The INTERACT Program: The Role of SNFs in Cross-Continuum Community Coalitions to Reduce Hospital Readmissions

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• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day

• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington

• QIOs: the largest federal network dedicated to improving health quality at the community level
Objectives for the Session

• Discuss the relationships between hospitals and post-acute providers in efforts to reduce hospital readmissions

• Describe why reducing readmissions to acute care from the SNF setting is important and how the INTERACT Program can help

• Identify specific components of the INTERACT Program
Why Focus on Care Transitions?

- 1 in 5 Medicare patients re-hospitalized within 30 days
- 2/3 of Medicare patients are rehospitalized or die within one year of index hospitalization
- Unplanned re-hospitalizations cost Medicare over $17 billion
- Care transitions are error prone—most have an error or near miss
- 70% of post-surgical rehospitalizations are for medical reasons
- Poor care transitions affect the worst-off most, causing suffering, disability, and death
Why Focus on Skilled Nursing Facilities?

• As hospitals are being penalized for excess readmissions, they are turning to SNFs with reputations for high performance and track records for lowering hospitalization rates via clinical readiness and enhanced capabilities

• Readmission penalties at hospitals now will likely become a reality in SNFs in the future

• Awareness of acute changes of condition and rapid response facilitates appropriate treatment changes

• Resident and family satisfaction increases as their preferences for care are accommodated and advanced care plans are respected

Source: Advancing Excellence
The Role of Skilled Nursing Facilities

Patients admitted to SNF for rehab/recovery are often sicker and have higher needs than those who go directly home

- Already at higher risk for readmission

SNF are a key component in successful transitions

- Tools, skills, and processes are necessary to:
  - Quickly and appropriately identify and respond to changes in condition
  - Communicate effectively with MDs and hospital providers
  - Track progress on QI initiatives and continuously improve
Two Approaches to Interventions

System changes
• Hardwiring standard and reliable processes
• Benefit: Broad reach for all patients, all payers, all units
• Challenge: Improving and sustaining processes is hard work!

Targeted population interventions
• Usually chronic condition-specific (like HF)
• Coaching, case management
• Benefit: care based on identified risk
• Challenge: narrow focus, may not move overall readmit rate

The INTERACT Program is a system/culture change intervention
Differences with the INTERACT Program

• Facilities using the INTERACT Program components are focused on improving the quality of care for patients and reducing hospital readmissions

• Use of INTERACT tools provide nursing staff guidelines for assessment and intervention to identify changes in condition sooner

• INTERACT tools assist facilities to identify and provide for educational needs of staff

• Use of evidence-based, standardized tools allows for clear, comprehensive communication and coordination across all settings, particularly during transfers
Acknowledgement

- The INTERACT Program and Tools were initially developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare & Medicaid Services (CMS).

- The current version of the INTERACT Program was developed by the INTERACT interdisciplinary team under the leadership of Dr. Joseph G. Ouslander, MD with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by The Commonwealth Fund.
The INTERACT Program

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources
- The program is located at http://interact2.net
- Includes an excel program for tracking readmissions and reporting outcomes
The INTERACT Program Design and Purpose

- Improve care and reduce the frequency of potentially avoidable acute care transfers of nursing home residents
- Minimize risks associated with hospitalization
- Improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities
- Target is avoidable transfers, NOT to prevent all transfers
- More rapid transfer of residents who do need hospital care
Organization of Tools

- Quality Improvement Tools
- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools
The INTERACT Program
The INTERACT Program is Much More than a Toolkit

• Most providers are only aware of INTERACT as a few tools like “Stop and Watch” or “SBAR”

• The overall Program is much more and can provide significant benefit to hospitals and other post-acute providers

• Prime examples are one of the Communication Tools – the Capabilities List and the Quality Improvement Tools
Overview INTERACT Documents

• INTERACT Implementation Checklist
• Engaging Hospitals in Your Program
• INTERACT Version 3.0 Tools
• Implementation Guide 2013
Quality Improvement Tools

