

The Effect of Pediatric Patient Centered Transition Bundle on Asthma Home Management Skills and Asthma Readmissions

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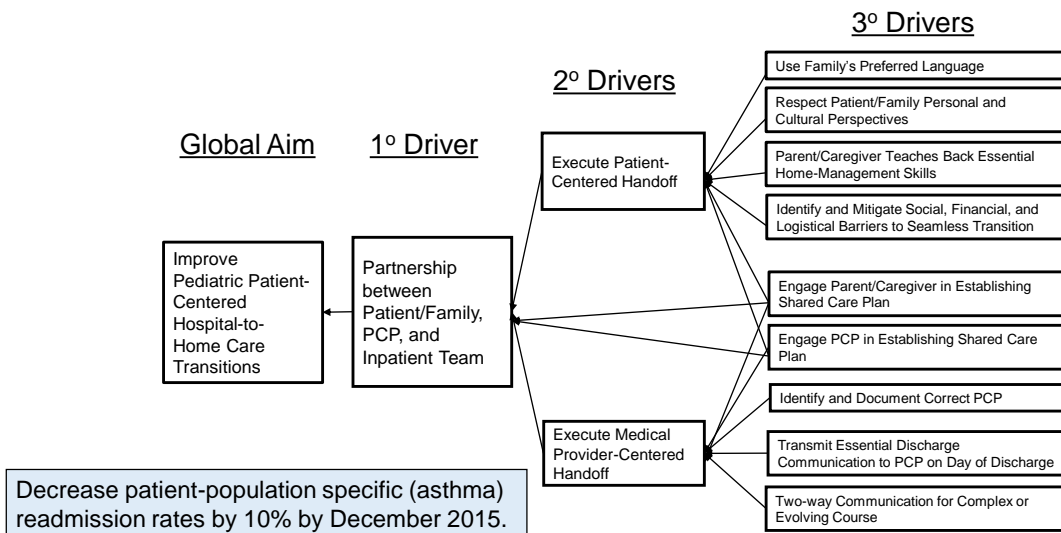


**No financial relationships to disclose or
Conflicts of Interest (COIs) to resolve.**

Background

- Project IMPACT (Improving Pediatric Patient Centered Care Transitions), a multi-centered QI research collaborative developed 4-element transition bundle.
- Global aim of this project was to test the effect of this bundle on transitions from hospital to home.
- Asthma is the leading chronic disease in children with prevalence close to 10%.
- Several studies have emphasized the role of education and communication in reducing pediatric asthma morbidity.

Key Driver Diagram



Patient-Centered Care Transitions (PACT) Bundle: Four Elements

Transition Checklist

Teach Back

Timely and Complete
Communication with PCP

Post-Discharge Phone Call



Project IMPACT AIMS

- To improve pre-discharge teach back rates to 90%
- To improve outpatient provider handoff to 90%
- To improve post-discharge call connectivity rates to 70%
- To improve parent/caregivers teach back of home management skills during follow-up telephone call to 80%
- To decrease 30-day readmission rates post hospital discharge by 10%



