INTERACT IV Overview

Interventions to Reduce Acute Care Transfers

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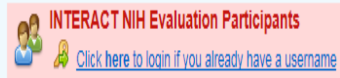
What is INTERACT?

INTERACT (**Interventions** to **Reduce Acute Care Transfers**) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.



Jocelyn Montgomery RN
Director of Clinical Affairs
California Association of Health Facilities

What is INTERACT IV? And how can it help?

INTERACT is a quality improvement program designed to improve the care of nursing home residents with acute changes in condition

In a 6 month study of SNFs in 3 states, hospital readmissions were reduced by 17% post INTERACT implementation

INTERACT is a Quality Improvement Program

"A lot of facilities are saying they are implementing the INTERACT program but they are sporadically using the tools – NOT using the quality improvement approach of INTERACT"

Dr. Joe Ouslander, lead developer of the INTERACT Program

INTERACT Institute, Florida, January 8, 2013

INTERACT III to INTERACT IV

Version 4.0 Tools have been improved based on ongoing user feedback, and to facilitate incorporation into electronic health records and other forms of health information technology

- Specifically changes made to
  - SBAR
  - Decision Support Tools
  - Stop and Watch
  - Advanced Care Planning Tracking Sheet
  - Quality Improvement Audit tool based on review of over 5,000 tools

How does INTERACT help?

To help to safely reduce hospital readmissions by:

Preventing conditions from becoming severe enough to require hospitalization through early identification and assessment of changes in the residents' conditions.

How does INTERACT help?

To help to safely reduce hospital readmissions by:

Managing some conditions in the nursing home without transfer when this is feasible and safe.

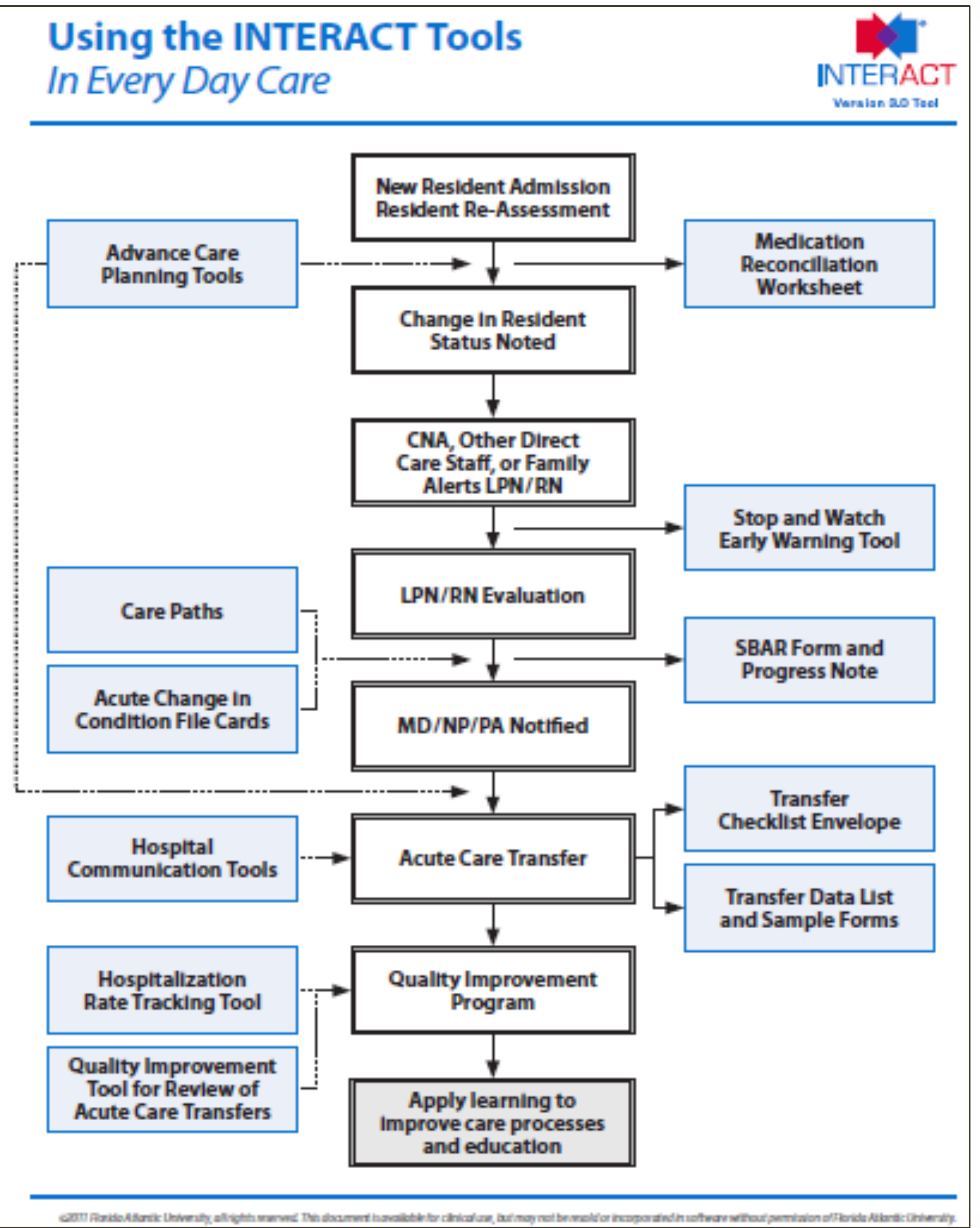
How does INTERACT help?

