Difficulties with Transitions for Center of Excellence Pediatric Standards Development Project

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Feb 21, 2013

Related Concepts

- Accountable provider at all points
- Shared care plan
- Use of HIT
- Timely, accurate, complete information transfer
- Caregiver/family education, engagement, experience
- Patient safety
- Outcomes

Care Team Processes

- Medication reconciliation
- Test tracking for labs, procedures
- Referral tracking
- Admission/discharge planning
- Discharge summary
- Follow up appointments
- Etc…

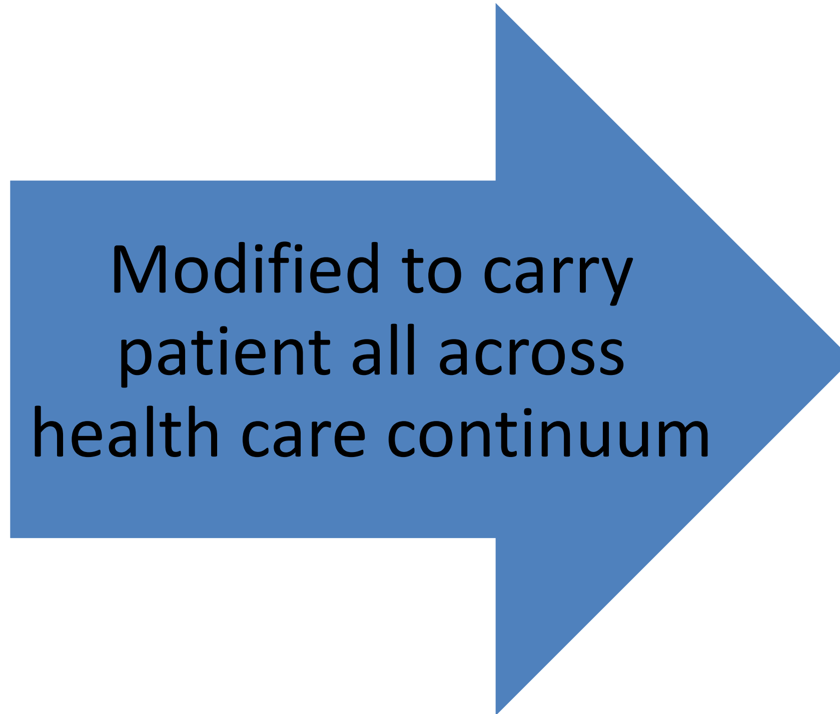
What is associated with improved patient-centered, utilization, and cost outcomes?

1. Assessment of needs early in process
2. Family centered discharge education
   - specific to child's condition
   - comprehensible
   - opportunity to practice self management skills
   - Assistance in scheduling f/u appointments
3. Providing Individualized transition record

- Post discharge processes (phone calls, home visits) in isolation are not associated with improved outcomes

CentraCare
Comprehensive Care Plan Project

Health Care Home Care Plan



Comprehensive Care Plan

Process in hospital

- Partnership of hospital and ambulatory care – culture clash
- Expand EHR medical/social history/Problem List documentation
- Expand care coordination role
- Revise discharge orders process
- Revise discharge summary documentation
- Medication reconciliation!!!!!!!!
- Revise After Visit Summary

To Do List

- Pilot
- Educate hospital staff – providers, nurses, unit support staff
- Patient testimonial video
- Continue to build patient engagement
- Don't forget Meaningful Use requirements phase 2

Input……