Spreading INTERACT® Practices Across the Continuum

Through Skilled Nursing, Assisted Living, Home Health and Homes With Services

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Learning Objectives

Following this presentation, the participant will:

1. Understand the paradigm changes taking place in the American health system
2. Recognize the importance of post-acute care (PAC) providers in achieving quality care transitions and reducing avoidable hospital readmissions
3. Be able to define the triple aim of CMS to improve the quality of health care for older adults.
4. Understand the various innovative care models for improving care transitions, with particular attention to INTERACT

Speaker Disclosure

Dr. O'Neil is a full-time employee and shareholder of Brookdale Senior Living.

Disclaimer Re:
CMS Health Care Innovations Award

- The project described was supported by Grant Number 1C1CMS331037 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

- The contents of this presentation are solely the responsibility of the author and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

Geriatrics is a TEAM Sport!

It’s a lot easier if we pull together!

Evolution of Accountable Care

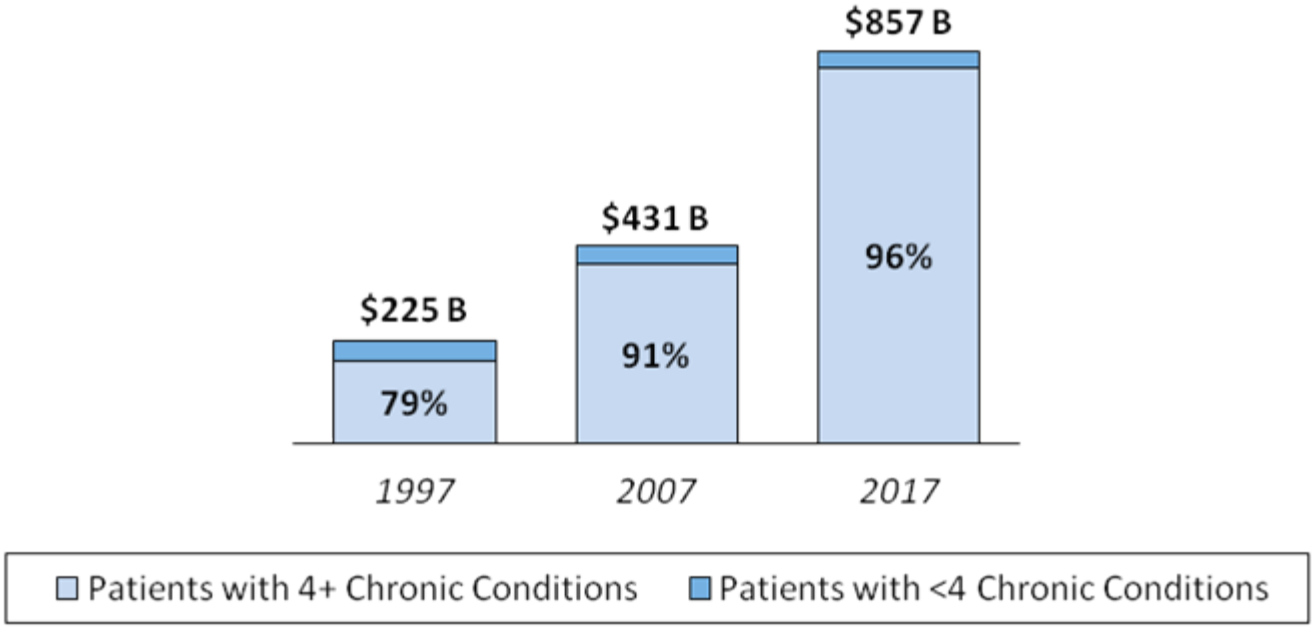
Year	Milestones
2010	Affordable Care Act (ACA) enacted
2011	Center for Medicare Innovation Medicare Shared Savings Program
2012	Hospital readmission penalties Independence at Home Demonstration
2013	Bundled Payment Pilots New Medicare Tax Passive income Tax Excise tax on medical devices
2014	Health benefits exchanges Individual, employer mandate Independent Payment Advisory Board begins submitting recommendations
2015	Payment adjustments for hospital-acquired conditions
2016	Individual, employer penalties rise
2018	Excise tax on Cadillac health plans

Courtesy: Advisory Board Company

Payment Reform

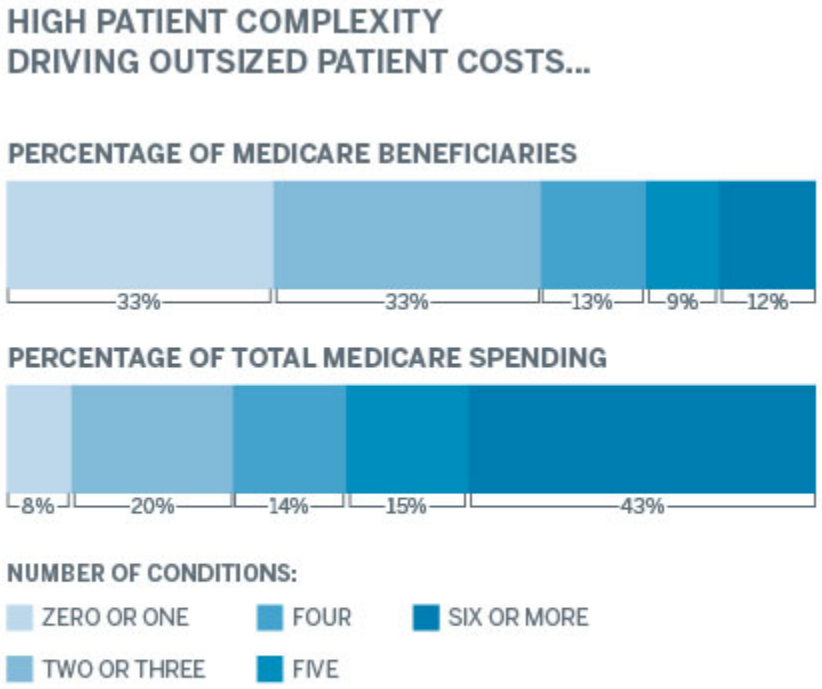
- Goal: tying 30% of traditional Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or Bundled Payment arrangements by the end of 2016
- Tying 50% of payments to these models by the end of 2018.
- HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.
- First time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

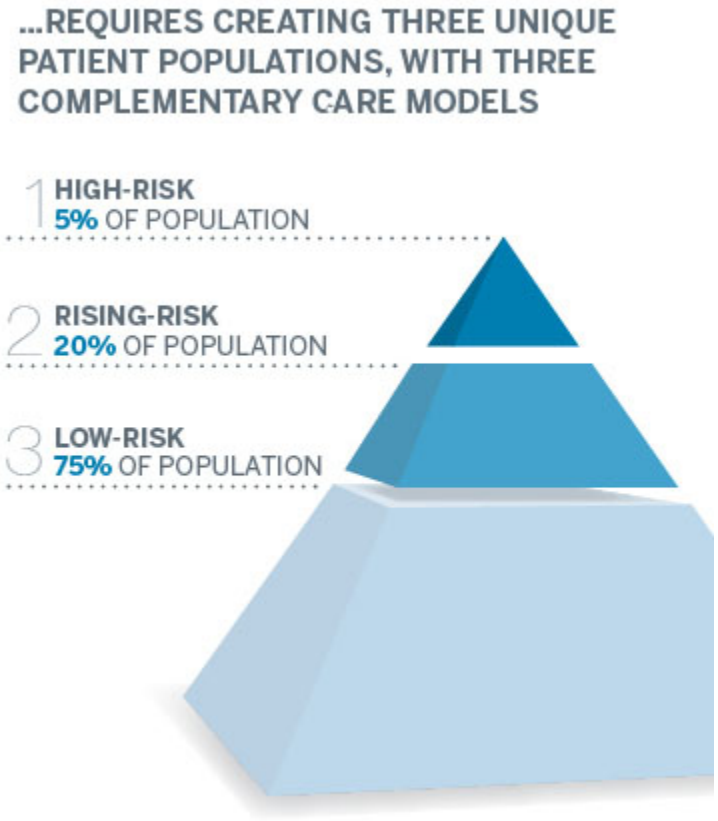
Complex Patients Spurring Medicare Cost Growth



Courtesy: Advisory Board Company

Prioritizing Population Health Interventions





Courtesy: Advisory Board Company

Triple Aim of CMS

- Better health of populations
- Better care for individuals while lowering the per-capita costs of care over time
- Improve the care experience

