Improving Transitional Care Access and Decrease Risk of Readmission Through the UCMC Post-Discharge Clinic (PDC)

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Timeliness in transitional care improves clinical outcomes by delivering medical care at the most vulnerable post-hospitalization time. Primary care access to in-network and out-of-network patients’ post-hospitalization has been a challenge, especially for sicker patients with high risk of readmissions. Decreasing readmissions has been one of the main goals of the UCMC Annual Operating Plan. The UCMC Post-Discharge Clinic (UCMC) was created to bridge this transitional quality need developing processes that will improve timely transitional access according to the risk of readmission.

**Problem**

To provide transitional care access to in-network and out-of-network patients within 7- and 14-days post-hospitalization according to the risk of readmission.

**Goal**

To improve transitional care access to in-network and out-of-network patients within 7- and 14-days post-hospitalization according to the risk of readmission.

**Innovation**

When patients are in the hospital, it is difficult to schedule patients without knowing or discussing appointment availability since the Patient Navigator Coordinators (PNCs) do not have access to a scheduling view of available appointments as is present in outpatient settings and must rely on central scheduling for appointments without input from the patients. The PDC developed processes that provide an easy PNC access to PDC providers’ clinic schedule, allowing the PNCs to have overall view of openings in the schedule and offer availability to patients as needed.

Furthermore, the decision of when patients should be seen is critical to scheduling. The PDC in partnership with the Office of Clinical Transformation developed processes to risk stratified scheduling for patients in high risk of readmissions to be seen within 7 days post-hospitalization vs patients with other risk within 14 days post-hospitalization. PDC provides the flexibility to open PDC clinic sessions if the demand exceeds the capacity within 14 days post-hospitalization. PDC provides face-to-face sessions for sicker patients or patients who prefer to be seen in-person, and virtual sessions for sicker patients who are unable to come to appointments or patients who prefer to be seen virtually. We were able to have financial support from the institution to provide cost-effective transitional care for the out-of-network population that meet criteria for increased close post-discharge surveillance, to decrease length of hospitalization or risk of readmission.

**Impact**

- PDC readmission rate for high risk of readmission category within 30-days post-hospitalization: 23%
- No PDC readmission rate for high risk of readmission category within 30-days post-hospitalization: 36%

**Access**

PDC Average/Median days to new appointment within 14 days: 14.2/12.0. The PDC has a significant impact improving transitional access at DCAM (Average/Median days to new appointment within 14 days: 99.7/30)

**Emergency Department (ED) return visits**

- PDC ED return rate for high risk of readmission category within 30-days post-hospitalization: 35%
- No PDC ED return rate for high risk of readmission category within 30-days post-hospitalization: 50%

**Conclusions**

Timely access is critical to the sicker population we serve. Our innovative processes have produced an increased capacity for in-network and out-of-network patients and serve as major contributors to provide decreased rate of readmission and return visits of our most vulnerable populations.

**Acknowledgements**

Stephen Weber, MD, Chief Medical Officer. Tipu Puri, MD, Associate Chief Medical Officer. Ken Navas, MD, Chief Ambulatory Medical Officer. Aytek Oto, MD, Chief Physician of the University of Chicago Medicine Physicians. Shwetha Devanagondi, MS, Director Clinical Analytics. Angela Woodfork, MA, Practice Manager Primary Care Group.

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