



Safe Transitions: Core 4 Elements Reduce Readmissions in Pediatrics

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A Core 4 Story

- Page from PCP
- Patient in office for **follow-up appointment**
- Medications brought to appointment, antibiotic not listed on **discharge summary** or **reconciled EMR medication list**

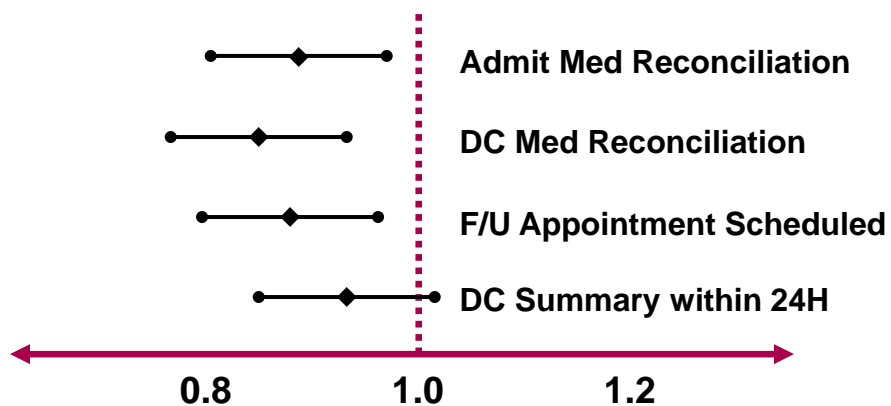


What makes a safe transition to home?

- Education
- Medications
- Clinically appropriate follow-up
- Relevant hand-off

Identifying what matters most

N=152,370 Health System Discharges (Jan-Dec 2015)

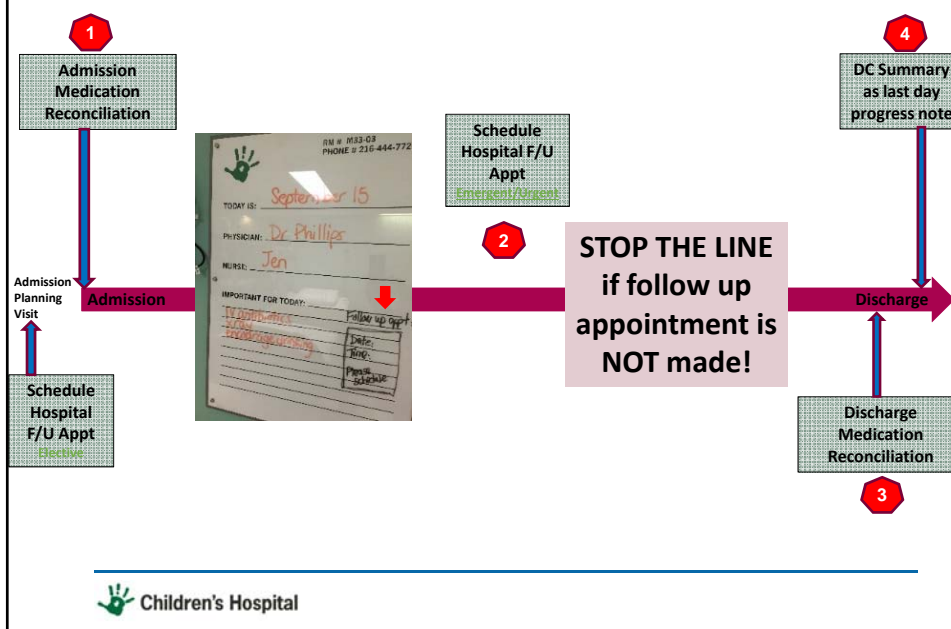


Project Aim

The rate of patients discharged from our pediatric hospital with all Core 4 processes of care completed will increase from 30% to 50% by December 1, 2016