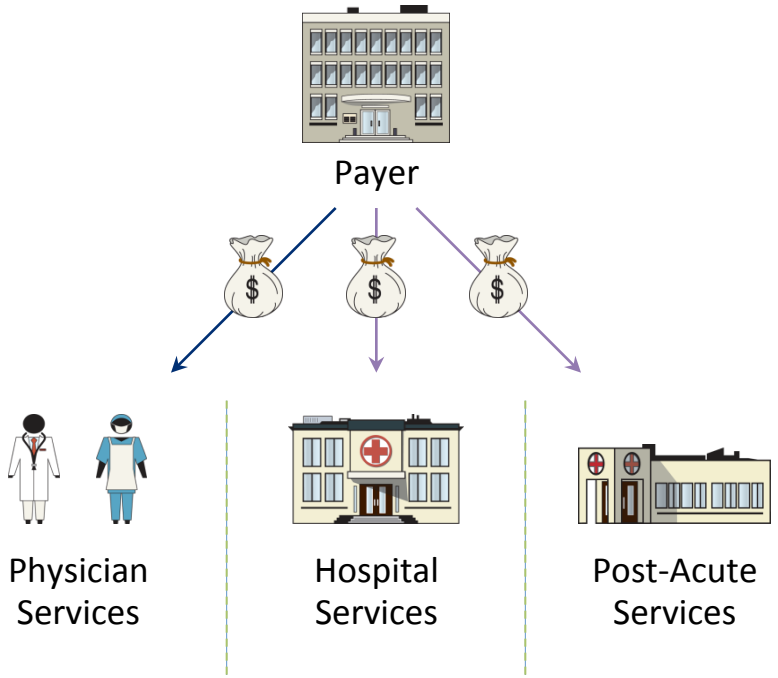
CMS Innovation Center

- The Innovation Center was established in 2011
- Purpose: to test “innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care” for those who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.

Bundled Payments Drive Delivery System Integration

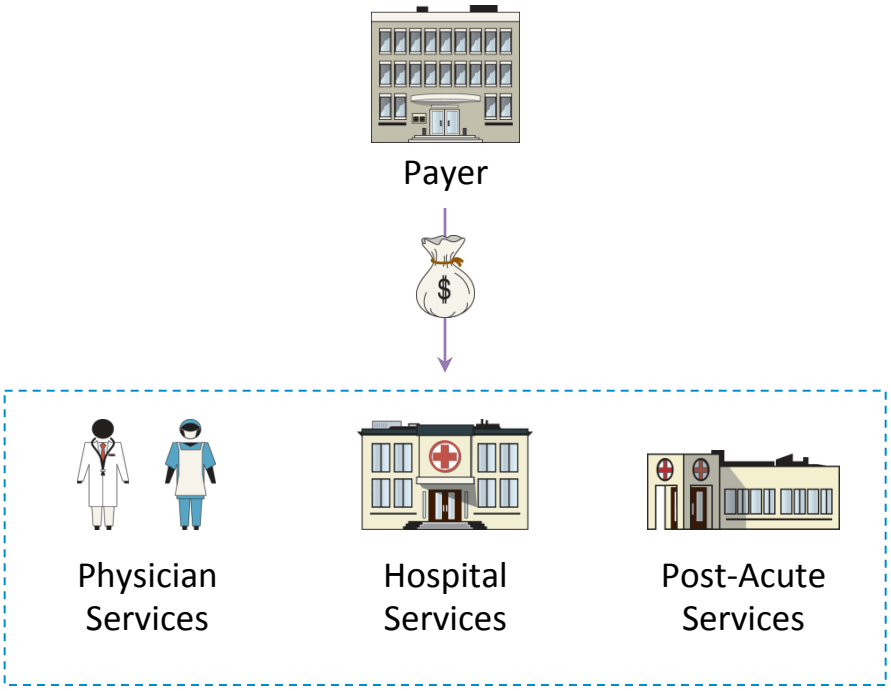
Fee-for-Service Environment

Individual Payments Reinforce Siloed Care Delivery



Bundled Payment Environment

Lump Sum Payments Drive Integration through Shared Accountability



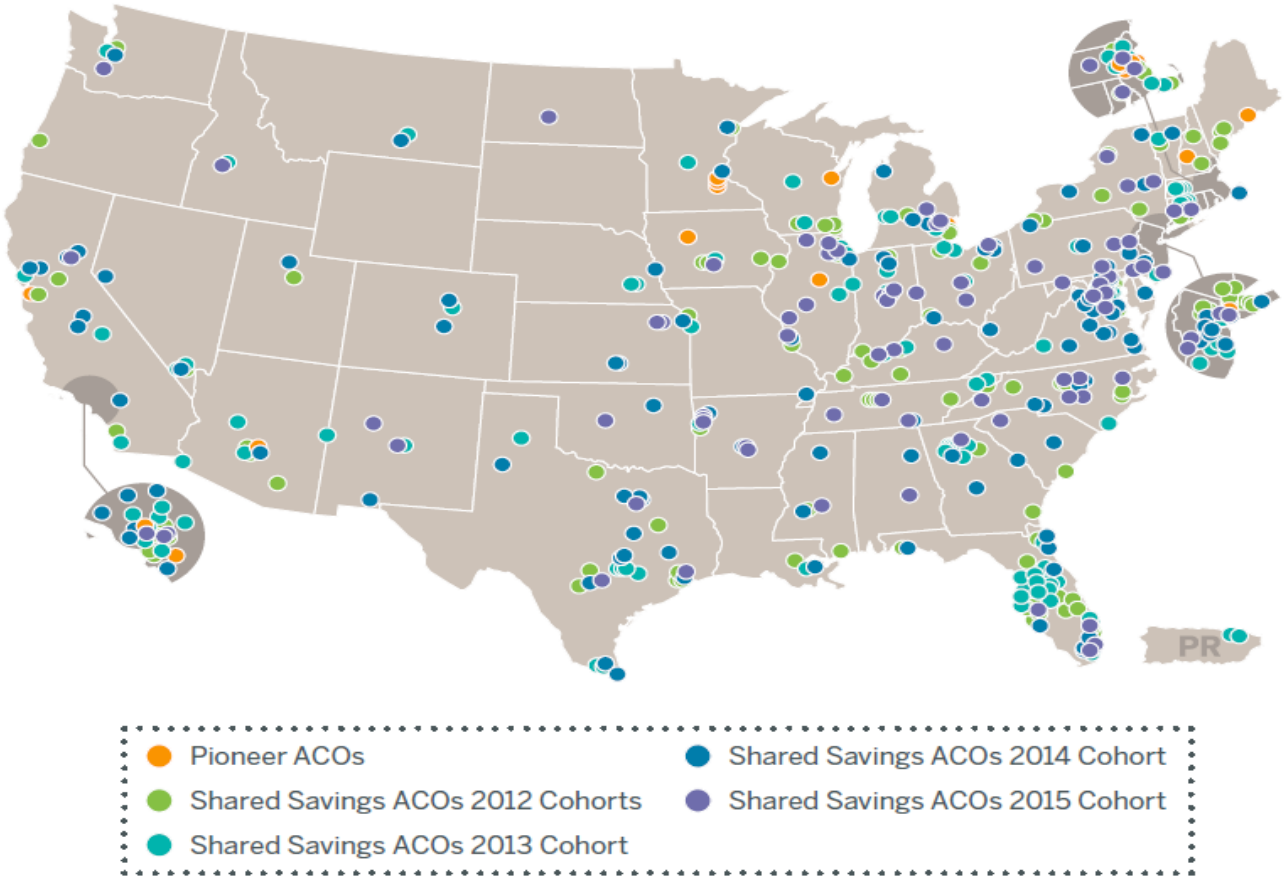
Source: Health Care Advisory Board interviews and analysis.

New Paradigm

- Reimbursement will no longer be based on volume of services
- Based on performance metrics:
  - Avoidable readmissions
  - Disease quality metrics
  - Health outcomes
  - Patient and family satisfaction

Where the Medicare ACOs Are

19 Pioneer and 405 Shared Savings Program ACOs[1] as of January 2015



1 Accountable Care Organization.

Courtesy: Advisory Board Company

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

Transitional Care

"Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location."