Methods

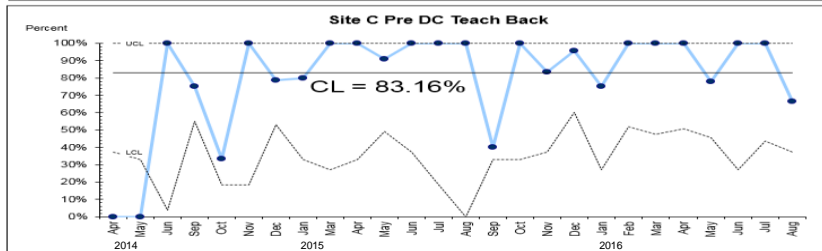
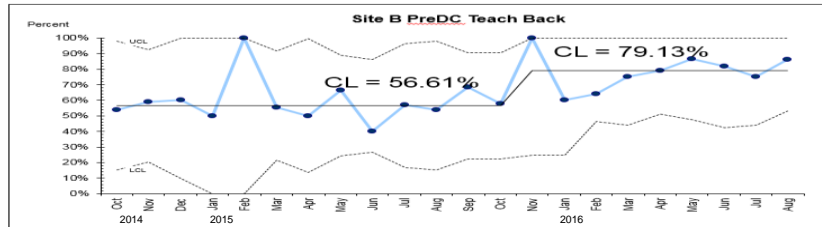
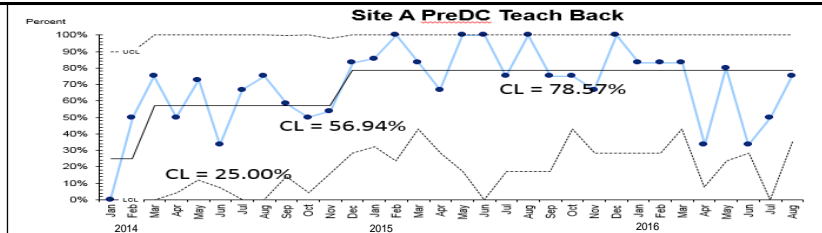
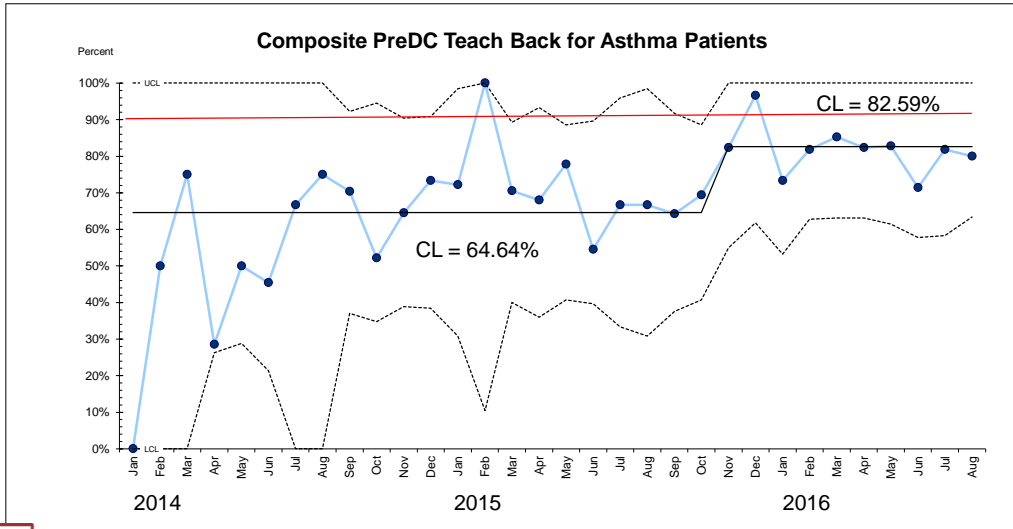
- Observational time series study - Jan 2014 to Aug 2016
- Sub-population analysis of 2-17 year old patients with asthma
- Multiple planned sequential interventions to promote transition bundle use in 3 different medical centers
- Data collected via electronic health record (EHR) review and post-discharge follow-up phone call interview
- QI Control charts using the API rules for detecting special cause variation were applied