Process Map for Core 4 Safe Transitions of Care



Test of Change #1: Non-system PCP/medical home

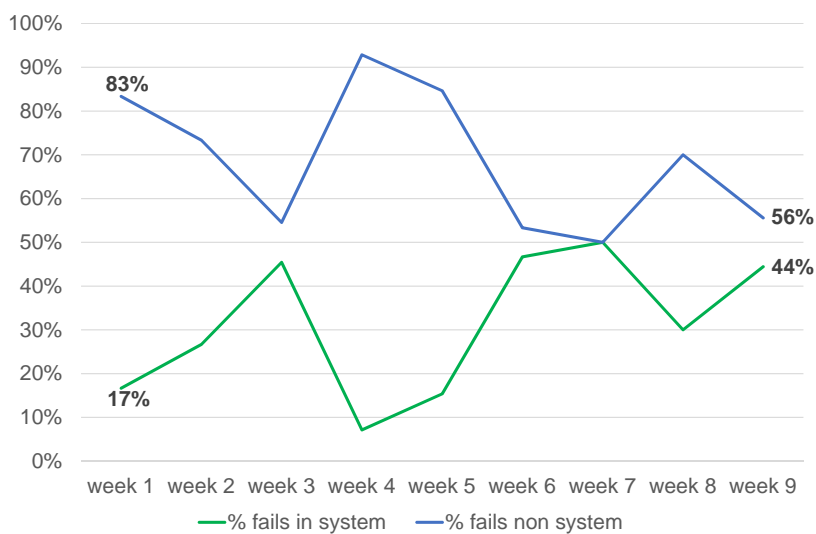
Best Practice: Parent call to schedule follow up appointment

Practice Change:

1. Any Team Member asks parent to schedule
2. Visual Reminder "BOX" on white board



Process: Focus on Non-System Medical Home



Test of Change #2: Weekends: Stop The Line for All Patients

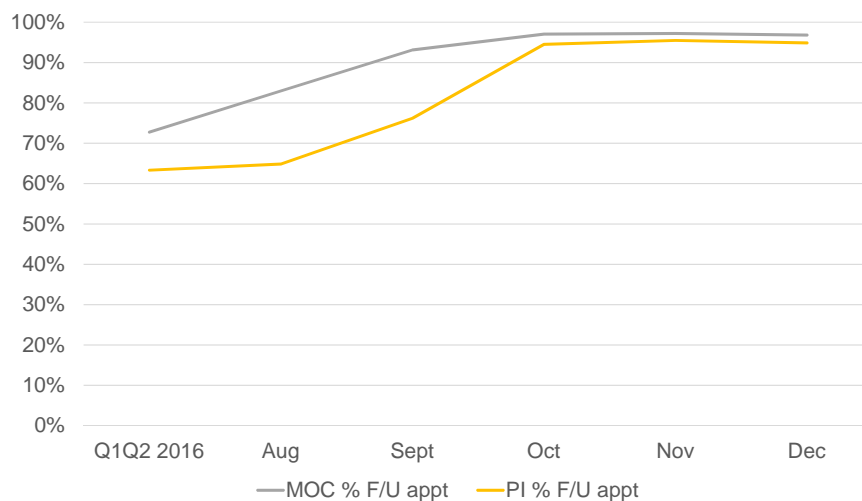
Best Practice: Parent calls to schedule f/u appointment for in-system and non-system PCP/medical home

