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Background

- Up to 25% of hospital readmissions are preventable (Auerbach 2016)
- Efforts to reduce readmissions are on different spots on arc of care

- Med rec
- Standard workflow and templates

Transitional

- Nurse visit
- Phone calls

Outpatient

- Prompt PCP followup

Why does it matter?

- Increased Disability
- Increased Cost

Inpatient

Transition

Outpatient

Me

The vision

- Develop a Transition of Care Clinic utilizing my role as both an inpatient attending as well as preceptor in the family medicine center reduce rate of readmissions

Starting point

- Already established on inpatient and outpatient settings
- Growth opportunities for multidisciplinary efforts (pharmacy, RN, SW)
- Had dedicated RN in office for prior Post COVID Clinic
- Had dedicated nursing coordinator who was assigned by TCH to reduce readmissions.

12/2022: Dedicated clinic RN left

1/2023: First patients seen in clinic

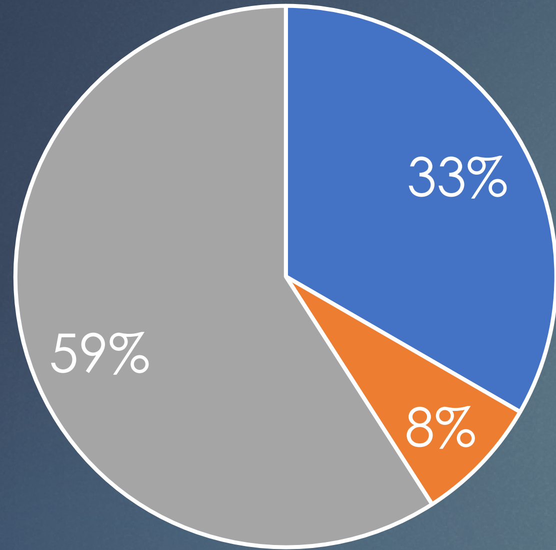
1/2023: Dedicated RN/CM left clinic

3/2023: Followup card for use on inpatient

4/2023: Relationship with new CM for adding patients to clinic

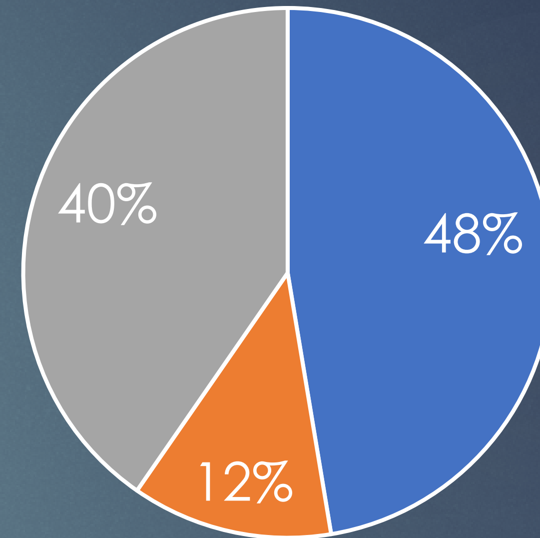
5/2023-present: Improved scheduling directly to MA/FMC scheduler

Post Discharge Follow-up Outcomes by Percentage from 8-10/2022



- Followup in 2 weeks
- followup after 2 weeks or after SNF
- Did not followup

Post discharge followup outcomes by percentage from 2-4/2023



- Followup in 2 weeks
- TCM f/u after SNF or >14d
- No followup

Who did we care for?

- Victim of sex trafficking with newly diagnosed HIV
- Patient with recurrent UTIs with no foley exchanges done as outpatient
- Complex leg wounds with patient rationing bandages because HHC didn’t show up
- Virtual home visit for a patient with chronic CHF exacerbations and discovered MDD

Lessons learned

- Difficulties with losing key personnel during rollout phase
- Process development is key
- Identification of growth opportunities within the arc of care (multidisciplinary efforts in clinic, pre discharge screening)
- Sharing the passion leads to other opportunities (grant submission!)

Next steps

- Streamline notification reminders for residents on service so getting patients in clinic doesn't rely always on me
- Maintain list of those discharged to SNFs to increase their followup after discharge
- Incorporation of residents in clinic for teaching
- Incorporation of SDH assessments and interventions

Thank you!