ Parálisis cerebral	☐ Epilepsia	☐ Anemia falciforme
☐ Asma	☐ Depresión	☐ problemas auditivos	☐ Problemas del habla
☐ Trastorno del espectro autista	☐ Retraso en el desarrollo	☐ Discapacidad intelectual	☐ Síndrome de Tourette
☐ Problemas de comportamiento	☐ Diabetes	☐ Discapacidad de aprendizaje	☐ Problemas de la vista
☐ Problemas de huesos, articulaciones o músculos	☐ Otro (por favor especifique):		

Factores de riesgo del niño o de la familia:	Necesidades presentes	Servicios actuales	Servicios pasados	Barrera presentes
Hospitalización/hospitalizado por admisión actualmente	☐	☐	☐	☐
Dos o más visitas a la sala de emergencia por condiciones crónica en los últimos 12 meses	☐	☐	☐	☐
Incapacidad de seguimiento con las citas médicas o regimiento de medicamentos	☐	☐	☐	☐
Problemas escolares (bajo rendimiento, ausentismo, comportamiento)	☐	☐	☐	☐
Dificultades con la vida diaria	☐	☐	☐	☐
Incapaz de interactuar socialmente con los demás	☐	☐	☐	☐
Trauma	☐	☐	☐	☐
Preocupación por la salud mental o retraso cognitivo del padre o cuidador	☐	☐	☐	☐
Violencia doméstica	☐	☐	☐	☐
Uso de sustancias ☐ Padre ☐ Cuidador ☐ Niño	☐	☐	☐	☐
Incertidumbre alimentaria	☐	☐	☐	☐
Problemas en el hogar (mantenimiento de la vivienda)	☐	☐	☐	☐
Otra (especificar)	☐	☐	☐	☐

¿La familia requiere coordinación de cuidados intensivos a través de Cedar? ☐ Sí ☐ No

