Project IMPACT: Improving Pediatric Patient-Centered Care Transitions

DAVID COOPERBERG, MD, FAAP

Background
What comprises the ideal?

- Partnership with Patients/Families
  - Patient-Centered
  - Patient/Family Engagement
- Partnership with Primary Care Providers

Deliver Patient-Centered Care

- On first meeting your patient: ask the patient dignity question
  - “What do we need to know about you and your child to provide the best possible care?”

- Every patient encounter: ask
  - What other questions do you have?
  - What other concerns do you have?
  - Do you have other expectations that we have not addressed?

Patient and Family Engagement

- Patient and Family actively engaged in transition planning and execution
  - Build Transitions Record
    - Follow-up
    - Medications
    - Contingency Plan
    - Contact numbers

AAP SOHM Transitions of Care Collaborative

- Work to date includes:
  - Improved timeliness of hospitalist-PCP communication at discharge
    - (Shen, et al., Hospital Pediatrics 2013)
  - Defined essential content for this communication
    - (Coghlin, et al., Hospital Pediatrics 2014)
Essential DC Communication Bundle

- Admission and DC dates
- DC diagnosis
- Medications
- Follow-up appointments
- Brief hospital course
- Pending lab tests
- Immunizations given during hospitalization

Coghin, et al, Hospital Peds 2014

Project IMPACT

IMPROVING PEDIATRIC PATIENT-CENTERED CARE TRANSITIONS
Improving Pediatric Patient-Centered Care Transitions

- AAP SOHM QI Collaborative
- IRB approved
- ABP Maintenance of Certification, Part 4
  - AAP Portfolio
  - 1st MOC project to undergo evaluation and approval by the AAP Council on Quality

Project Aims (MOC-only group)

**Primary Aim**
- Improve caregiver’s ability to teach-back essential self-management components of care pre-discharge
- Improve timely communication of essential information to PCPs

**Secondary Aims**
- Reduce hospital re-utilization
- Improve PCP perception of medical provider handoff
Core Components (MOC-only group)

- Pre-DC Teach-back
- Hospitalist-PCP Handover
- Annual PCP Survey
- Hospital Utilization

Pre-DC Teach-back

Teach-back of each of the following prior to discharge:

- Medications
  - How to give, how much to give, when, how often, for how long
- Follow-up appointments
- Contingency plan
  - When to call PCP sooner
  - When to go to ED
  - When to call 911 (if applicable)
- Home equipment contact number (if applicable)
Hospitalist-PCP Handoff

Timely Communication of the following to the PCP on day of discharge:

- Admission and DC dates
- DC diagnosis
- Medications
- Follow-up appointments
- Brief hospital course
- Pending lab tests
- Immunizations given during hospitalization

Annual PCP Survey

“The communication I receive from the inpatient team has all the information I need to provide care for my patients”

Metric = Likert scale (1-5)

(Additional survey questions)
Hospital Re-utilization

Population-specific readmission rates (3, 7, 15, 30-day)

PDSA Cycle Strategy

Cycle 1 (2-4 weeks):
Test on a Very Small Scale (i.e. single team on a single unit)

Cycle 2 (2-5 months):
Pilot on a Small Scale (i.e. subsequent team on same unit)

Cycle 3 (6-12 months):
Spread (i.e. subsequent med-surg units)

DATA
Getting Started

Demonstrate Value to Administration

Determine Patient Population(s) for IMPACT project

Assemble Improvement Team

Pre-Implementation Training (Teach-back)

Integrate Data Collection Tool in Medical Records/ EHR

Key Stakeholders

- Hospital Administration, Directors (and others)
  - Establish the urgency
  - Make the case for change
  - Provide background and Project Aims

Who are the Essential Stakeholders at your site?
(Consider Influence and Interest)
Patient Populations (Choose 1 or more of those listed in green)

Technology-Supported
- Ventriculo-peritoneal Shunt
- Tracheostomy tube
- Central Venous Catheter
- Gastrostomy tube

Non-Technology Supported
- Asthma (ages 2-17 years)
- Infants < 6 months of age
- Infants <12 months of age
- Children < 2 years of age
- All pediatric patients (ages <18 years)

Exclude: oncology patients, cardiac critical care unit patients, newborn nursery patients, neonatal intensive care unit patients

Assemble your Improvement Team

- Patient/Family Representative(s)
- Nursing*
- Case Manager*
- Hospitalist*
- Social Worker*
- Resident
- NP/ PA
- Pharmacy
- Transitions Coach
- Quality
- Utilization Management
- Research Assistant
- Study Coordinator
- Data Manager
- Primary Care Provider Partners
- Subspecialists
**Standardize the Process**

**Patient/Family demonstrates Teach-back**

- Medication use
- Follow-up
- Equipment contact number
- Contingency plan

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**Standardize the Process**

**Communicate essential information to PCP on day of discharge**

- Diagnosis; Admit/DC Dates; Meds; Follow-up; Brief hosp course; pending study results; Immunizations received

- Is there a standardized ‘Discharge Communication’ template that you can modify?

