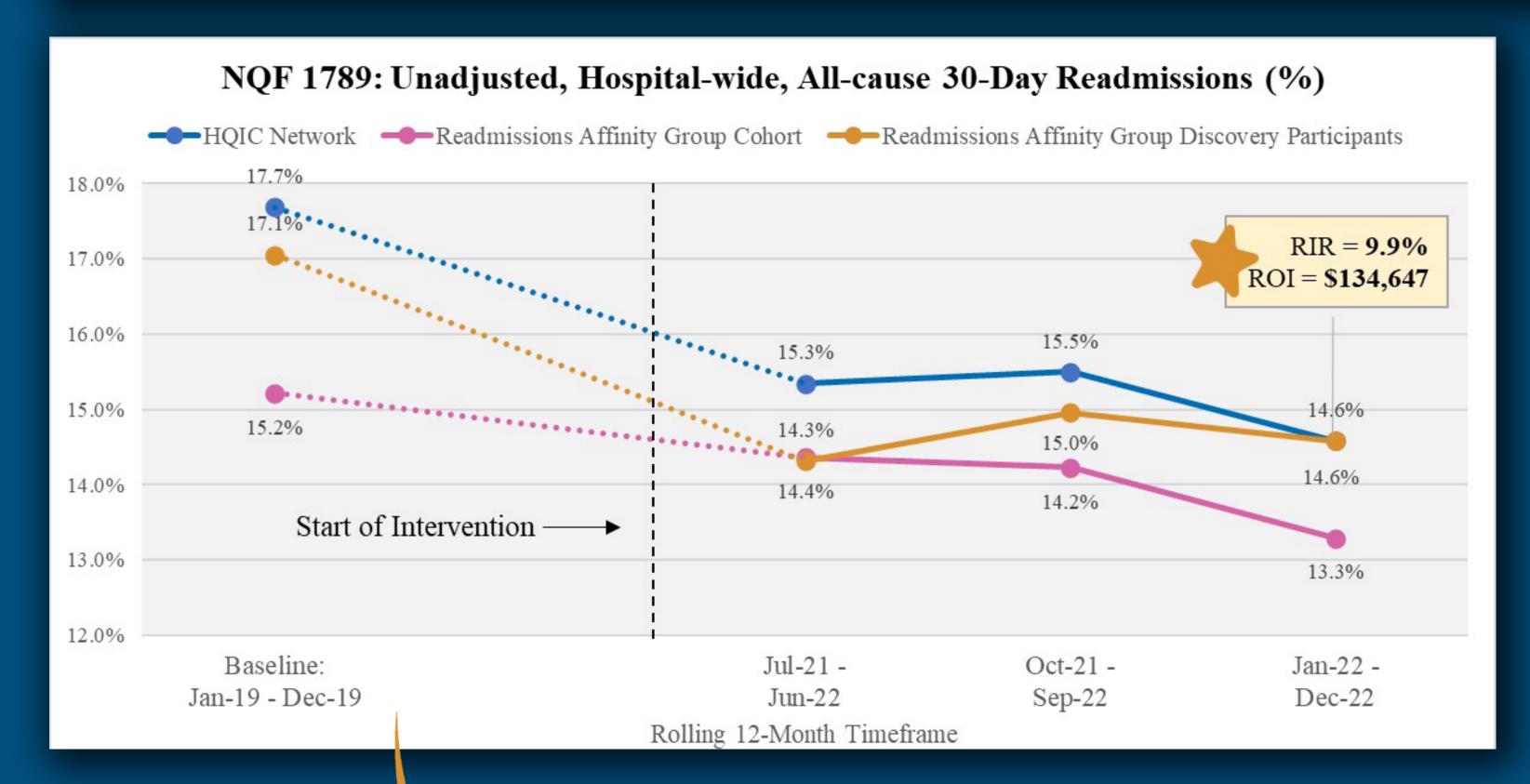
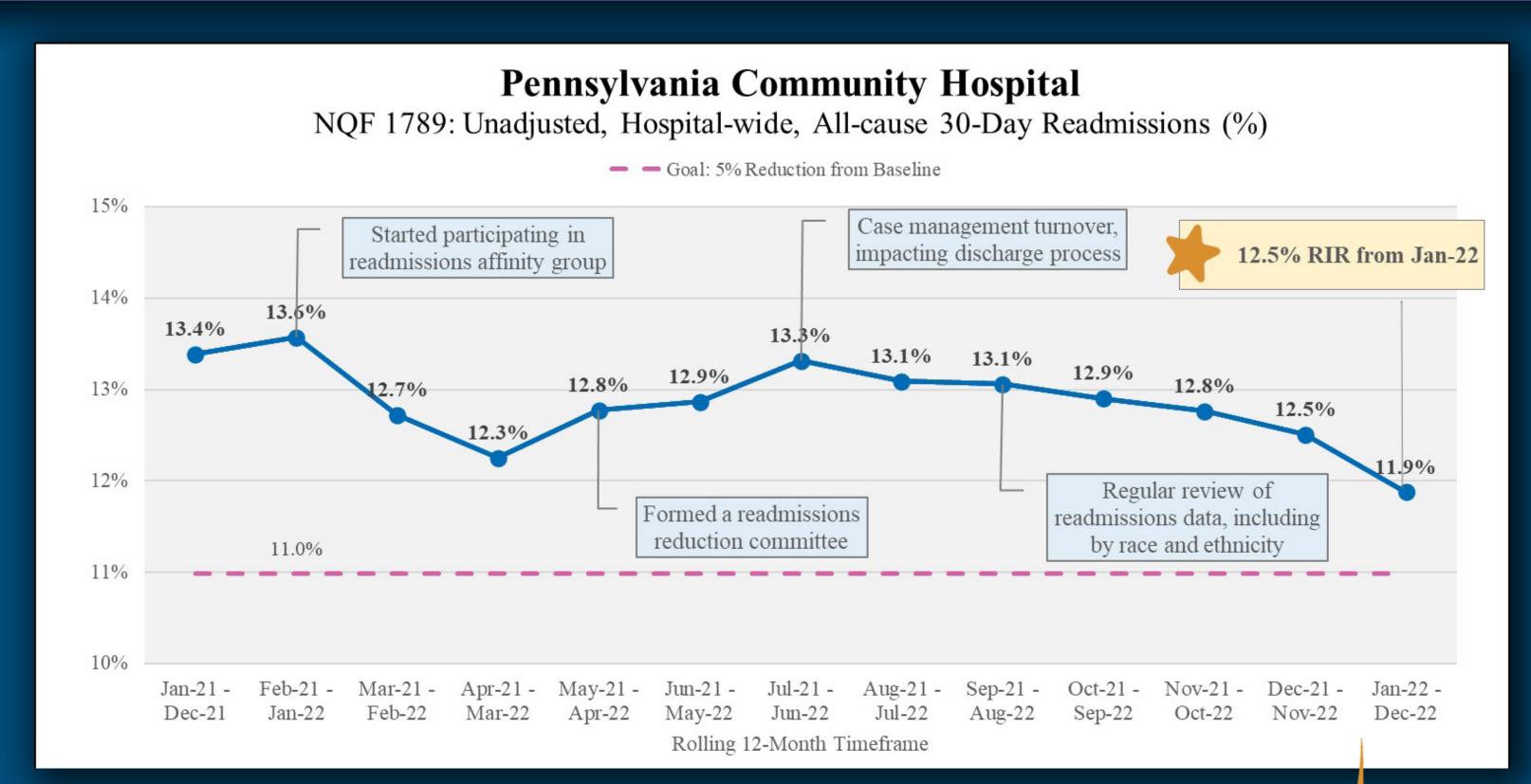
Affinity Series Supports Continued Focus to Improve Readmission Efforts

