An Evaluation of a Care Conference Model and Improvement in the Transition Process for Medically Complex Pediatric Patients between Inpatient and Outpatient Care

Tamara Van Kampen, DNP, RN vankampt@gvsu.edu 616-331-5763

Grand Valley State University
Kirkhof College of Nursing

Background

- Medically complex pediatric patients:
  - 1% of general population but account for 30% of pediatric healthcare expenditures
  - 15-33% of overall healthcare costs ($50-100 billion annually)
  - 34% of all pediatric Medicaid expenditures ($1.6 billion)
  - 71% of unplanned 30-day readmissions
- Reducing readmission rates and length of stay decreases healthcare expenditures
- Care conferences bring key stakeholders together to discuss care and transitions
- Early involvement of primary care provider can reduce readmission rates

Clinical Question

Does implementation of a revised discharge / transition process, in combination with a pediatric care coordination conference, improve pediatric transition experiences from inpatient to outpatient primary care compared to transition experiences prior to implementation?

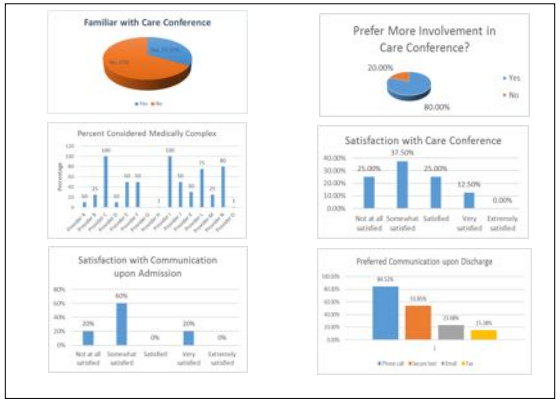
Frameworks

•Conceptual framework: I_2E_2

•Implementation model: IHI's Plan-Do-Study-Act (PDSA) model

Methods & Design

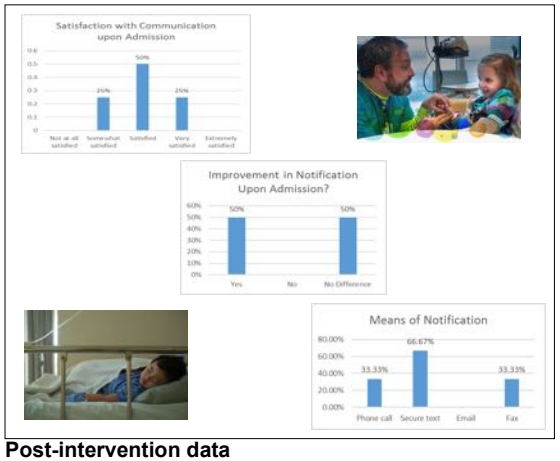
- Organizational assessment to determine readiness for change
- Literature review to determine best practices for improving transitions of care for medically complex patients
- Initiated quality improvement project from August to November aimed at improving communication between hospital physicians and PCPs



Pre-intervention data

Intervention

- Care Coordination Committee wrote standard work to streamline care conference process
- Survey sent to PCPs to determine satisfaction with current processes.
- Physician residents sent out secure text message to PCPs when medically complex pediatric patients admitted



Post-intervention data

Results

- Care Coordination Committee
  - Streamlined processes, shorter meetings, standardized format
  - Conferences seen as more valuable
  - Length of stay did not significantly change
  - 30-day readmissions met 10% reduction goal
- Pre-Survey Results (N=15)
  - 67% of PCPs unaware of care conference process
  - 80% of PCPs desire more involvement in care coordination conferences
  - PCPs desire notification when medically complex patients admitted to hospital
  - Satisfaction with communication: 20% very dissatisfied, 60% somewhat satisfied, and 20% very satisfied
- Post-Survey Results (N=4)
  - More focused on changes in communication
  - 50% of respondents felt communication improved
  - Secure text most common means of communication
  - Satisfaction with communication: 25% somewhat satisfied, 50% satisfied, 25% very satisfied

Conclusions

- PCPs desire improved communication with hospital physicians, especially as it relates to medically complex pediatric patients
- PCPs want more involvement with care coordination process

Implications for Practice

- Improvement in care coordination and transitions of care can lead to reductions in overall healthcare utilization costs and improved patient outcomes
- Sending a secure text to PCPs upon patient admission is a viable way to improve communication