Source: AGS Position Statement, 2002

Communication

The single biggest problem with communication is the illusion that it has taken place.

-George Bernard Shaw

Why Focus on Care Transitions?

- 20% of Medicare beneficiaries readmitted within 30 days
- Negative physical, emotional, psychological impact
- Costs Medicare billions of dollars[1]
  - $26 billion annually
  - $17.5 billion on in-patient spending
- Avoidable hospitalizations/readmissions a key strategy
  - 25-42% of readmissions are avoidable[2]

1. Jordan Rau. Medicare Revises Hospitals' Readmissions Penalties, Kaiser Health News. Oct. 2, 2012.

2. Long-Term Quality Alliance. Improving Care Transitions: how quality improvement organizations and innovative communities can work together to reduce hospitalizations among at-risk populations. June 2012.

CMS Special Study in Georgia
Expert Ratings of Potentially Avoidable Hospitalizations

Based review of 200 hospitalizations from 20 NHs

	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	**69%**	**31%**
Other	**65%**	**35%**
HIGH Hospitalization Rate Homes	**75%**	**25%**
LOW Hospitalization Rate Homes	**59%**	**41%**
TOTAL	**68%**	**32%**

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

Major Problem Areas

- Acute change in condition
- Care transitions
- Medication management

AMDA Conference, 2006

Poor Transitions and ADEs

- ADEs are responsible for 5% to 28% of acute geriatric hospital admissions
- ADEs incidence: 26/1000 hospital beds
- In nursing homes, $1.33 spent on ADEs for every $1.00 spent on medications
- 350,000 ADEs in NHs each year
- Annual cost of ADEs in NHs is $7.6 billion

Impact on Hospitals

- More than 2000 hospitals have received readmission penalties
- Penalties: >$280 million
- “Reputation Penalty”: Hospital Compare website

Ineffective Transitions

- Wrong treatment
- Delay in diagnosis
- Severe adverse events
- Patient complaints
- Litigation
- Increased healthcare costs
- Increased length of stay

Source: Australian Council for Safety and Quality in Health Care. Clinical hand-over and Patient Safety literature Review Report. March 2005.

Hospital Challenges

- Lack of control over PAC setting
- Gathering data on quality metrics and outcomes
- Collaboration with PAC providers that address hospital needs
- Limiting PAC networks to quality providers

CEO/CFO

- 78 million boomers turning 65
- Where are my margins?
  - CV procedures, hip/knee replacements
- Margins on frail older adults with unplanned hospitalizations flat or negative
- Rx: Keep my beds for the high-margin cases and find alternative quality locations for others
- CMO: The hospital can be a dangerous place for an older adult (e.g., delirium, HAIs, falls, pressure ulcers)

Post-Acute Care

- 40% of Medicare beneficiaries admitted to post-acute and long-term care settings
- Skilled nursing, assisted living, and home care become critical to reducing re-hospitalizations
- Need to build collaborative relationships in the communities we serve
- Need to empower patients AND families

Co-Opetition

Co-Opetition = Cooperation + Competition

Spotlight on Transitions

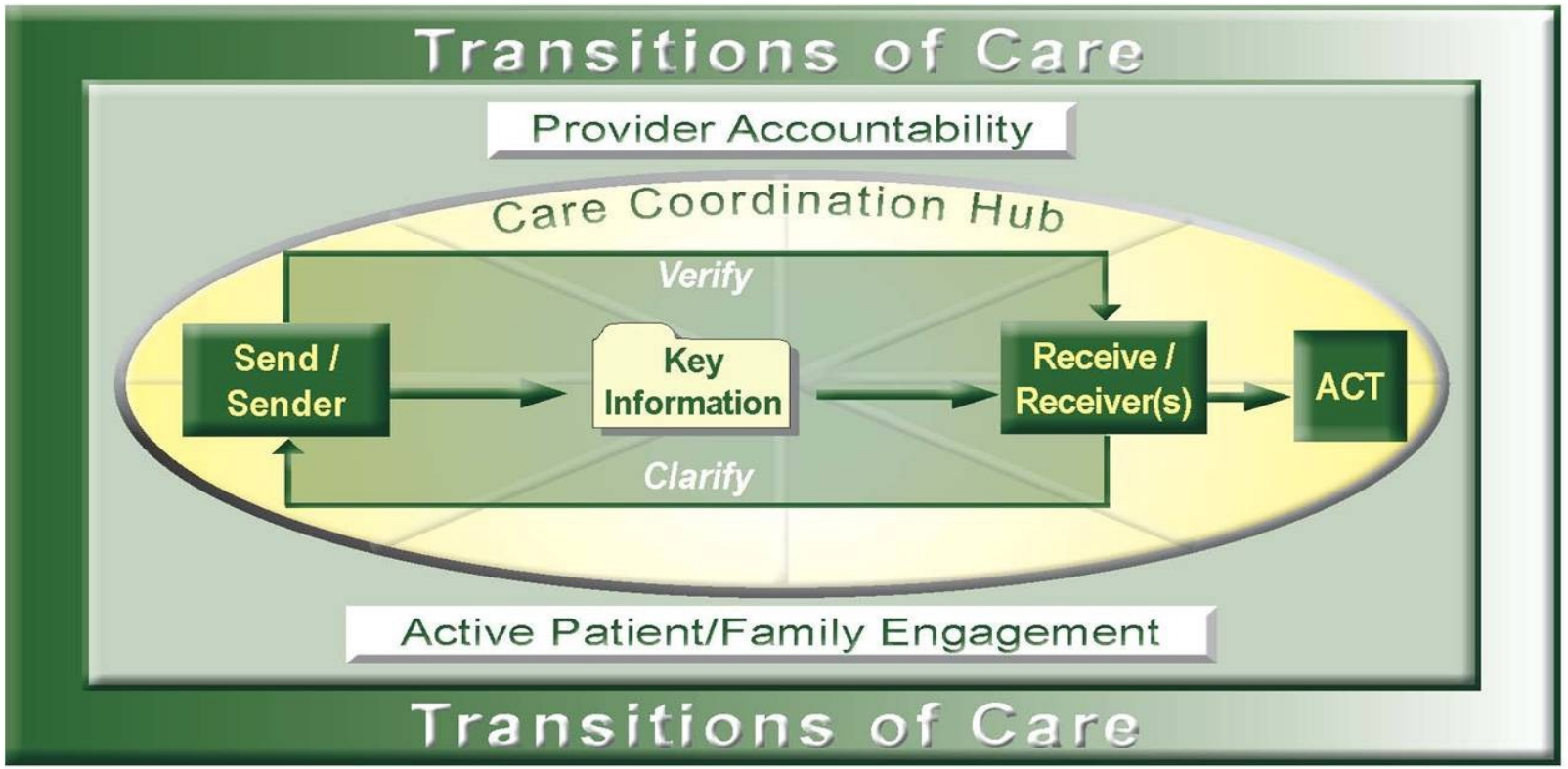
- Government: Quality Improvement Organization 9th Scope of Work
- Joint Commission: including care transitions in accreditation requirements and in 2009 Patient Safety Goals
- ASIM: Step Up to the Plate Alliance—safe, effective, patient-centered, timely, efficient, equitable service
- AGS: Position statement on care transitions
- AMA: passed a resolution submitted by AMDA
- Society of Hospital Medicine: Project BOOST
- AMDA: Created a Clinical Practice Guideline
- National Transitions of Care Coalition

Communication

The single biggest problem with communication is the illusion that it has taken place.