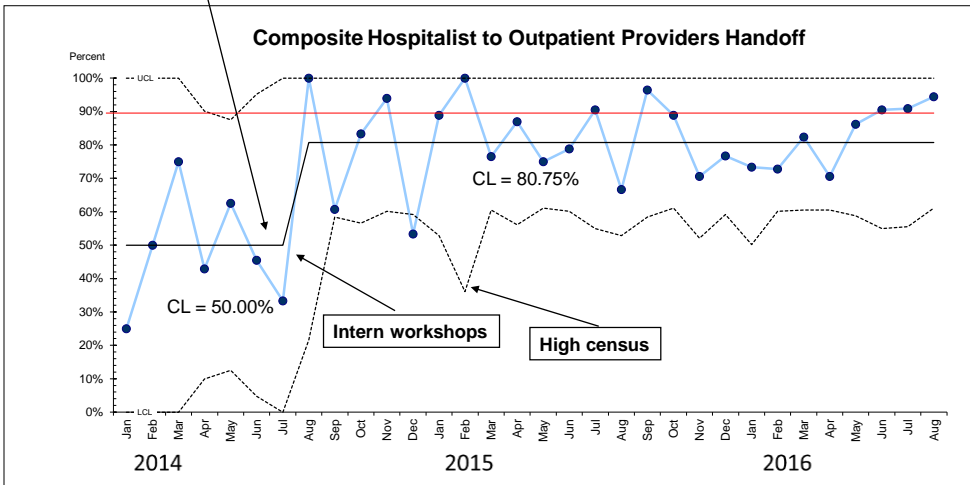
Results: Population

- A total of 697 patients from 3 sites with a discharge dx of asthma
- Number of patients enrolled by site:
 - Site A: n=203
 - Site B: n=304
 - Site C: n=190

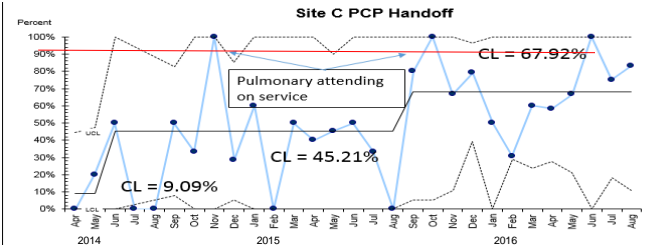
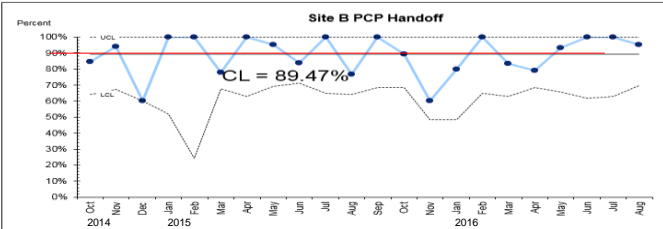
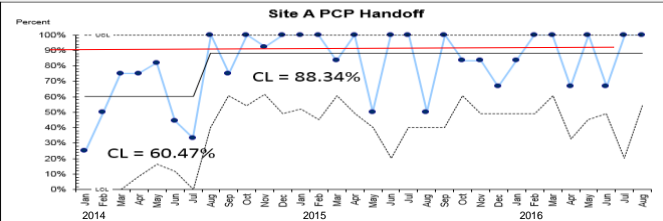