To help to safely reduce hospital readmissions by:

Improving advanced care planning and the use of palliative care plans when appropriate as an alternative to hospitalizations for some residents.

INTERACT TOOLS
Basically Three Types

- Communication Tools – Between staff, between care settings, between staff and resident/family
- Clinical Decision Making Tools or Care Paths
- Advance Care Planning



Using the INTERACT Tools
In Every Day Care
INTERACT
Version 3.0 Tool
New Resident Admission
Resident Re-Assessment
Advance Care Planning Tools
Medication Reconciliation Worksheet
Change in Resident Status Noted
CNA, Other Direct Care Staff, or Family Alerts LPN/RN
Stop and Watch Early Warning Tool
LPN/RN Evaluation
Care Paths
Acute Change in Condition File Cards
SBAR Form and Progress Note
MD/NP/PA Notified
Transfer Checklist Envelope
Hospital Communication Tools
Acute Care Transfer
Transfer Data List and Sample Forms
Hospitalization Rate Tracking Tool
Quality Improvement Program
Quality Improvement Tool for Review of Acute Care Transfers
Apply learning to improve care processes and education
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Hospital Communication Tools

Engaging Hospitals in Your Program

Keys to Engaging Your Local Hospitals

1. **Transitions in care require two partners.** Although there are numerous process improvements that INTERACT facilities can implement to improve care and reduce acute care transfers, safely and effectively sending patients to the hospital and receiving patients from the hospital are fundamental to improving transitional care. Hospital discharges to post-acute care (PAC) are very important and high-risk transitions in care setting. By definition, an effective transition requires the active participation of both a sending provider and a receiving provider.

2. **The best 'sending' to the acute care setting is only meaningful if the receiver uses the information.** The INTERACT III Tools include a sample **NH-Hospital Transform Form**, and a **Transfer Document Checklist** that can be printed on or taped to an envelope to help guide best-practice with complete NH-hospital transitional care information. INTERACT facilities should invest effort in ensuring that high quality information is transferred to the hospital. You will want to establish a partnership with hospital leadership to ensure that information you send is used to inform and improve care.

3. **INTERACT facilities should stand ready to accept the patient back to the facility and avoid a hospitalization, if safe and appropriate.** On occasion, a NH clinician will transfer a resident for tests and evaluation, but the clinician and the NH would be willing to accept the patient back following the evaluation when safe and appropriate. This represents a practice change for many hospitals and Emergency Rooms (ERs). Specific dialog about your NH capabilities will benefit your INTERACT goals. In addition, ERs should be encouraged to keep the INTERACT III **NH Capabilities List** readily available to consult in these situations.

4. **INTERACT facilities can influence improved methods of communication and transitioning patients from hospital to NH.** INTERACT facilities may note when using the INTERACT III **Quality Improvement Tool** for review of acute care transfers that early returns to acute care are often a result of poor hand-offs or missing information regarding the hospital clinical course. Hospital-NH partnerships to improve information and hand-off practices will benefit patients, hospitals, and post-acute care facilities. INTERACT III tools include a **Hospital to Post-Acute Care Data List** and **Sample Form** to help achieve this goal.

5. **INTERACT facilities will demonstrate their value-added in an increasingly competitive post-acute care business environment.** Improving care and reducing readmissions and other preventable hospital transfers will not only benefit your

Hospital Communication Tools

Nursing Home Capabilities List

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility ______________________________

Address ______________________________

Tel (________) ____________________ **Key Contact** ____________________

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N

Hospital Communication Tools
Hospital to SNF Transfer Forms

Hospital to Post-Acute Care Transfer Form

INTERACT®
Version 3.0 Tool

A. Patient Information
Name
DOB ______/______/______ Gender: ☐ M ☐ F
Language: ☐ English ☐ Other
Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other