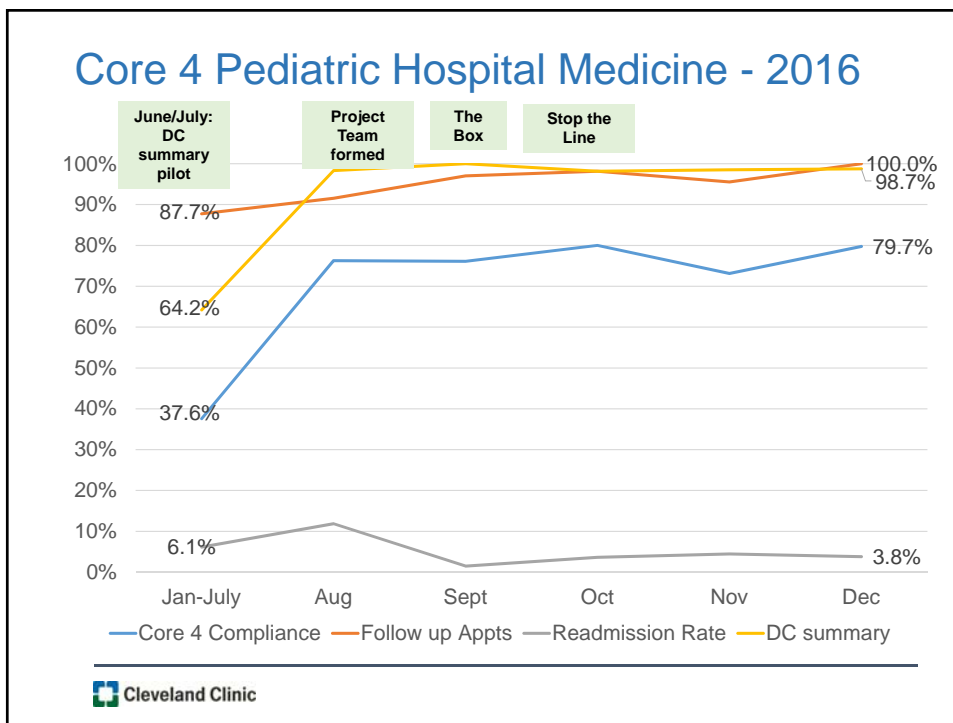
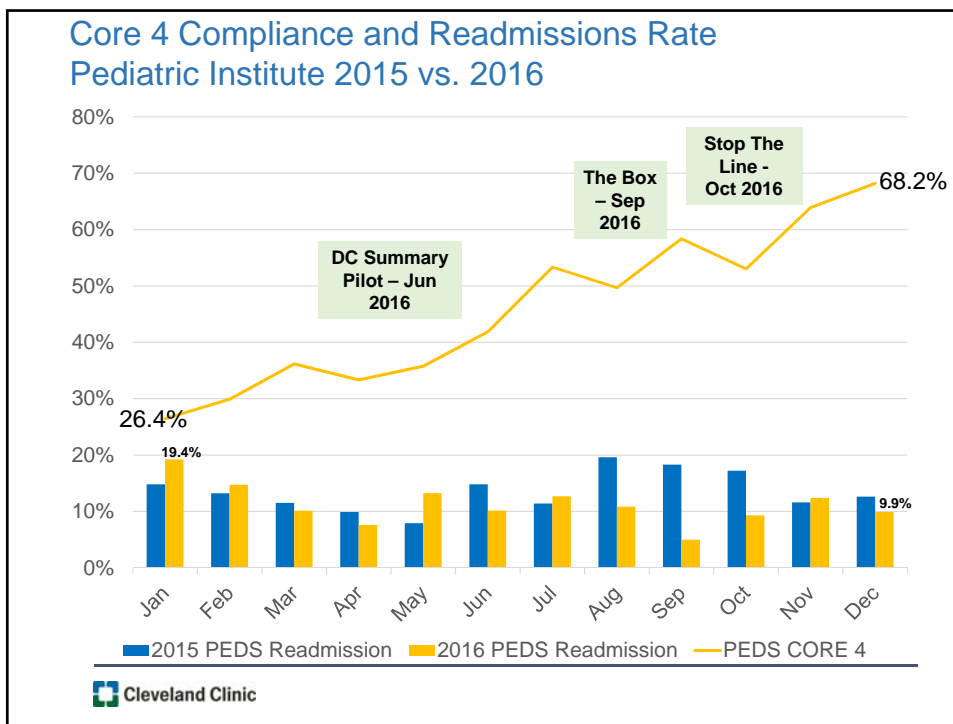
Practice Change

- Require a f/u appt be scheduled prior to every discharge
- Physician: use “box”
- Nursing: call primary service at discharge