\$ Incentives for "Perfect" PCP Handoff

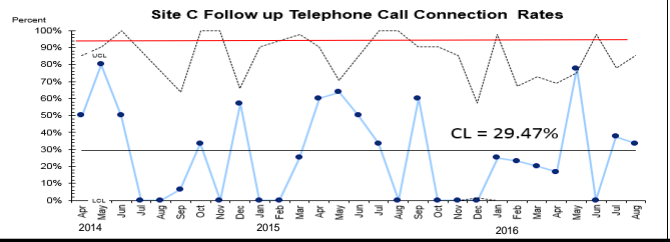
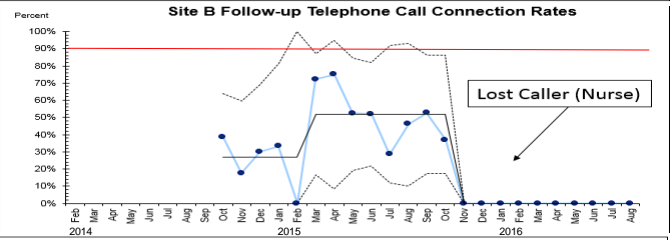
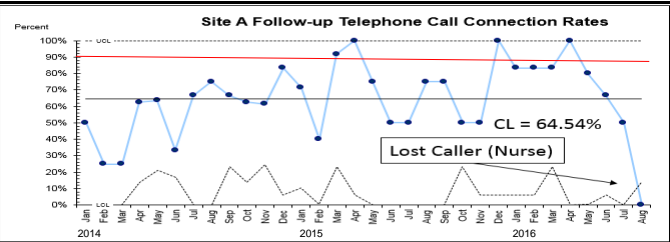
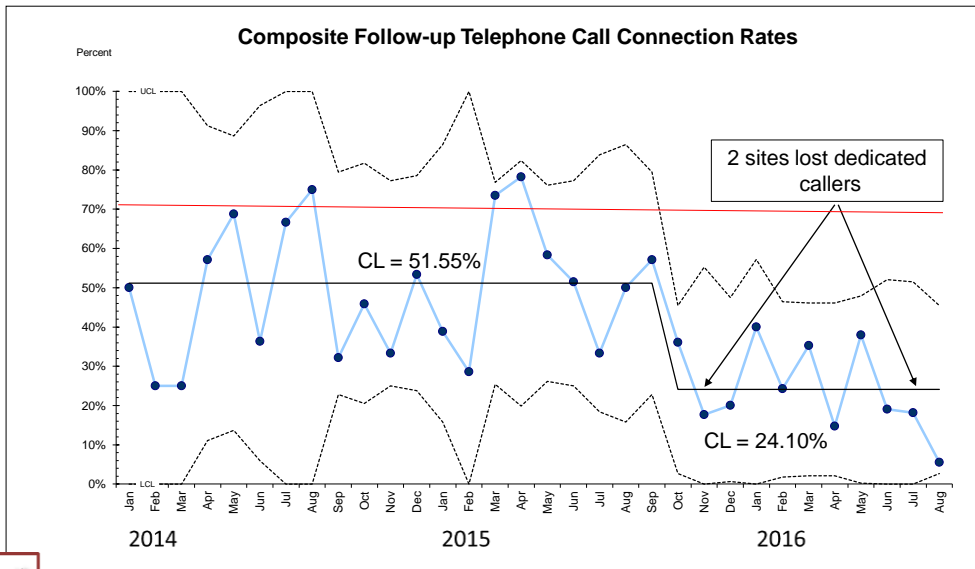