• Hospitalization Rate Tracking Tool
• Acute Care Transfer Log
• Quality Improvement Tool for Review of Acute Care Transfers
• Quality Improvement Summary
Quality Improvement Tools to Benefit SNFs and Hospitals

- Identifying and tracking acute care transfers over time
- Answer some basic questions:
  - How many transfers from your hospital?
  - When do they occur?
  - How many days since admit?
- What other factors went into movement from setting to setting?
Quality Improvement Tool

- Root Cause Analysis: The Rest of the Story
- Demographics
- What happened?
- Contributing factors
- Attempts to manage in SNF
- Avoidable?
- Staff thoughts about this

- “Ah ha” moments
- Should have returned sooner?
- Opportunities for improvement
- Online version coming
- Cross continuum review of cases
Quality Improvement Tool

Purpose
• Review transfers to understand the reasons for transfers
• Identify possible opportunities to prevent avoidable transfers

When to Use
• Within 24-48 hours after transfer
• Representative sample of transfers to look for common patterns & identify improvements
Quality Improvement Summary Worksheet

Summarizes findings from the QI Tool for common factors – **drives education and care process changes**

Step 1: Number and time frame of QI Tools

Step 2: Compare answers:
- Resident characteristics
- Changes in condition leading to transfers
- Actions taken prior to transfers
- Hospital transfer and contributing factors

Step 3: Summarize common factors
Communication Tools

• Enhanced Nursing Assessment
• Builds on early recognition
• Standard approach
• MD/NP response
• Warm hand over
• How might this compliment disease management?
Communication Tools

Two sections of Communications Tools:

1. Communications within the nursing home
2. Communications between nursing home and hospital
Communication Tools

1. Communications within the nursing home
   - Stop and Watch Early Warning Tool
   - SBAR Communication Tool
   - Medication Reconciliation Worksheet
Communication Tools
Enhanced Nursing Assessment

Stop and Watch & SBAR Communication Form

- Builds on early recognition
- Standard approach
- MD/NP response
- Warm hand over
- How might this compliment disease management and other improvement efforts at hospitals, etc.?
Early Warning Tool  
(Stop and Watch)

**Purpose**

- Identify and document changes in residents
- Communicate changes to other nursing staff
- Identify possible opportunities to prevent a hospital transfer
- Improve over all level of care

**When to use**

- Tool should be completed for **ALL** changes on a shift-by-shift basis, by staff with direct contact with the resident
Medication Reconciliation Worksheet

Structured medication reconciliation for new admissions or patients returning from the hospital to identify discrepancies and other issues

• Part 1: Hospital recommended medications needing clarification
• Part 2: Medications Prior to hospitalization needing clarification
2. Communications between nursing home and hospital:

- Engaging your Hospitals – Tip Sheet
- Nursing Home Capabilities Sheet
- Nursing Home – Hospital Transfer Form
- Nursing Home – Hospital Data List
- Acute Care Transfer Checklist
- Hospital – Post-Acute Transfer Form
- Hospital – Post-Acute Data List
Communication Tools Across Settings

Goal is to improve communication and care with local hospitals

Two provide helpful basic information:

• Engaging Hospitals in Your Program – assists nursing home to facilitate collaboration

• Nursing Home Capabilities List – standardized pre-populated checklist explaining about the facility
Communication Tools
Engaging Hospitals in Your Program

Keys to Engagement:

• Transitions in care require two partners – both involved
• While forms are great, communication is more important
• Facilities need to stand ready to accept the patient back to the facility from the ED if appropriate and avoid a hospitalization
• Remember that your facility can influence improved methods of communication and transition – be models of change
• Facilities can demonstrate being value-added in a competitive environment
Communication Tools
Engaging Hospitals in Your Program

Share how your use of the INTERACT Program can benefit the hospital:

• Implementing a set of strategies, tools, care process improvements, and related staff education aimed at effectively identifying changes in condition early, effectively evaluating and communicating changes
  • Organized, comprehensive information to ER
  • List of facility’s capabilities to support return to facility
  • Improving hand-overs via phone calls, process improvement, etc.
  • Pro-actively engaging in advance care planning with facility residents to clarify goals of care
Communication Tools – Transfer Form