-George Bernard Shaw

Conceptual Model



Source: National Transitions of Care Coalition

Overview of Transition Programs

INTERACT is One of Several Evidence-Based Care Transitions Interventions

"BOOST"
(***Better Outcomes for Older Adults Through Safe Transitions***)
http://www.hospitalmedicine.org

"Project RED"
(Re-Engineered Discharge)
https://www.bu.edu/fammed/projectred

- Enhanced hospital discharge planning

"Bridge Model"
http://www.transitionalcare.org/the-bridge-model

- Social Worker coordinating Aging Resource Center Services at hospital discharge

"Care Transition Program"
http://www.caretransitions.org

- Transition coach
- Trained volunteers
- Empowered patients and caregivers

High Quality Care Transitions for

Older Adults & Caregivers

"Transitional Care Model"
http://www.transitionalcare.info/index.html

- APN coordinates care during and after discharge
- Home, SNF, and clinic visits

"POLST" (or "MOLST")
(***Physician (or Medical) Orders For life Sustaining Treatment***)
http://www.ohsu.edu/polst

- Advance care planning

"INTERACT"
(***Interventions to Reduce Acute Care Transfers***)
http://interact2.net

- Communication Tools, Care Paths, Advance Care Planning Tools, and QI tools for nursing homes and SNFs

Slide used with permission of Dr. Joseph Ouslander

- Can help safely reduce hospital transfers by:

1. Preventing conditions from becoming severe enough to require hospitalization through early identification and assessment of changes in resident condition
2. Managing some conditions in the NH without transfer when this is feasible and safe
3. Improving advance care planning and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents