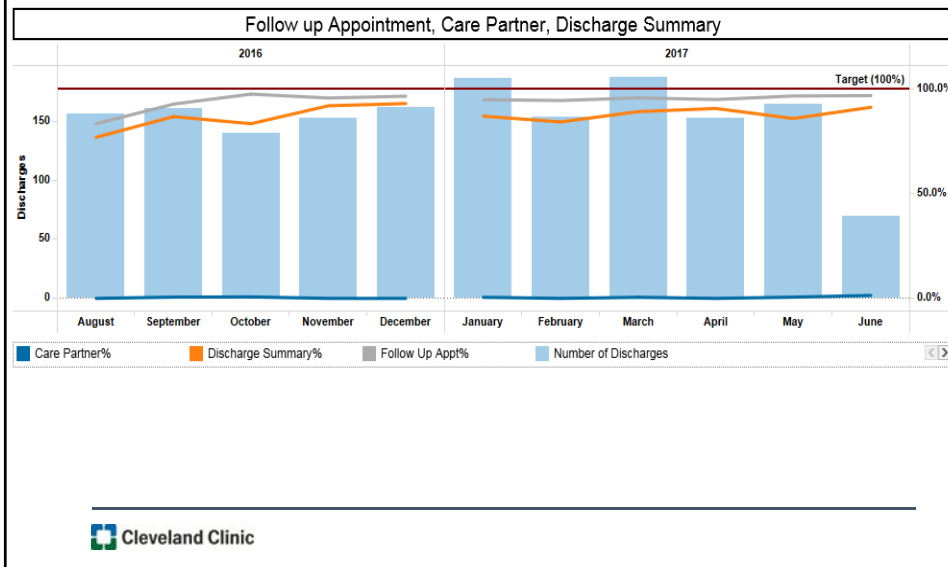


Process - F/U appointment scheduled prior to discharge

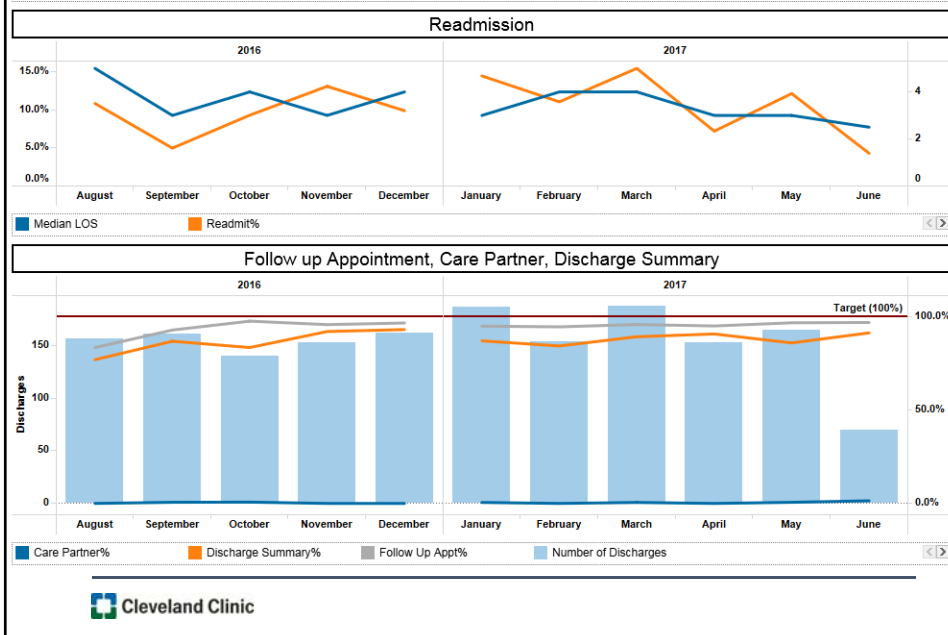




Sustainability – Follow-up Appointment



Sustainability – Follow-up Appointment and Readmission



Best Practices

- Completion of Core 4 elements is associated with reduced readmissions
- Asking parents to make a follow-up appointment prior to discharge is reliable and feasible
- Resident awareness of the Core 4 elements brings success for all services
- An engaged multi-disciplinary performance improvement team develops sustainable reliable safe transition of care



Cleveland Clinic Children's

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