Title of Abstract:

Improvement of High Risk Infant Follow-up Rate Associated with Novel Transition of Care Program in a Safety-net Hospital

Name of Abstract Submitter:

Matthew Nudelman, MD - Data Manager

Organization:

Santa Clara Health and Hospital System

Co-Author / Co-Investigators:

Rupalee Patel, DNP, IBCLC, C-PNP; Matthew Nudelman, MD; Priya Jegatheesan, MD; Dongli Song, MD, PhD; Balaji Govindaswami, MBBS, MPH

Abstract Description:

Background: High Risk Infants (HRI) have complex care needs and benefit from follow-up care to optimize long term outcomes. High Risk Infant Follow-up (HRIF) provides early identification of neurodevelopmental delays essential to preventing poor outcomes. In 2011, Santa Clara Valley Health and Hospital System launched Babies Reaching Improved Development and Growth in their Environment (BRIDGE) program to provide continued care and oversight of high risk infants before and after hospital discharge.

Objective: Evaluate follow up rate for first visit at 6 months.

Design: Study participants included HRI born between July 2010 and May 2016 who met California Children's Services, HRIF eligibility criteria. Infants who moved out of county or whose parents declined were excluded. QI Macros Statistical Processing Chart (SPC) is used to evaluate pre and post BRIDGE program HRIF rate.

BRIDGE program, Nurse Practitioner's (NP) relationship with the family provided feedback to multidisciplinary care teams (MCT) regarding patients' transition of care challenges (Figure 1). This information was utilized to improve our discharge processes to anticipate the specific needs and challenges of our patients. New processes included BRIDGE program NP participation in weekly clinical rounds and tailoring discharge plans to meet the needs of the patients. NP feedback was also utilized by MCT to address patient and family needs such as need for universal physical therapy (PT) referrals, transportation vouchers, text message appointment reminders, and creation of an electronic patient tracker.

Results: A total of 339 infants qualified for HRIF of whom 100 received BRIDGE visits. Follow-up rates for infants pre-BRIDGE were as low as 84%. Post BRIDGE program implementation HRIF rates increased to 100% to date (figure 2). Statistical process control illustrates the sustained gains in post BRIDGE HRIF follow up rates.

Conclusion: We attribute the improvement and sustainability of our high follow-up rate to interventions provided by the BRIDGE program, including universal PT referrals for all HRI at NICU discharge, post discharge home visits, improving NICU discharge process and HRIF program by incorporating BRIDGE program NP feedback. The transition care evolved based on BRIDGE feedback to be more adept at meeting the patient's transition of care needs, thus improving family engagement with the healthcare system. It remains to be seen whether more long term success can be achieved and maintained by novel programs such as BRIDGE.

Funding Acknowledgement (if applicable):

First Five, VMC Foundation