INTERACT: A Quality Improvement Program

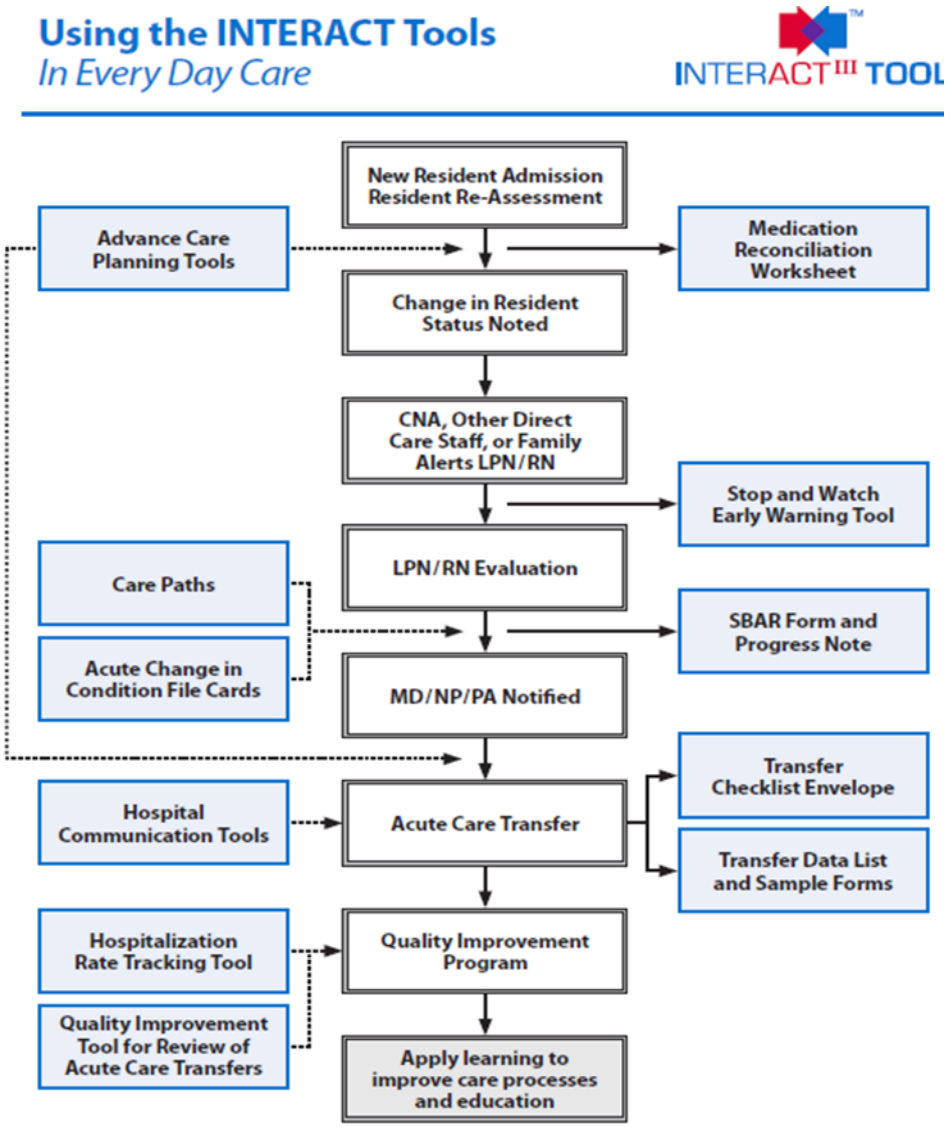
Quality Improvement Tools

Communication Tools

Decision Support Tools

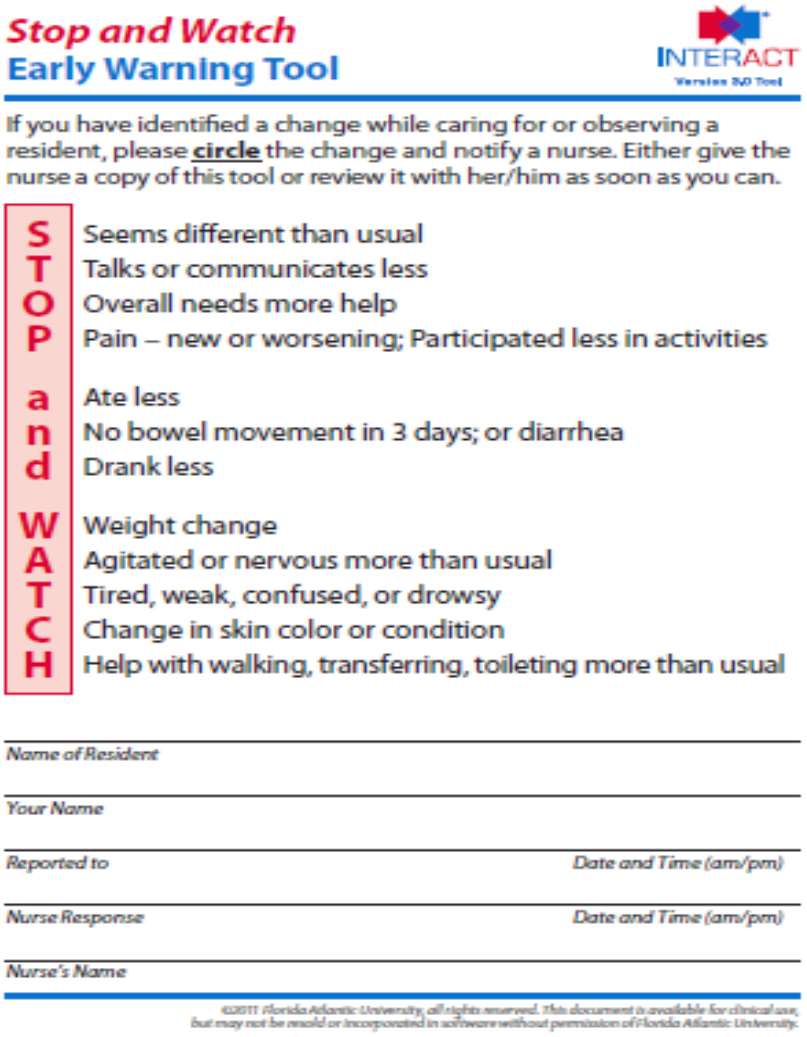
Advance Care Planning Tools

Checklists



www.interact.fau.edu

Stop and Watch



Stop and Watch
Early Warning Tool

INTERACT
Version IV.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

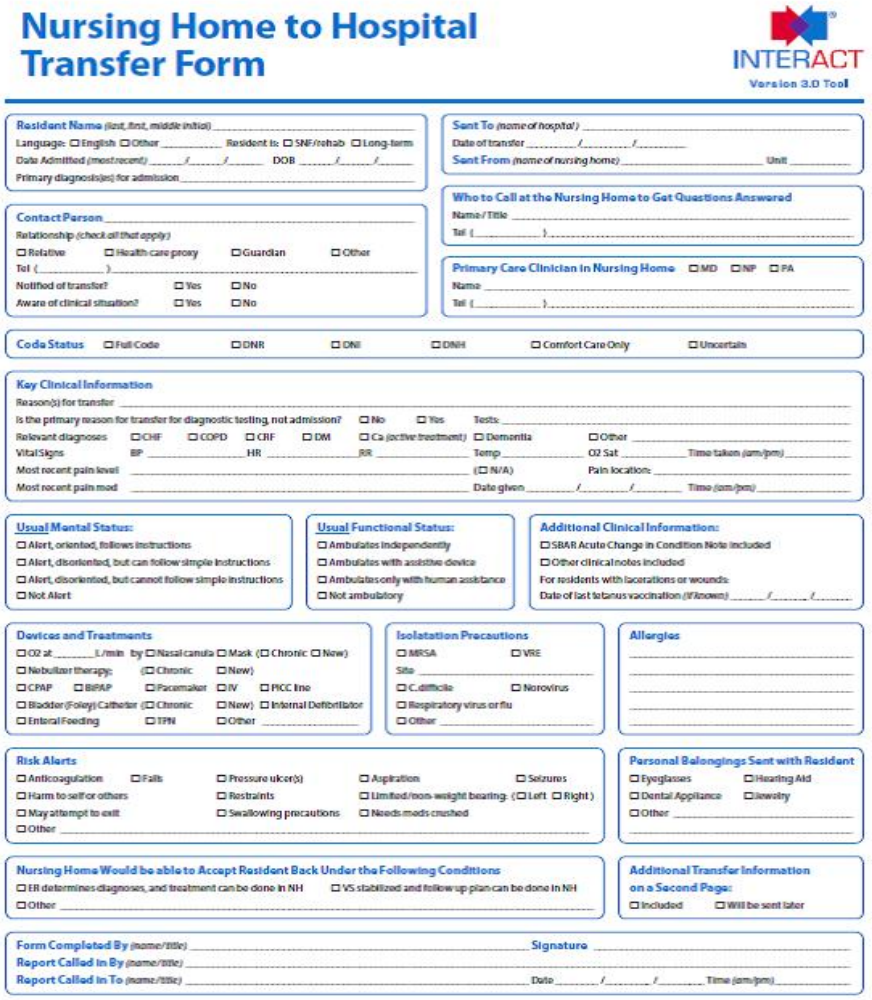
Nurse Response *Date and Time (am/pm)*

Nurse's Name

Interacting with Hospitals

The NH to Hospital Transfer Form has two pages.

- The first page has information that ED physicians and nurses identified as essential to make decisions about the resident
- Consistent and clear clinical terms are used



Nursing Home to Hospital Transfer Form

INTERACT Version 3.0 Tool

Resident Name (last, first, middle initial) _____
Language: ☐ English ☐ Other _____ Resident is: ☐ SNF/rehab ☐ Long-term
Date Admitted (most recent) ____/____/____ DOB ____/____/____
Primary diagnosis(es) for admission _____

Sent To (name of hospital) _____
Date of transfer ____/____/____
Sent From (name of nursing home) _____ Unit _____

Who to Call at the Nursing Home to Get Questions Answered
Name/Title _____
Tel (____) _____

Contact Person _____
Relationship (check all that apply)
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (____) _____
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

Primary Care Clinician in Nursing Home ☐ MD ☐ NP ☐ PA
Name _____
Tel (____) _____

Code Status ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain

Key Clinical Information
Reason(s) for transfer _____
Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____
Relevant diagnoses ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ Ca (active treatment) ☐ Dementia ☐ Other _____
Vital Signs BP _____ HR _____ RR _____ Temp _____ O2 Sat _____ Time taken (am/pm) _____
Most recent pain level _____ (☐ N/A) Pain location: _____
Most recent pain med _____ Date given ____/____/____ Time (am/pm) _____

Usual Mental Status:
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert

Usual Functional Status:
☐ Ambulates independently
☐ Ambulates with assistive device
☐ Ambulates only with human assistance
☐ Not ambulatory

Additional Clinical Information:
☐ SBAR Acute Change in Condition Note included
☐ Other clinical notes included
For residents with lacerations or wounds:
Date of last tetanus vaccination (if known) ____/____/____

Devices and Treatments
☐ O2 at _____ L/min by ☐ Nasal canula ☐ Mask (☐ Chronic ☐ New)
☐ Nebulizer therapy: (☐ Chronic ☐ New)
☐ CPAP ☐ BiPAP ☐ Pacemaker ☐ IV ☐ PICC line
☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator
☐ Enteral Feeding ☐ TPN ☐ Other _____

Isolation Precautions
☐ MRSA ☐ VRE
Site _____
☐ C.difficile ☐ Norovirus
☐ Respiratory virus or flu
☐ Other _____

Allergies
_____
_____
_____
_____
_____

Risk Alerts
☐ Anticoagulation ☐ Falls ☐ Pressure ulcer(s) ☐ Aspiration ☐ Seizures
☐ Harm to self or others ☐ Restraints ☐ Limited/non-weight bearing (☐ Left ☐ Right)
☐ May attempt to exit ☐ Swallowing precautions ☐ Needs meds crushed
☐ Other _____

Personal Belongings Sent with Resident
☐ Eyeglasses ☐ Hearing Aid
☐ Dental Appliance ☐ Jewelry
☐ Other _____

Nursing Home Would be able to Accept Resident Back Under the Following Conditions
☐ ER determines diagnoses, and treatment can be done in NH ☐ VS stabilized and follow up plan can be done in NH
☐ Other _____

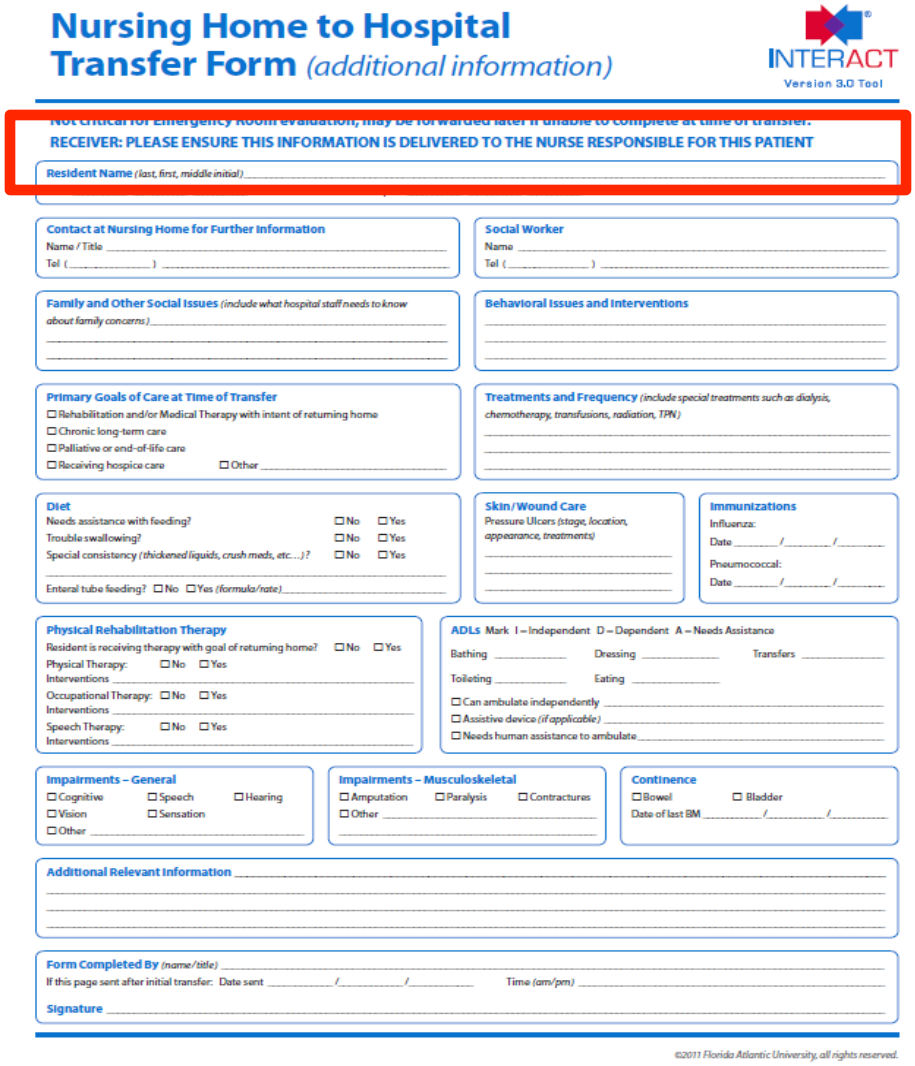
Additional Transfer Information on a Second Page:
☐ Included ☐ Will be sent later

Form Completed By (name/title) _____ **Signature** _____
Report Called In By (name/title) _____
Report Called In To (name/title) _____ Date ____/____/____ Time (am/pm) _____

Interacting with Hospitals

The NH to Hospital Transfer Form has two pages.