- How is the PCP contacted? By whom?

- How is the correct PCP identified?
- How is PCP contact information kept current?
Pre-Implementation Planning

- Teach Back (training video link available):
  [http://cupublic.chw.org/media/HealthLiteracy/improvingtransitionsofcare/index.html](http://cupublic.chw.org/media/HealthLiteracy/improvingtransitionsofcare/index.html)

- Site-specific Database for local Plan-Do-Study-Act improvement
  - Template excel spreadsheet will be posted on website
  - Standardized Monthly Quality Report to be submitted to Drexel REDCap database (link...)

Integrate Checklists into Medical Records

- Documentation of Teach-Back
- Essential Contents of PCP Communication

- ...or maintain an easily accessible log:
  - Documenting teach-back
  - Documenting date of PCP communication of essential content
Data

- Need to include 30 discharged patients per month. Documentation of teach-back prior to discharge.
- Documentation of inclusion of essential content in PCP communication on day of discharge.

(sites choosing technology-supported may include 10 discharged patients per month)

PCP Survey

“The communication I receive from the inpatient team has all the information I need to provide care for my patients.”

Metric = Likert scale (1-5)

(Additional survey questions)
Measures (for MOC QI project)

- **Outcome**
  - PCP survey agreement (5-point Likert scale) with statement, "The information I receive from the inpatient team has all the information I need to provide care for my patients" (via annual survey of 30 referring PCPs Summer 2014, 2015)
  - Hospital re-admission rates (specific for chosen population: 3, 7, 15, 30 day) (monthly)

- **Process**
  - Successful Pre-Discharge Teach Back completion (numerator = successful teach-back of all applicable elements/denominator = # opportunities (at least 30 charts per month))
  - Hospitalist-PCP handoff (essential content on day of discharge) (numerator = documentation of PCP communication of each of 7 essential elements communicated on day of discharge/denominator = # opportunities (at least 30 per month))

- **Balancing**
  - PCP perception of omission of essential information (via annual survey of 30 referring PCPs Summer 2014, 2015)

MOC Requirements
Team Requirements (Each Site)

- Monthly meetings of local improvement teams
  - Perform monthly Plan-Do-Study-Act cycles
    - Present data and annotate local context
    - More frequent review/huddles regarding enrollment failures
    - Transparent data sharing and learning with front-line staff at least monthly
  - Monthly conference calls with multisite local team leaders and central PI
    - Participants will share:
      - Barriers
      - Lessons Learned
      - Improvement Strategies

Individual Participant Requirements

1. Provide direct or consultative care for patients in the improvement project
2. Complete 1 or more tests of change to improve care
3. Remain active in the project for a minimum of 12 months
4. Complete participation under current ABP certificate or MOC cycle
5. Attend at least 10 conference calls or local team meetings in which collaborative data are reviewed and plans for improvement activities are made locally
6. Collect data on a subset of patients as defined by the project
7. Review monthly feedback reports (run charts and/or statistical process control charts)
Pediatric Hospitalist Improvement Team Leader (aka ‘Local Leader’) Requirements

- Attend 10 multi-site conference calls during which collaborative data for this study are reviewed or plans to new improvement activities are made
- Serve as leader in the attestation process required by the American Board of Pediatrics (ABP) for Part 4 Maintenance of Certification. These responsibilities include:
  1. Providing each physician in practice interested in participating for MOC credit a document describing the requirements of their participation
  2. Monitoring physician participation, and attesting that they met the project’s completion criteria

QI Education

- The project leader will provide QI education during a two-hour QI training session after participating sites are identified and prior to beginning data collection and implementation of intervention
- QI educational materials will be distributed electronically for each local leader to use in providing QI education for each participating site's team members
- It is expected that each local leader or designee will provide QI education during each month's local PDSA meeting
Next Steps

- Provide your email address (or site lead if different) to david.cooperberg@drexelmed.edu
- Discuss with your local team
- Complete Survey Monkey ‘Application’ for participation
  - Commit to patient population
- Attend QI Tools webinar (May 22 or May 27)

AAP SOHM Transitions of Care Collaborative Planning Team

<table>
<thead>
<tr>
<th>David Cooperberg, MD (chair)</th>
<th>Vivian Lee, MD</th>
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<tbody>
<tr>
<td>Lora Bergert, MD</td>
<td>David Ming, MD</td>
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<td>Daniel Coghlin, MD</td>
<td>Leah Mallory, MD</td>
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<td>Sean Ervin, MD, PhD</td>
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<td>Monica Joseph, MD</td>
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<td>Ann Kao, MD</td>
<td>Kristen Zanger, MD</td>
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For further questions, please contact

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