Creating a reliable system for outreaching patients in transition

**The Problem**
Studies have demonstrated that many patients experience adverse events within 3 weeks of discharge, nearly three-quarters of which could have been prevented or reduced.

Among 488 consecutive patients at an academic hospital, 76 (10%) had adverse events soon after discharge, most either preventable or amenable to intervention (Source: Forster AL. Ann Intern Med. 2009;149:163-167)

We inconsistently reached our patients after they were discharged from the hospital. Each nurse and each clinic had a different approach / intervention for our patients. Transitions in care are recognized as high risk for patient safety.

**Aim/Goal**
We aim to reach at least 60% of our primary care patients within two days of hospital discharge and have at least 50% of our primary care patients have a visit in the primary care location (or home) within seven days by Dec 2015. We will use a standardized questionnaire to contact patients discharge from the hospital or emergency room. Nursing staff will include patient self management and motivational interviewing to identify readiness to change and assess barriers.

**The Team**
- Susan Natale RN, MSN, ACNO Ambulatory Nursing
- Alice Knowles, MS: Business Data Analyst
- Aimee Chevalier, RN, BSN, MHR Informatics Development Analyst
- Primary Care staff nurses
- Ambulatory Nurse Practice Council
- Fiona McCaughan, RN MS, Nurse Practice Administrator

**The Interventions**
- We were using a list of all discharges from the hospital, all nursing staff reviewed the list, scanning for their patients, this created redundancy (all the clinics used the same list); waste (every chart had to reviewed); human error (missed patients).
- Collaborate with IT to develop a user friendly report that provides staff the universe of patients who need a contact (denominator); direct access to the patient’s EMR; and standard documentation, including medication reconciliation, patient self management, motivational interviewing.
- Created visits designated for Hospital Follow Up to ensure access.
- All members of the care team have access to report and can include it in huddles and team meetings.

**The Results/Progress to Date**
- Improved our completion of 2 day contact from 44% to 78%
- Improved our primary care visits within 7 days to 43% to 66%
- We have continued to provide this in a patient-centered approach and our patients have had a positive experience

**Lessons Learned**
- We have achieved improvement in our rates of successfully outreaching patients and their families.
- We consistently review their hospital course, discharge instructions and medications and establish follow up care.
- Displaying data for staff in different forms is helpful in sustaining the gains.

**Next Steps/What Should Happen Next**
Describe the actions that the Team will be taking to:
- Focus on the ED discharges and use.
- Focus on ED use and outreach