Communication Tools Across Settings

• Nursing Home Capabilities Checklist
• Medication Reconciliation Worksheet
• Transfer forms both directions
• Data lists both directions
• Not about the forms
• Is about the relationships
• Can use as platform to start discussion about which elements nurses will use for warm hand off
Communication Tools
Nursing Home Capabilities List

• Excellent cross-community tool for informing discharge planners in any setting about services available at your facility

• Most value is when it is done by all facilities in a community and updated regularly

• Examples of current effectiveness in Pierce and Kitsap Counties
Care Paths & Change in Condition File Cards

Purpose

• Guide the assessment and management of common changes in resident status that result in acute care transfers

• Provide evidence-based assessment & management

• Insure timely assessments, communication with providers and acute care transfer as needed

• Manage in place when feasible and safe

• Improve the overall level of care for residents with changes in status
Care Paths & Change in Condition File Cards

When to Use
• Use as a reference and guide when assessing acute changes & determining when to contact primary provider
• Complete with SBAR Form & Progress Note

Who
• Licensed nursing staff
• Primary MD / NP / PA
• Interdisciplinary team for clinical policies & procedures
Care Paths

CARE PATH: Symptoms of Congestive Heart Failure (CHF)

Symptoms or Signs of CHF in a resident with known CHF or Risk Factors for CHF:
- Unrelieved shortness of breath or new shortness of breath at rest
- Unrelieved or new chest pain
- Wheezing or chest tightness at rest
- Inability to sleep without sitting up
- Inability to stand without severe dizziness or light headedness
- Weight gain of > 5 lbs. in 3 days
- Worsening edema

Take Vital Signs:
- Temperature
- BP, Pulse
- Apical heart rate
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

Vital Sign Criteria (Any Met?):
- Temp > 102°F (> 38.9°C)
- Apical heart rate > 100 or < 50?
- Respiratory rate > 28/min?
- BP < 90 systolic?

YES → Notify MD/NP/PA Immediately
Care Paths

- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Fever
- GI Symptoms – nausea, vomiting, diarrhea
- Shortness of Breath
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI
Advance Care Planning

“A process of communication about anticipated medical choices throughout the adult lifespan, focused on patient goals and values”

*Should be imbedded into everyday operations in the nursing facility
In order to make a difference, we must change our focus away from forms and toward work systems

- Proactive communication about stages of illness and progressive frailty
- Anticipate complications
- Use values to set goals
- Use goals to make decisions
- Offer specific alternatives
Advance Care Planning Tools

• Advance Care Planning Communication Guide
• Advance Care Planning Tracking Tool
• Comfort Order Set
• Educational Information
  Risks and Benefits of Hospitalization
  Decision Making Vignettes on CPR and Enteral Feeding
Advance Care Planning Tools

- Identifying Residents to Consider for Palliative Care & Hospice – Pocket Card
- Communication Guides – File Cards
- Comfort Care Order Set – File Cards
- Educational Information (for residents & family members)
- Tracking Tool
Advance Care Planning Tools

Purpose
- Guide conversations about EOL, advance directives and comfort / palliative care
- Communicate effectively with residents & family members
- Provide residents with comfort and dignity measures
- Assure residents receive level of care consistent with their wishes
- Increase staff dialogue about EOL care, advance directives and comfort / palliative care
Which Tools Have You Seen?
Summary and Recommendations

• Meet with local hospitals and other post-acute settings at least quarterly to discuss trends to identify areas of focus

• Engage in open dialog regarding admitting assessment findings and diagnosis to allow facilities to review through their Quality Improvement Program

• Agree upon standardized tools to improve care transitions between health care settings

• Develop mutually agreed upon protocols reacted to trends to reduce risk factors for avoidable rehospitalization

• Learn from others and Celebrate successes!
Effective Communication

• It is not just about the forms or tools… it is about the connections

• Receivers need to be aware of what the form or document includes

• Goal is to have receiver use the information

• Poor communications = poor outcomes
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