Ideas that Work | Circle Back

Ideas that Work are strategies your facility can use to improve care coordination for patients, reduce hospital readmissions and connect patients to community services.

The Challenge

Approximately one in four patients who are discharged from the hospital and transferred to a skilled nursing facility will be readmitted to the hospital within 30 days. By improving communication between settings of care, you can not only reduce unnecessary hospital stays, but improve health outcomes and patient and family satisfaction.

The Idea

Implement Circle Back in your community to improve communication between hospitals and nursing homes to reduce errors and re-admissions. **This intervention facilitates a structured transition conversation from hospital to nursing home, which includes the asking of six, consistent questions:**

1. Did the patient arrive safety? *(Transportation)*
2. Did you find the admission packet in order? *(Documentation)*
3. Were the medication orders correct? *(Medication)*
4. 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? *(Patient/Family Experience)*
6. Have we provided you everything you need to provide excellent care to the patient? *(Customer Service)*

The Results

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 follow-up 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.

Resources

1. Circle Back Video
2. Circle Back Tracking Template

Steps for Implementation

1. Establish your initial goals for starting Circle Back.
2. Determine process and outcome measures. (Call completions, % of yeses for calls, etc.)
3. Establish the points of contact and best times for a phone call.
4. Identify discharges to nursing homes each day for your call schedule.
5. Track the results of your activities (call outcomes and cumulative data in tracking sheet).
6. Evaluate your successes after small tests and monthly data collection reviews.
7. Establish a feedback loop for improvement.

Tips for Success

- Assign specific nurses, or other staff with knowledge of patient care, for these calls to maintain consistency as much as possible.
- Establish best times for phone calls (i.e., avoid change of shift or med pass times).
- Start small: one call about one patient transfer to one nursing home.
- Ensure both parties have access to patient records during the phone call.
- Build trust and engage in honest, open conversations about what is working and what is not.

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Put new ideas to work in your community:

Circle Back is just one of several care transitions interventions highlighted in HQIN's Ideas That Work series. To explore other strategies for strengthening care coordination activities in your community, check out our YouTube Playlist and the HQIN Resource Center.

Questions? Contact Carla Thomas at cthomas@hqi.solutions.

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