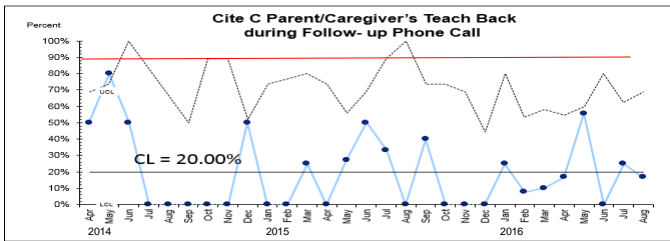
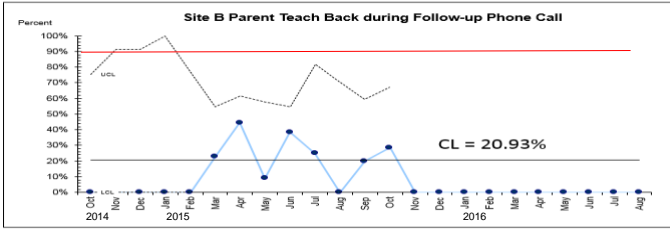
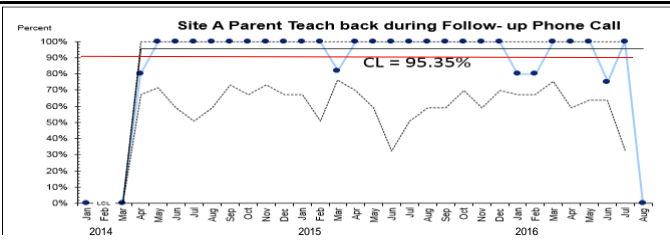
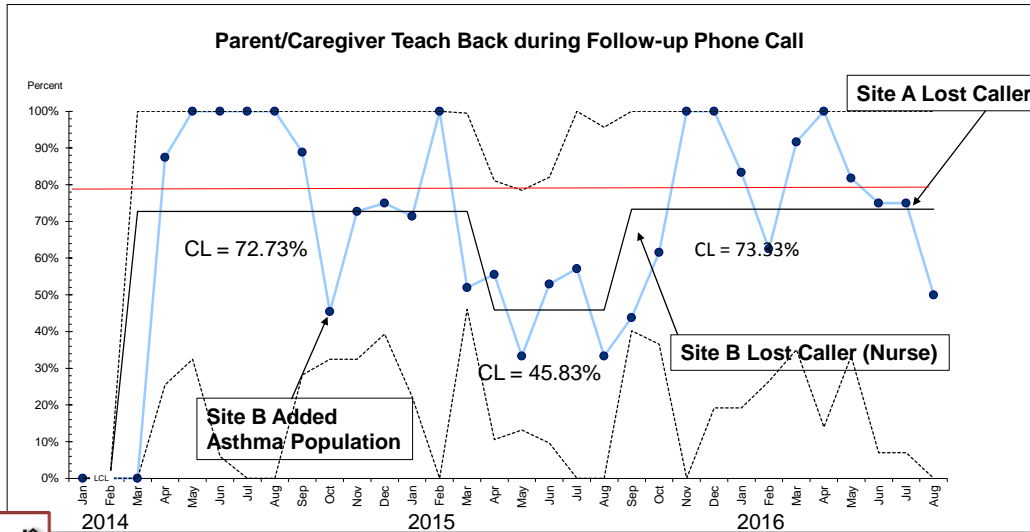
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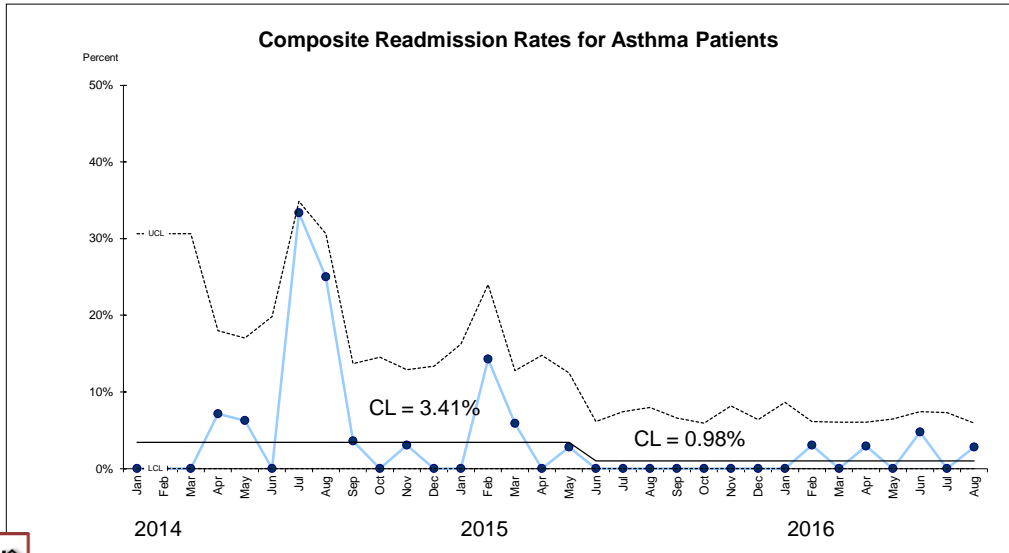


