Hospital discharge can be a challenging time for patients, often plagued with miscommunication. One study estimates nearly half of all discharged patients experience at least one error in medication continuity, test follow-up or diagnostic workup. Up to one in five Medicare beneficiaries will be readmitted within 30 days.\(^1\)

Improvements in the transitions of care have been proposed to improve 30-day hospital readmission rates; however, mixed results have overall failed to demonstrate such an effect.\(^{1,2}\)

Alternatively, some suggest post-discharge phone calls can identify areas of patient safety, and may have more impact when centered in the primary care practice. There is increased support for the PCP to coordinate and manage care after discharge.\(^1\)

**BACKGROUND**

**OBJECTIVE**

Within our Internal Medicine Resident clinic, there is currently no standardized process by which patients discharged from the inpatient medicine service are contacted after their hospitalization.

We aimed to standardize a follow up process after hospital discharge to identify areas of patient safety and that of greatest improvement potential.

**METHODS**

Patients discharged from the resident inpatient medicine service between September 2015 and March 2016 were contacted by the primary care office nursing staff within 72 hours of being discharged.

Nurses followed a standard script using open-ended questions focusing on patient’s overall understanding of their health and hospitalization, medication questions and/or difficulty getting medications, follow up planning, durable healthcare equipment and home care services, and remaining patient questions including signs of worsening illness.

Patients were also asked about the usefulness of the phone call.

Patient answers were documented in the electronic medical record using a standard dot phrase and saved as a telephone encounter.

Problems identified during phone calls that required intervention were either resolved immediately by nursing staff, or directed to the appropriate person (i.e. resident, attending, pharmacy, social work).

Information collected from phone calls were compiled to identify areas of patient safety concerns.

**RESULTS**

We identified areas for intervention in over half of discharge phone calls made. The majority of interventions were related to medication misunderstandings/difficulty getting medications, which could have serious implications on patient safety.

The primary care practice is an ideal setting to target improvements in transitions of care after hospital discharge. Nursing staff remains a critical part of this process.

Patients responded positively to the phone calls and could be a future target of patient satisfaction.

**REFERENCES**