- The second page has additional information that will be helpful to inpatient teams, and can be sent within 24 hours if the resident is admitted.



Nursing Home to Hospital Transfer Form *(additional information)*

INTERACT Version 3.0 Tool

RECEIVER: PLEASE ENSURE THIS INFORMATION IS DELIVERED TO THE NURSE RESPONSIBLE FOR THIS PATIENT

Resident Name *(last, first, middle initial)*

Contact at Nursing Home for Further Information
Name / Title
Tel ( )

Social Worker
Name
Tel ( )

Family and Other Social Issues *(include what hospital staff needs to know about family concerns)*

Behavioral Issues and Interventions

Primary Goals of Care at Time of Transfer
☐ Rehabilitation and/or Medical Therapy with intent of returning home
☐ Chronic long-term care
☐ Palliative or end-of-life care
☐ Receiving hospice care ☐ Other

Treatments and Frequency *(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN)*

Diet
Needs assistance with feeding? ☐ No ☐ Yes
Trouble swallowing? ☐ No ☐ Yes
Special consistency *(thickened liquids, crush meds, etc…)*? ☐ No ☐ Yes
Enteral tube feeding? ☐ No ☐ Yes *(formula/rate)*

Skin / Wound Care
Pressure Ulcers *(stage, location, appearance, treatments)*

Immunizations
Influenza:
Date ___/___/___
Pneumococcal:
Date ___/___/___

Physical Rehabilitation Therapy
Resident is receiving therapy with goal of returning home? ☐ No ☐ Yes
Physical Therapy: ☐ No ☐ Yes
Interventions
Occupational Therapy: ☐ No ☐ Yes
Interventions
Speech Therapy: ☐ No ☐ Yes
Interventions

ADLs Mark I – Independent D – Dependent A – Needs Assistance
Bathing Dressing Transfers
Toileting Eating
☐ Can ambulate independently
☐ Assistive device *(if applicable)*
☐ Needs human assistance to ambulate

Impairments – General
☐ Cognitive ☐ Speech ☐ Hearing
☐ Vision ☐ Sensation
☐ Other

Impairments – Musculoskeletal
☐ Amputation ☐ Paralysis ☐ Contractures
☐ Other

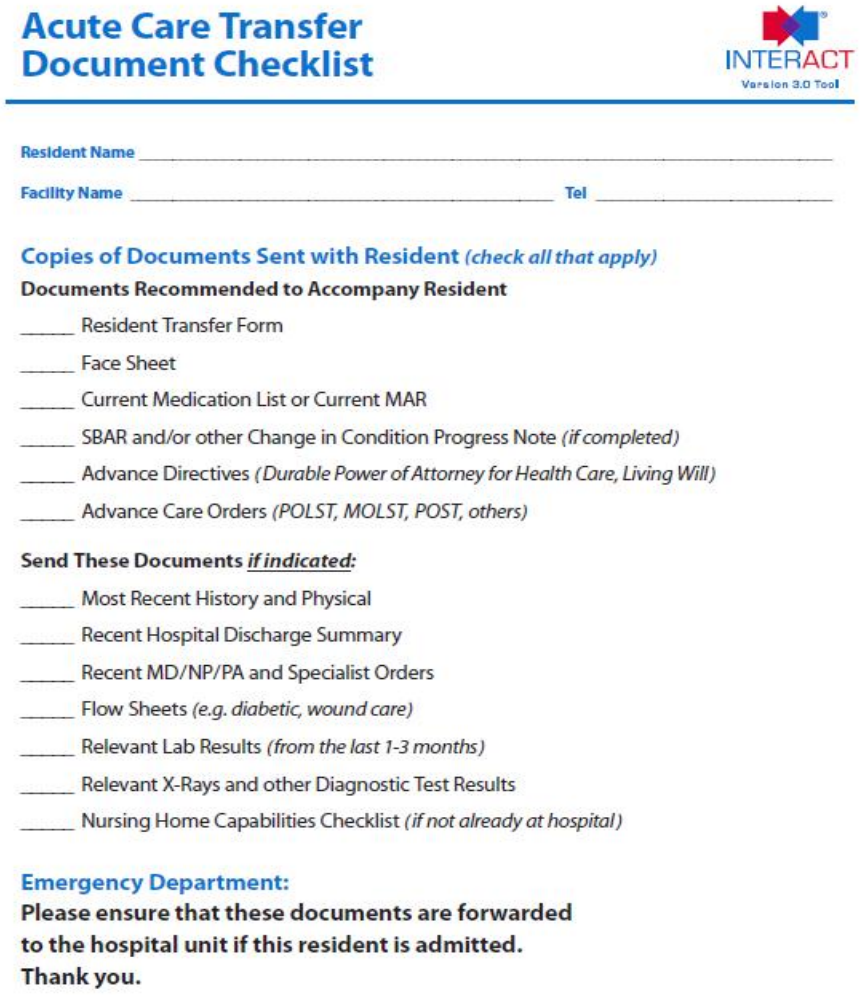
Continence
☐ Bowel ☐ Bladder
Date of last BM ___/___/___

Additional Relevant Information

Form Completed By *(name/title)*
If this page sent after initial transfer: Date sent ___/___/___ Time *(am/pm)*
Signature

Interacting with Hospitals

This **Transfer Checklist** can be printed or taped onto an envelope, and is meant to compliment the Transfer Form by indicating which documents are included with the Form



Acute Care Transfer Document Checklist

INTERACT Version 3.0 Tool

Resident Name _____

Facility Name _____ Tel _____

Copies of Documents Sent with Resident *(check all that apply)*

Documents Recommended to Accompany Resident

_____ Resident Transfer Form

_____ Face Sheet

_____ Current Medication List or Current MAR

_____ SBAR and/or other Change in Condition Progress Note *(if completed)*

_____ Advance Directives *(Durable Power of Attorney for Health Care, Living Will)*

_____ Advance Care Orders *(POLST, MOLST, POST, others)*

Send These Documents *if indicated*:

_____ Most Recent History and Physical

_____ Recent Hospital Discharge Summary

_____ Recent MD/NP/PA and Specialist Orders

_____ Flow Sheets *(e.g. diabetic, wound care)*

_____ Relevant Lab Results *(from the last 1-3 months)*

_____ Relevant X-Rays and other Diagnostic Test Results

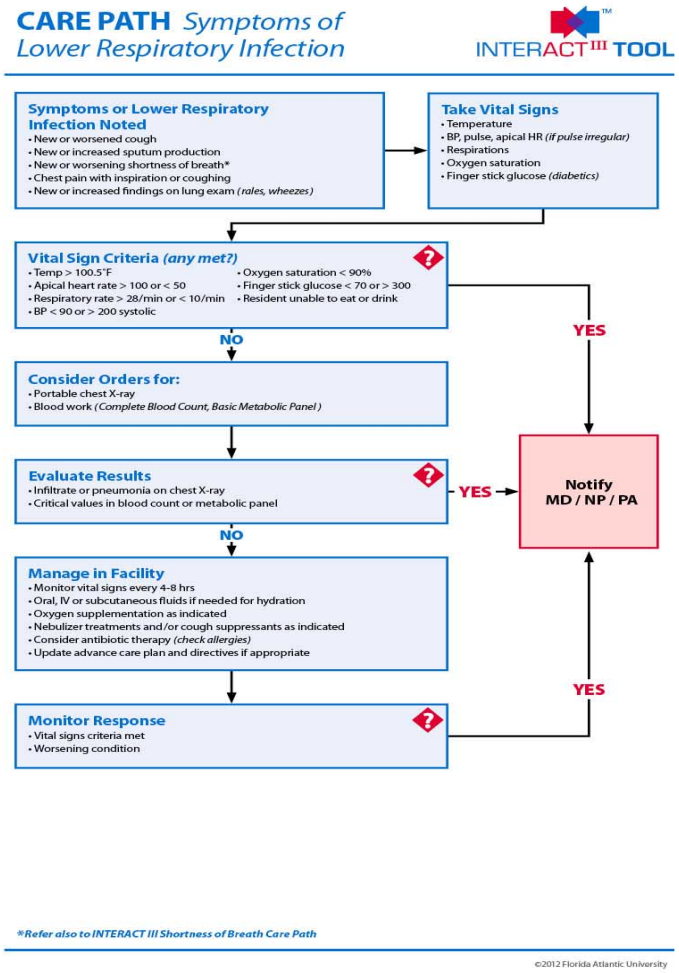
_____ Nursing Home Capabilities Checklist *(if not already at hospital)*