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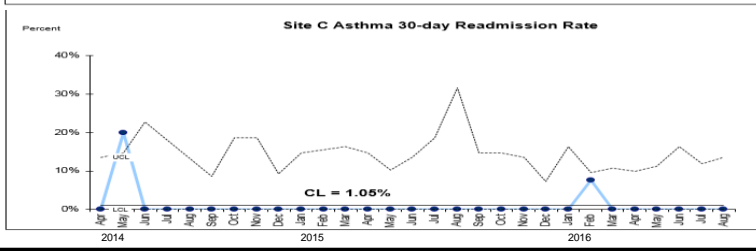
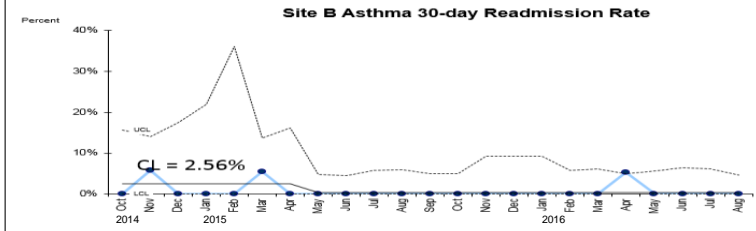
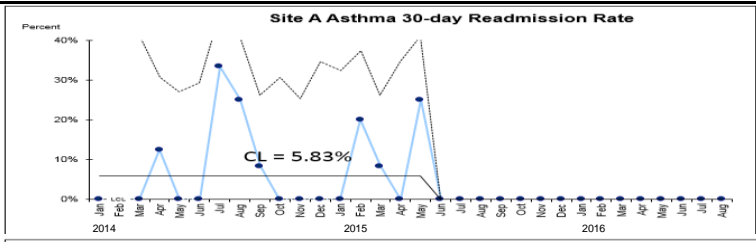








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GOAL



Limitations

- Observational study
- Inability to randomize
- Low connectivity rates on post discharge telephone interview
- Intra- and inter-site variability: Quality of “Yes”
- Did not reach reliable implementation of all bundle elements

Lessons Learned

- Sharing lessons learned via multisite collaboration
- Deference to expertise: nursing expertise in teach back and FAC’s experience with follow-up phone calls
- Developing shared interventions
- Sharing EHR-specific tools



Summary

- Reliable implementation of 2 out of 4 bundle elements was associated with a reduction in asthma population readmissions
- Poor connectivity rates and loss of post-discharge call support limited assessment of home management skills
- Further study is needed to better understand the impact of the post-discharge phone call and the transition checklist



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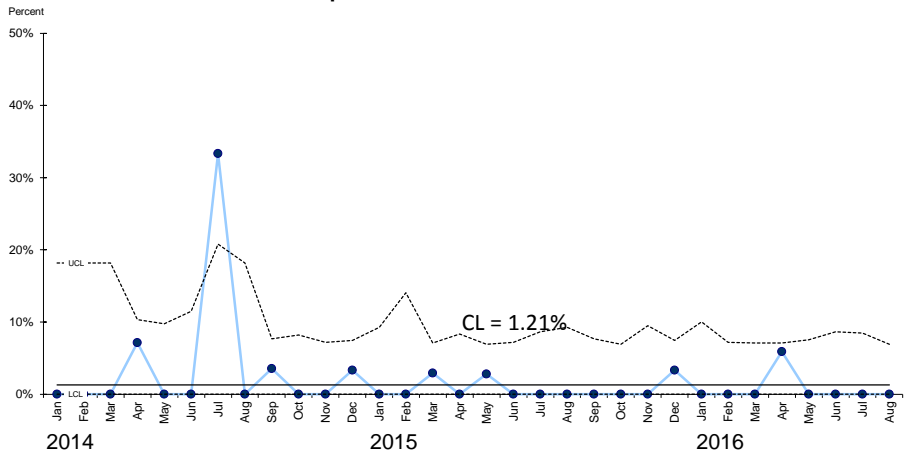
- Niccole Alexander
- Monique Phillips
- SOHM Executive Council



Thank You!



Composite Asthma ED Returns



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