Effects of the UCM Post-Discharge Clinic on Care Access, Quality and Outcomes

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Problem

Timely, effective follow-up after hospital discharge can improve the efficiency and outcomes of care by increasing hospital throughput and decreasing readmissions and other adverse events after discharge. The University of Chicago Medical Center (UCMC) has chronic bed shortages and a medically and socially complex patient population that makes optimal management of post-discharge care especially important. We established a post-discharge clinic (PDC) to address the needs of patients, hospitalists, and primary care physicians (PCPs) to improve ambulatory care access within 14 days post-discharge, improve quality of care and operational efficiency.

Goal

Access the PDC's effectiveness on ambulatory care access within 14 days post-discharge, quality of care and operational efficiency.

Strategy

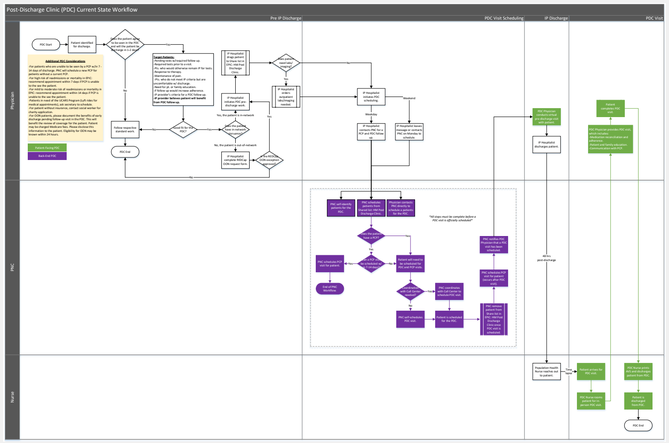
The PDC provides multimodal care to facilitate smooth transitions from inpatient to outpatient care. Three workflows were developed.

1. Patient Identification: Patients were identified based on criteria that meet the needs patients and the organization to decrease length of stay and readmissions.

2. Scheduling: A novel self-scheduling system allowed Patient Navigation Coordinators (PNCs) to schedule patients directly in the PDC providers' schedule.

A shared folder was created in which inpatient providers can place the patient information for the PNCs to schedule.

3. Clinic Flow: We mapped a lean workflow. PDC visits were offered both in-person and virtually via MyChart and Doximity. The PDC partnered with UCM finance to determine an out-of-network workflow. The PDC partnered with the Population Health team for 48-hour RN post-discharge phone visits. The PDC was able to participate in Transitional Care Management (TCM) and thus



Results

Patient Access: A total of 214 patients completed a PDC visit between December 2021 – June 2022.

The average time between discharge and being seen in the PDC was 8.7 days, with 88% of PDC-eligible patients completing a PDC visit within 14 days post-discharge.

For the broader UCMC patient population discharged between December 2021 – June 2022, only 50% of completed an ambulatory visit within 14 days post-discharge. For discharged patients establishing new primary care at UCMC, only 42% have an appointment with 14 days.

Identification of Adverse Events and Readmissions: ED referral rates and readmission rates were compared for patients attending the PDC and patients not attending the PDC, stratified by risk group. Results are limited by the small sample size of patients seem in the PDC in each group, but show trends towards lower ES visits and readmissions in some risk groups.

ED Referrals by Risk Group

Flag Completed PDC Visit After Admission	HOSPITALR..	Numera..	Denomi..	Rate
No	LOW	393	2,405	16%
	MED	348	1,696	21%
	HIGH	314	628	50%
	Null	312	3,916	8%
Yes	LOW	10	82	12%
	MED	8	35	23%
	HIGH	6	10	60%
	Null	4	29	14%

Readmissions by Risk Group

Flag Completed PDC Visit After Admission	HOSPITALR..	Numera..	Denomi..	Rate
No	LOW	224	2,405	9%
	MED	245	1,696	14%
	HIGH	224	628	36%
	Null	295	3,916	8%
Yes	LOW	4	82	5%
	MED	5	35	14%
	HIGH	4	10	40%
	Null	1	29	3%

Conclusions

The PDC seeks to improve UCM care access, quality and outcomes by providing transitional care access to patients discharge from the hospital within 30 days of hospitalization. Early evidence suggests improved access to post-discharge care and the potential for reductions in emergency department visits and readmissions. Further development and evaluation of the PDC is in progress.

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