Background and Project Objective

The Mayo Clinic Children’s Center, located in Rochester, Minnesota, is a tertiary referral center for complex pediatric care. With high patient volume (250,000+ annual visits) and a wide range of clinical specialty practice, the Pediatric Aerodigestive Clinic (PAC) has been identified as a priority for quality improvement. The PAC is a multi-disciplinary clinic that provides care for patients with aerodigestive disorders, including those with congenital anomalies, and patients with conditions that affect the upper airway, larynx, trachea, esophagus, and nasopharynx. The clinic is staffed by a team of pediatricians, surgeons, otolaryngologists, and other specialists, and is designed to coordinate the care of patients with complex aerodigestive conditions.

The project team identified the need for a streamlined, efficient, and coordinated approach to patient care, including improved scheduling and coordination of diagnostic evaluations. The team aimed to reduce wait times and improve the overall patient experience.

The project team consisted of a multi-disciplinary taskforce that included pediatricians, surgeons, nurses, and other healthcare providers. The taskforce met regularly to discuss patient care and implement new protocols and guidelines to improve patient outcomes.

The goal of the project was to improve patient experience and standardize care for this complex patient population. Mayo Clinic Children’s Center’s first steps were to understand the current state by assessing a cohort of the defined patient population (Table 1) and defining the care team (Diagram 1) for this complex patient population. Stakeholder input from hospital, children and their families, referring providers, and other stakeholders was obtained to inform the project.

Methods and Tools

A multispecialty and multidisciplinary taskforce met to create a new model of care, including best practice guidelines, prior to implementing any new strategies. The taskforce was comprised of representatives from multiple departments and specialty practices, including pediatricians, surgeons, nurses, and other healthcare providers.

A significant improvement was observed in the number of anesthetic exposures. Post-implementation, anesthetic exposures decreased by 45% from an average of 4.2 per patient to 2.2 per patient. Similarly, post-implementation, consults with the necessary subspecialists decreased by 44%, from an average of 11 per patient to 6 per patient. The 3.5-month median and 7-month average time to first visit was condensed to 1 week, and the time from initial appointment to completion of diagnostic evaluation was reduced to one month or less.

Measuring Success

The project team evaluated the success of the new model of care by measuring improvements in patient satisfaction, wait times, and consults with subspecialists.

Satisfaction with the new practice model went from average 11 to 6 consults per patient visit. Improved care coordination helped in reducing the stress and confusion for the patient and their families. Love, 100% satisfaction with the new practice model went from average 2.2 to 1.5 consults per patient visit. The process was done quickly! The time from initial appointment to completion of diagnostic evaluation is one month or less.

The project team measured the success of the new model of care by reducing wait times and improving patient satisfaction. The new model of care resulted in increased patient satisfaction and reduced wait times, leading to improved patient outcomes and increased patient satisfaction.