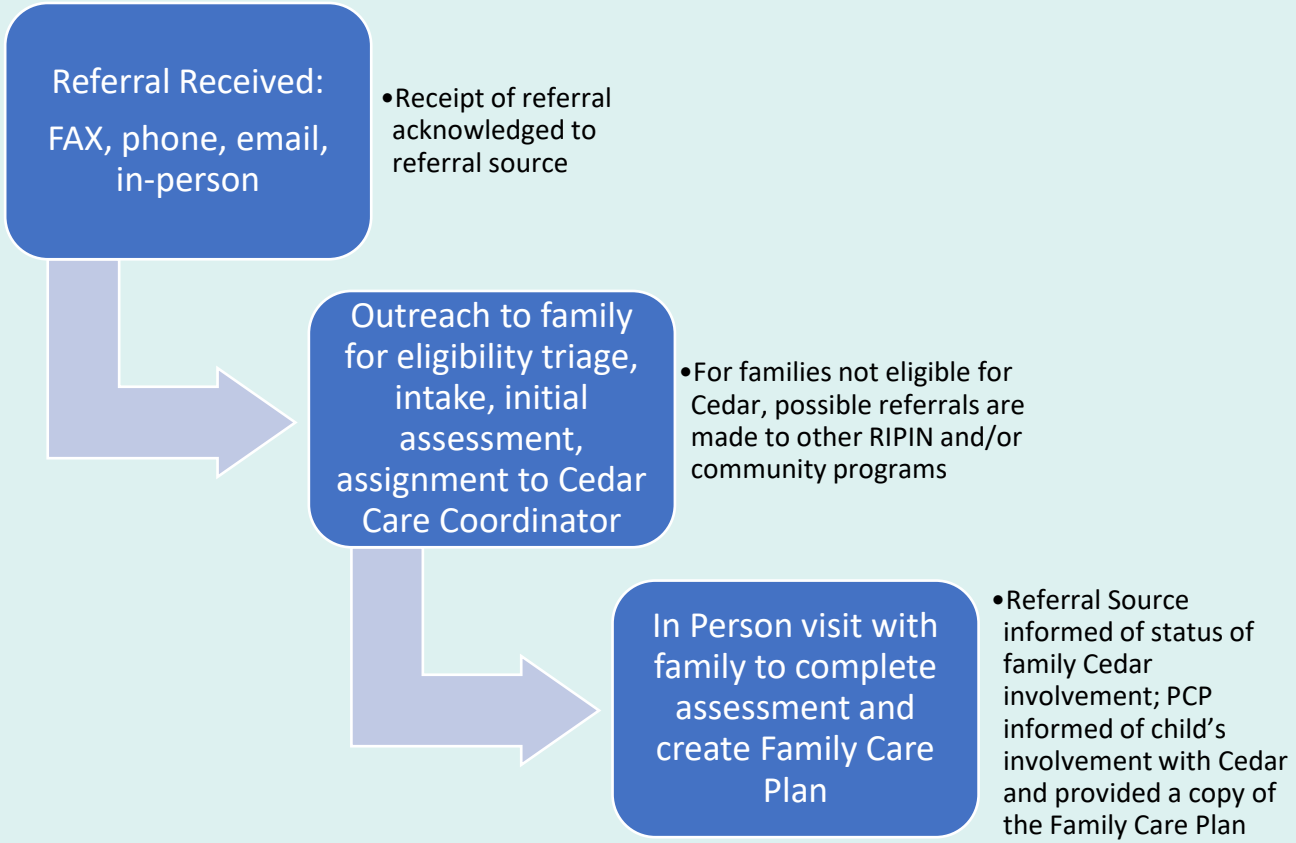
Alternativas sugeridas

Trabajador de Cedar y la fecha (Cedar Staff/Date)

CDR-0027 2021.04.01

RIPIN

RIPIN Cedar Referral Process



RIPIN

What is a Cedar Care Coordinator? What do they do?

A Cedar Care Coordinator will work side-by-side with you to make connections to the appropriate services that help your family best, and to help you navigate complex systems of care.

Cedar does NOT provide any direct services. Instead, we are the pipeline between families and the services that are available in RI.

We guide parents in challenging situations advocate for themselves and their child.

RIPIN Cedar Family Center

Care Coordination Services provided by a team of Community Health Workers who are culturally and linguistically representative of the families served

- Referrals to home based therapeutic services
- Connections to Developmental Screening
- Support for transition from EI
- Special Education information and support
- Access to health insurance, SSI, Child Care
- Connections to specialty providers, DME
- Social determinants of health
- Transition to adult services

RIPIN

Questions???

RIPIN

Contact Us

401-270-0101 ext. 365

Monday through Friday

8:00 AM – 5:00 PM

RIPINCedarFamilyCenter@ripin.org

Website: ripin.org

Facebook: @RIPIN.ORG

Twitter/Instagram: @RIPIN_RI

RIPIN

Next Steps
Pediatric Practices

(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 as patients are seen. Submit final PDSA with PPT to deliverables@ctc-ri.org by October 9, 2024 Submit current Pediatric Assessment of HCT Activities by October 9, 2024

Adult Practices

Confirm Completion of Initial Adult Visit and HCT Feedback Survey	• Complete initial adult PCP visits with 7 transferring patients. • Communicate with pediatric practice to confirm initial appointment was completed. • Request completion of HCT Feedback Survey by young adult at initial visit. • Share progress in monthly QI meeting.	Months 9-12 July 2024 August 2024 September 2024 October 2024	HCT Feedback Survey for Young Adults Submit final PDSA with PPT to deliverables@ctc-ri.org by October 9, 2024 Submit current Adult/Family Assessment of HCT Activities by October 9, 2024

Final Collaborative Meeting

October 22, 2024 – 7:30am -8:30am

Zoom Link

https://ctc-ri.zoom.us/j/954708383?pwd=ZkttcS9qRU4xSDBoRzk5UjRucHQ2Zz09


Thank You
Merci
Obrigado
Dyakuyu
Salamat
Arigato
Grazie
Asante
Kiitos
Spasibo
Dank Je
Multumesc
Maake
Mochchakkeram
Raibh Maith Agat
Matur Nuwun
Juspaxar
Mamana
Dankon
Vinaka
Cam on ban
Kia Ora
Chokrane
Terma Kasih
Matondo
Ua Tsaug Rau Koj
Welalin
Meri
Nirringrazzjak
Salamat