University of Chicago Medicine
Readmission Reduction Success Story

Submitted by the J.C.R. H.E.N. with hospital permission

The University of Chicago Medicine (U.C.M.) has been working on our readmission reduction program for the past 3 years.

Background:

Timeframe	**Patients Discharged with a Primary Diagnosis of Acute Myocardial Infarction or Heart Failure** 30 Day Readmission Rate
FY 2012 July 1, 2011-June 30, 2012	23.15%
FY 2013 Year to Date July 1 – November 1, 2012	18.70%

The first two years of the program focused on all patients with a primary diagnosis of heart failure and acute myocardial infarction. This group was led by our Cardiology service with significant project management support from our Clinical Effectiveness department.

Beginning in July 2012, while the Cardiology team maintained a focus on heart failure and acute myocardial infarction, Clinical Effectiveness began to spread successful implementation strategies to three additional patient populations. These patient populations are:

- Pediatric Asthma
- Adult patients discharged to a skilled nursing facility (S.N.F.)
- Adult high utilizers (24 patients whose complex medical needs were not being met)

The readmission goals are aligned with the strategic priorities for the Institution and reported on a monthly basis to the U.C.M. Quality Committee.

Each group is customizing interventions to fit the needs of their patient populations; however, we have implemented several interventions for all patient populations at U.C.M. The interventions we have been implemented across the Medical Center include:

- Using teach back principles on inpatient pediatric and adult nursing units with emphasis during annual nursing competencies
- Standardizing patient education materials and ensuring an appropriate health literacy level
- Redesigning the "After Visit Summary" to ensure critical patient information is displayed and in a user friendly format
- Educating U.C.M. providers on readmission rates and new regulatory requirements
- Increasing collaboration between inpatient and outpatient providers

In addition U.C.M. is also implementing many patient-population specific interventions. For example; the acute myocardial infarction and heart failure group has been working on interventions including:

- 48-hours post discharge calls driven by pharmacists for heart failure patients
- Coordinating care between U.C.M. and homecare providers
- Increasing communication between the E.D. and Cardiology service
- Standardizing heart failure education among skilled nursing facility staff

The A.M.I./H.F. readmission goal for the FY 2013 was 20.62%, and the rate for the first quarter was 17.9%.

The team examining discharges to skilled nursing facilities are establishing internal workflows to ensure that the patient is ready for transportation. Interventions for this fiscal year include:

- Prompting automatic geriatric consults prior to transfer
- Holding monthly meetings with SNF partners to share data and issue resolution
- Ensuring important medical information is communicated prior to handoff

The SNF readmission goal for FY 2013 was 15.68% and the rate for the first quarter of 2013 was 17.19%.

The pediatric asthma group is working on increasing opportunities for patient, family, and caregiver education. This group is rolling out interventions such as:

- Additional patient education in the Children's Emergency department

- Providing after hours patient and family asthma education classes
- Increasing pediatric pulmonary consults during inpatient stays

The pediatric asthma readmission goal for FY 2013 was 2.16% and the rate for the first quarter of 2013 was 2.33%.

Finally, the high utilizer work group has created an individual care plan by collaborating with the patient and his or her entire care team including their specialists, social workers, pharmacists, and the primary care providers. This plan includes notifying the care team when the patient is unexpectedly seen anywhere at U.C.M. including in the Emergency Department. In addition, it links the patient to the proper support services that the patient may need including dietary consults, Chaplin services, and social work. The high utilizers' readmission goal for FY 2013 was 52.89% and the rate for the first quarter of 2013 was 51.72%.

Challenges:
Our main challenge with the readmission reduction program has been to incorporate new interventions with competing priorities and resources. U.C.M. is opening a new adult hospital in February 2013 and much of our staff, have been involved in many overlapping projects. We have not hired any new staff dedicated to work on readmissions; therefore all of our new activities have had to fit in to existing workflows and structure.

Another challenge has been to find ways to efficiently work with community providers to coordinate care. Not only do some of our patients have primary care physicians outside of our institution, but U.C.M. does not own any skilled nursing facilities or homecare agencies. We are constantly reassessing our communication workflows and identifying ways to better coordinate care.

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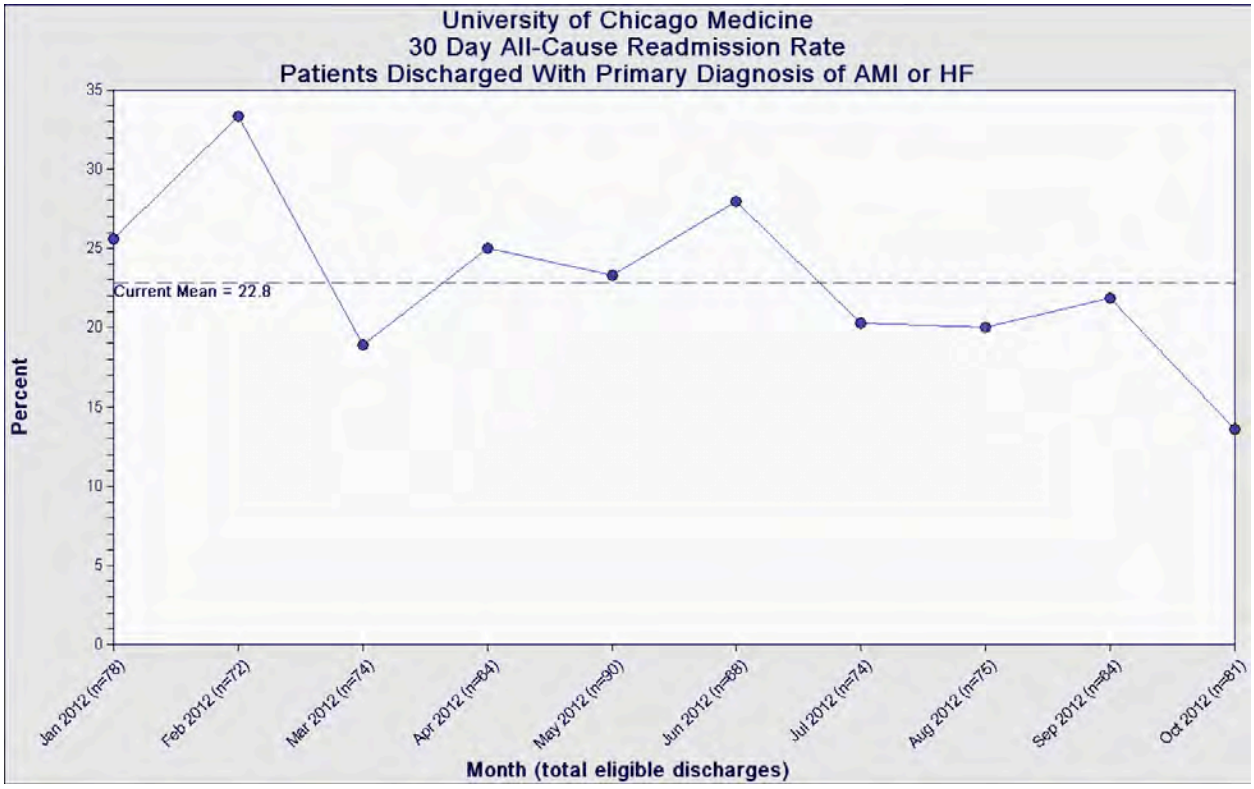

Clinical Effectiveness
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