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

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Problem

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 to 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.

Goal

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.

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 being seen in-person, and virtual sessions for sicker patients who are unable to come to appointments or patients who prefer to being 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

Readmission

ED Returns and Readmissions by Risk Group

Flag Completed PDC Visit After Admission	HOSPITALR..	Numera..	Denomi..	Rate
No	LOW	557	6,710	8%
	MED	614	4,410	14%
	HIGH	687	1,886	36%
	Null	1,335	15,150	9%
Yes	LOW	16	232	7%
	MED	18	117	15%
	HIGH	9	40	23%
	Null	5	120	4%

- 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%

Emergency Department (ED) return visits

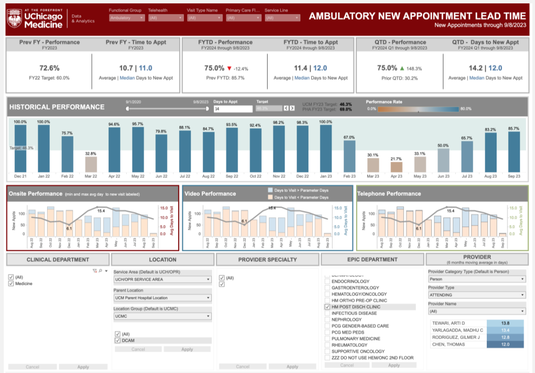
ED Returns and Readmissions by Risk Group

Flag Completed PDC Visit After Admission	HOSPITALR..	Numera..	Denomi..	Rate
No	LOW	1,083	6,710	16%
	MED	955	4,410	22%
	HIGH	938	1,886	50%
	Null	2,500	15,150	17%
Yes	LOW	33	232	14%
	MED	28	117	24%
	HIGH	14	40	35%
	Null	15	120	13%

- 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%

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)



Conclusions

Timely access is critical to the sicker population we serve. Our innovated 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.

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