B. Family/Caregiver/Proxy Contact
Family/Caregiver Name
Tel (______)
Healthcare Proxy/Guardian Name *(if different)*
Tel (______)

C. Advance Directives/Goals of Care
☐ Full Code ☐ DNR ☐ DNI (Do Not Intubate)
☐ DNH (Do Not Hospitalize) ☐ No Artificial Feeding ☐ Comfort Care
☐ Hospice Care
☐ Other *(specify)*
Were goals of care discussed during this hospitalization? ☐ No ☐ Yes *(specify)*
Patient decision making capacity? ☐ Capable of making decisions
☐ Requires proxy

D. Transferring Hospital Information
Hospital
Unit
Discharging RN
Tel (______)
Discharging MD
Tel/Page (______)
Date of Admission to Hospital ______/

E. Post-Acute Care Information
Transfered to ______ Tel
Nurse to Nurse verbal report? ☐ No ☐ Yes *(specify to whom)*

F. Hospital Physician Care Team Information
Primary Care Physician *(or Hospitalist)* ______ Tel
Specialist ______ Specialty ______ Tel
Specialist ______ Specialty ______ Tel

G. Key Clinical Information
Vital Signs Time Taken ______ Pain Rating ______ ☐ N/A Pain Site
Temp ______ BP ______ HR ______ RR ______ O2 Sat
Mental Status ☐ Alert ☐ Disoriented, follows commands ☐ Disoriented, cannot follow commands
Diagnoses Primary Discharge Diagnosis

Hospital to Post-Acute Care Transfer Form *(cont'd)*

INTERACT
Version 3.0 Tool

K. Nursing Care

Physical and Sensory Function
Ambulation ☐ Independent ☐ With Assistance ☐ With Assistive Device ☐ Not Ambulatory
Weight Bearing ☐ Full ☐ Partial L / R ☐ None L / R
Transfer ☐ Self ☐ 1-Person Assist ☐ 2-Person Assist
Sensory Function Sight: ☐ Normal ☐ Impaired ☐ Blind Hearing: ☐ Normal ☐ Impaired ☐ Deaf
Devices ☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutches
☐ Prosthesis ☐ Glasses ☐ Contacts ☐ Dentures
☐ Hearing Aid L / R
Continence ☐ Continent ☐ Bladder Incontinent ☐ Catheter Date inserted ______/______/______
Reason for catheter: ☐ Retention ☐ Skin protection ☐ Other *(specify)*
☐ Bowel Incontinent ☐ Ostomy ☐ Date of last BM ______/______/______

Nutrition and Hydration
Diet ______ Consistency ______ Free Water Restriction ______
Eating Instructions ☐ Self ☐ With Assistance ☐ Difficulty Swallowing (☐ *Attach speech therapy recommendations if available*)
Tube Feeding ☐ G-tube ☐ J-tube ☐ Date inserted ______/______/______ Free Water Bolus ______cc every______hrs
☐ Tube feed product ______ Rate: ______cc/h Duration______h/day

Treatments and Therapeutic Devices
☐ PICC ☐ Portacath Date inserted ______/______/______ *(Please attach imaging report confirming placement)*
Cardiac ☐ Pacemaker ☐ ICD ☐ Other *(specify)*
Respiratory ☐ CPAP ☐ BiPAP ☐ O2 ______ L ☐ prn ☐ continuous ☐ Suction ☐ Trach size ______

Therapies *(please attach assessment/recommendations)*
☐ PT ☐ OT ☐ Speech ☐ Respiratory ☐ Dialysis

Skin Care
☐ No skin breakdown ☐ Pressure ulcer: Stage ______ Location ______ ☐ 2nd Pressure ulcer: Stage ______ Location ______
☐ Other wounds *(specify)*

Risks and Precautions *(check all that apply)*
☐ Fall ☐ Delirium ☐ Agitation ☐ Aggression ☐ Unescorted exiting ☐ Aspiration ☐ Other ______
Precautions

Infection Control Issues
Infection/Colonization ☐ MRSA ☐ VRE ☐ C.difficle ☐ ESBL ☐ Norovirus ☐ Flu/respiratory

WHAT ELSE IS NEW?

Interventions to Reduce Acute Care Transfers

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- INTERACT Version 4.0 Tools For Nursing Homes
- INTERACT Version 3.0 Tools For Nursing Homes — (Authorized printed INTERACT materials are available for your convenience, for more information **click here**.)
- INTERACT Version 1.0 Tools For Assisted Living
- INTERACT Version 1.0 Tools For Home Health Care
- INTERACT Version 1.0 Tools For ACOs and Health Systems **Under Development** — (if you have a Username and Password for pilot testing these Tools **click here**)

Thank You

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INTERACT Website – Free tools
http://interact2.net/index.aspx