Emergency Department:

Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

INTERACT 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



Change in Condition File Cards

The INTERACT Change in Condition File Cards are meant to be visible and sit next to the phone for quick reference

INTERACT

Change in Condition: *When to report to the MD/NP/PA*

Immediate Notification

Any symptom, sign or apparent discomfort that is:

- Acute or Sudden in onset, and:
  - A Marked Change (*i.e. more severe*) in relation to usual symptoms and signs, or
  - Unrelieved by measures already prescribed

Non-Immediate Notification

- New or worsening symptoms that do not meet above criteria

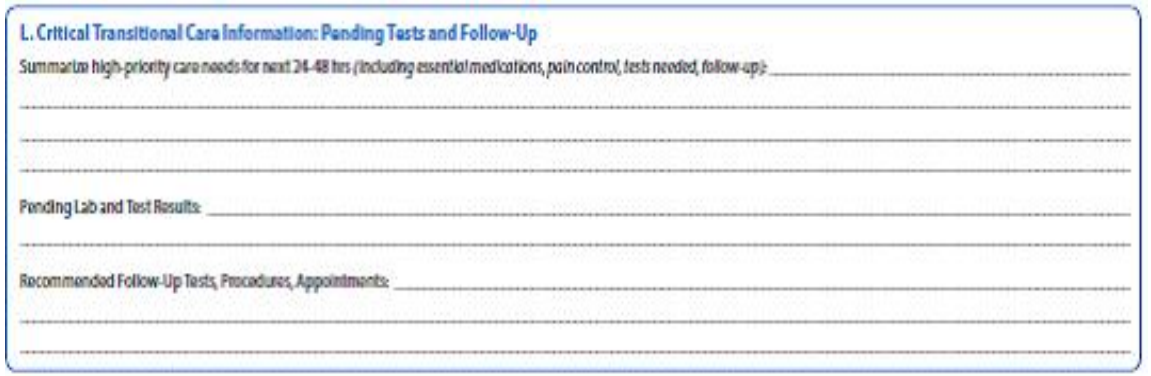
This guidance is adapted from: *AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting* 2003; and Ouslander, J, Osterweil, D, Morley, J. *Medical Care in the Nursing Home* McGraw-Hill, 1996

Interacting with Hospitals

Information Transfer From the Hospital

- The **Hospital to Post-Acute Care Transfer Form** highlights Critical Time Sensitive Information

- But, there is no substitute for a **warm handoff**.



L. Critical Transitional Care Information: Pending Tests and Follow-Up

Summarize high-priority care needs for next 24-48 hrs (including essential medications, pain control, tests needed, follow-up):

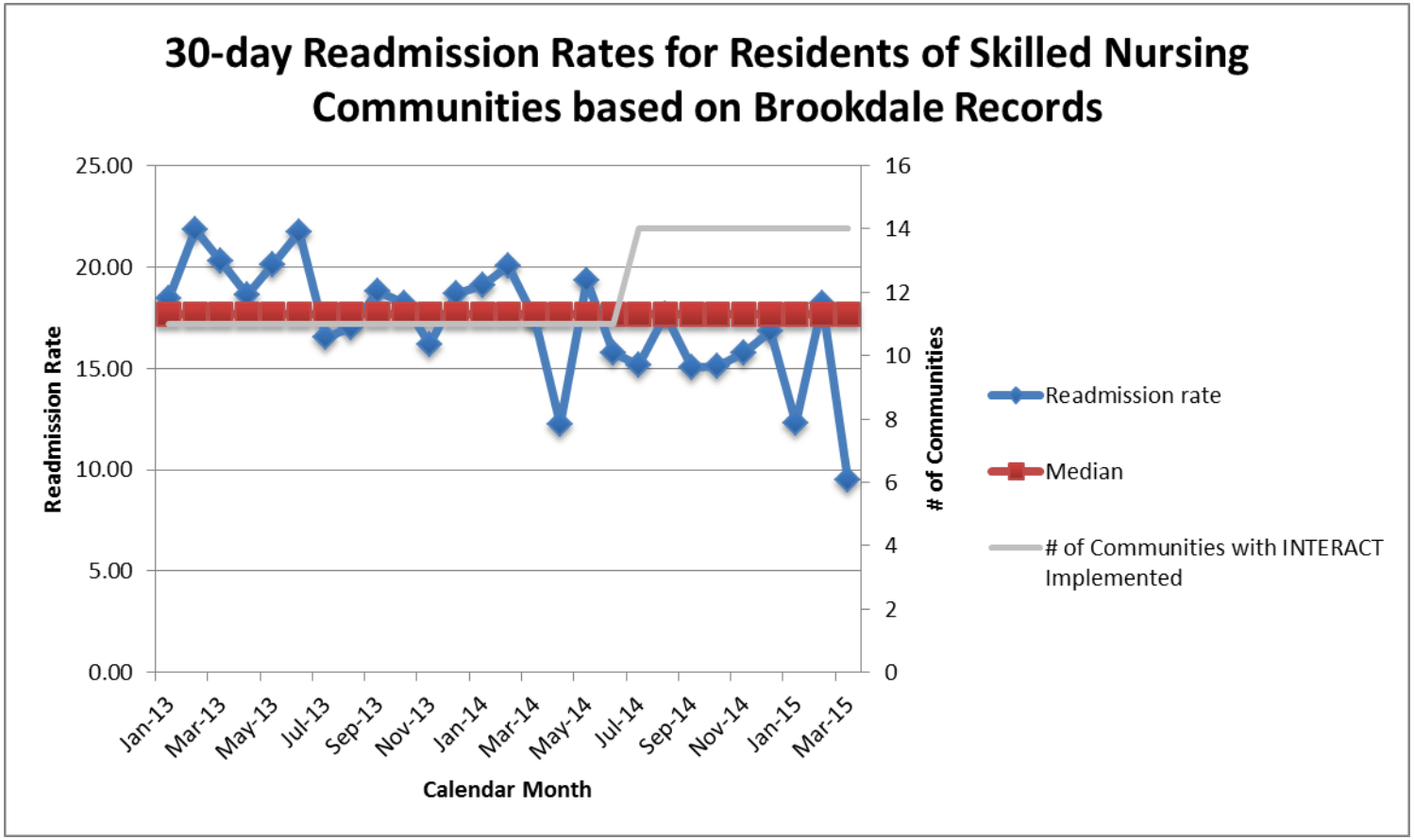
Pending Lab and Test Results:

Recommended Follow-Up Tests, Procedures, Appointments:

