Creating a reliable system for outreaching patients in transition

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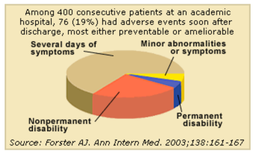
STATEMENT OF THE PROBLEM

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

We inconsistently reached our patients and varied our transition care.



BACKGROUND

Cambridge Health Alliance is an alliance of hospitals and neighborhood health centers serving an urban, underserved and multicultural/multilingual population. We have fourteen primary care centers, including Internal Medicine, Pediatrics and Family Medicine. We average 300 discharges from our own facilities.

PROJECT DESCRIPTION:

Patients in transition

1) Outreach by nursing within two days of hospital discharge.
2)Primary care visit within 7 days of hospital discharge.
4) Use a standard questionnaire to contact patients discharged from the hospital or emergency room. Include patient self management and motivational interviewing to identify readiness to change and assess barriers

Interventions

•Past: 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).

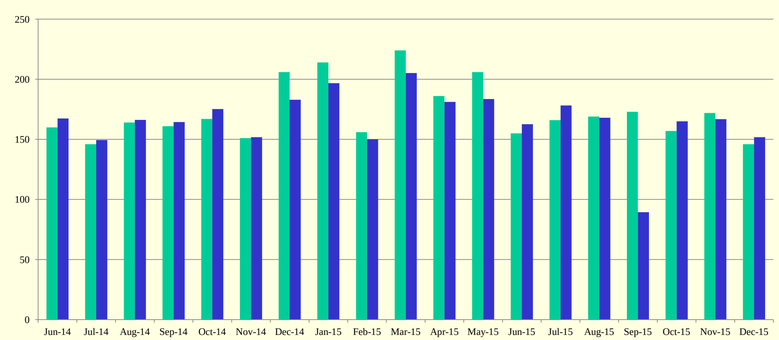
•Collaborate with IT to develop a user friendly report that provides staff the universe of patients who need a contact (denominator); direct access to the patient's EMR; and standard documentation, including medication reconciliation, patient self management, motivational interviewing.

•Created visits designated for Hospital Follow Up to ensure access.
•All members of the car team have access to report and can include it in huddles and team meetings.

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

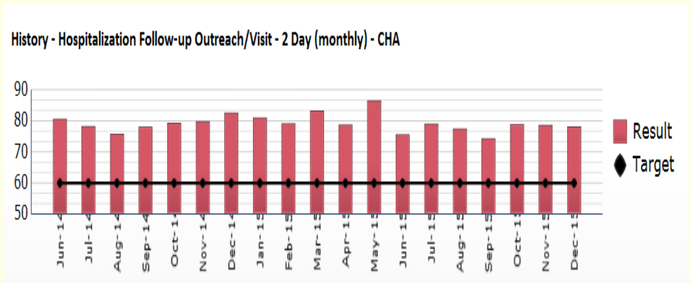
Next Steps: Focus on ED use and outreach

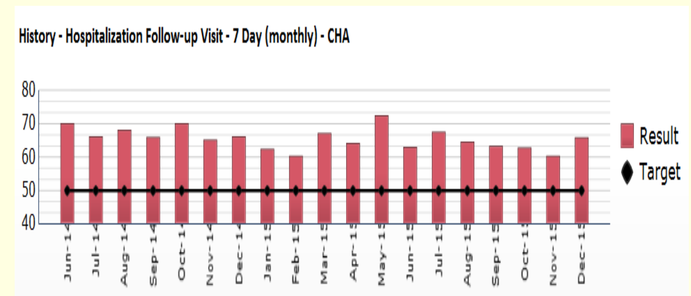
RESULTS



Display of data in terms of calls needed to reach the goal and calls completed, so staff can see the 'n' to meet the goal is small, generally less than 10 calls for the system.

RESULTS





Conclusions

Conclusions: 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.

Implementation is a team sport and requires follow up and monitoring.

Displaying data for staff in different forms is helpful in sustaining the gains.