Now more than ever, hospital teams recognize that delivering the right care in the right place is essential to preserve hospital capacity. Identifying and proactively discussing readmission risk factors to avoid readmission is a matter of safety, quality, equity and value for all hospitalized patients HQI hosted a 10-part series from January 2022 through May 2022. This series featured interactive sessions designed to deliver bite-sized, practical, feasible and effective readmission reduction strategies. Early results and feedback indicate this series was successful in helping hospitals implement these strategies to reduce readmissions. The collaboration with other hospitals who shared challenges and successes helped drive sustainability for readmissions efforts.





Successful Successful Strategies

to understand why

Setting readmissions reduction

Readmission rates for affinity group participants decreased consistently each quarter after the series began, as indicated by the pink line when compared to the blue line of the HQIC network. Discovery Participants, in orange, consist of five HQI network hospitals who committed to applying identified readmissions strategies and sharing success and challenges throughout the five-month session period. Their rates are more variable due to the small number of hospitals and their volume of discharges. Overall RIR of affinity group participants was 9.9% with a savings of \$134,647.

- Interviewing readmitted patients Identifying existing people and resources to provide enhanced/improved care
- Analyzing existing data to Identifying post-discharge supportive understand causes for readmissions services available to patients
- Measuring the consistency of implementing a Forming a Readmissions new improvement change Reduction Team
 - Identifying a pharmacist willing to do bedside medication review and teaching

This run chart is for a hospital that participated in the affinity group series, showing a 12.5% RIR in readmissions from the start of the series.

HQM

Take action now!

My temperature is below

Participant Comments

"One Bite at a Time—

the Readmissions

at breaking down steps

into manageable chunks

"It is a continuous process and

to gain success."

it is something you have to

"The opportunity to participate in

constantly keep working on."

the Readmissions Affinity Group

motivated our team to get back to

work. During the pandemic we had

halted all improvement teams because

our staff and leaders were all providing

operations. Participating in the Readmissions

Affinity Group was a great way to resume our

patient care and working to sustain

Affinity Group was great

by interviewing 10 to 25 patients to understand the patient and systems-based root eadmissions. Clinical or non-clinical staff can conduct the interviews Ideas that Work are strategies your facility can use to improve care coordination for patients reduce hospital readmissions and connect patients to community services. communication between settings of care, you can not only reduce unnecessary hospital stay out improve health outcomes and patient and family satisfaction. Implement Circle Back in your community to improve communication between hospitals and nursing homes to reduce errors and re-admissions. This intervention facilitates a structure transition conversation from hospital to nursing home, which includes the asking of six, Did the patient arrive safety? (Transportation)

work."

- Does the patient's presentation reflect the information you received? (Presentation) 5. Is the patient/family satisfied with the transition from the hospital to your facility: 6. Have we provided you everything you need to provide excellent care to the patient?
- The Health Quality Innovation Network (HQIN) engaged a Virginia hospital to pilot Circle Back for improving care coordination after a hospital stay. By dedicating a nurse to conduct followup calls with receiving nursing homes and tracking Circle Back outcomes, the hospital reduced readmissions of patients transferred to nursing homes from 28.6% to 10.5% in 16 months. Circle Back Video

Circle Back Tracking Template

nen did you notice something was wrong or that you were starting to have a siblem? or What happened between the day you were discharged and the point u decided to return to the ED?	all your doctor or y	Call or see your doctor now!
a decided to return to the ED?	a fever between and 101.4° F	I have a fever of 101.5°F greater
w long did this go on?	el cold and can't get m shivering	My temperature is be 96.8° F My teeth are chatterii My skin or nails are p
nat did you do once you realized there was a problem?	tired to do most of ual activities	I'm too weak to get out o bed
	nking feels slow or ht	My caregivers tell me I'm not making sense
no did you involve for help? ny did you – or someone else – decide you should go to the ED?	on't feel well ive a bad cough wound or I.V. site ks different iven't urinated ed) for 5 or more urs and/or my urine e) burns, is cloudy, k or smelly	I feel very sick My wound or I.V. site painful, red, smells or has pus I haven't urinated (pe for 6 or more hours and/or my urine (pee) very dark
	need to call 911 but all my doctor if:	I will call 911 if: My heartbeat is very f

for 6 or more hours and/or my urine (pee) My heartbeat is very fa My breathing is very fas My home blood pressu STAAR, ASPIRE & MVP Methods, President, Collaborative Healthcare Strategies. Views expressed in this material do not necess I have a fever of 103. pressure is 20 points My skin or nails are blue (top number) lower

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