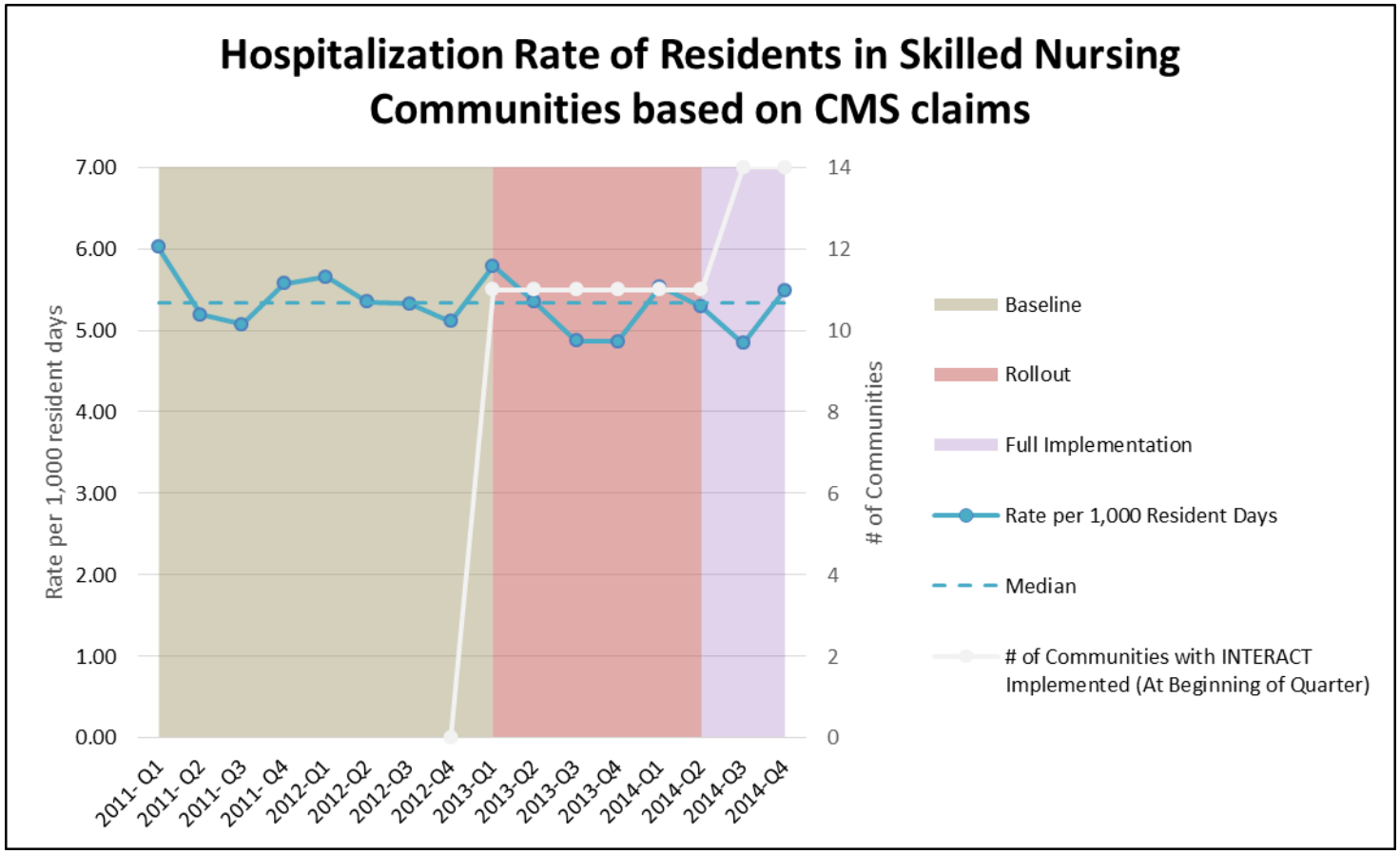
CMS Health Innovation Challenge Grant

- 3 Year Grant - Awarded July 1, 2012 to University of North Texas Health Science Center in partnership with Brookdale
- Goal: to revise and implement INTERACT Program in skilled nursing, assisted living, and home care settings
- 67 Brookdale Communities in Tampa Bay, Jacksonville, Dallas/ Ft. Worth, Houston, Austin, San Antonio, Kansas City, and Denver
- Program to be shared and disseminated
- Expected savings of more than $9 million

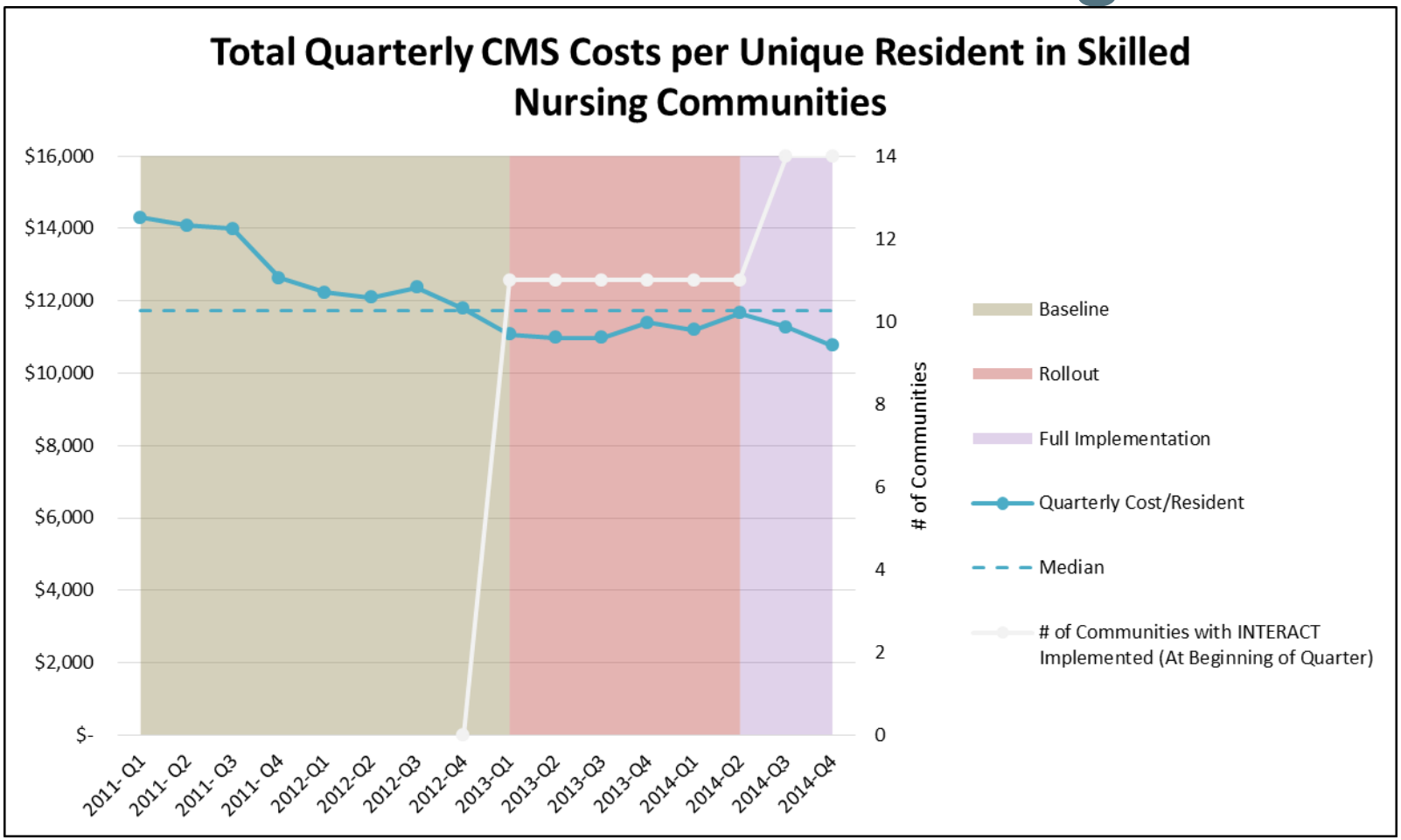
SNF 30-Day Readmission Rate



SNF Hospitalization Rate: CMS Claims



Cost of Care: Skilled Nursing



INTERACT-AL and INTERACT-HH

- Now available at www.interact.fau.edu
- Include:
  - Communication Tools
  - Quality Improvement Tools
  - Decision Support Tools
  - Advance Care Planning Tools

Case History

Madelyn O, 84 year old
Past history: hypertension, atrial fibrillation, CHF
Med: lisinopril, HCTZ, digoxin, warfarin

- Falls, fractures left hip
- Undergoes surgical repair
- Transferred to rehab. Warfarin held for prolonged INR

The Revolving Door

- After 2 week stay in rehab, transferred to assisted living
- Arrives with transfer papers, no discharge summary
- Med list does not include warfarin
- 1 week later, has sudden left-sided weakness and is transferred back to the hospital with an acute stroke.

QUESTION: Was this preventable or not?

Assisted Living Landscape

- Fastest growing segment of elder care
  - Over 31,000 ALFs
  - 971,900 beds

- Acuity level has increased*
  - 86% need assistance with taking meds
  - 72% with bathing
  - 57% with dressing
  - 41% with toileting
  - 36% with transferring
  - 23% with eating

Source: National Center for Health Statistics, 2010

INTERACT Assisted Living Version 1.0 Tools

- These are a modification of the ***INTERACT* Quality Improvement Program 3.0 Tools** based on feedback from an Assisted Living Facility (ALF) usability pilot-testing program.
- The majority of ALF participants reported *usability* of the tools
  - and experts in ALF care provided suggestions for improving the tools for use in every day care of residents.

Do you think this INTERACT AL is a useful tool?

Percentage of respondents agreeing that the tool is useful

Communication Tools	
SBAR Communication Form and Progress Note for RN/LPN/LVNs in AL/HH	70%
SBAR Communication Form and Progress Note for Caregiver in AL/HH	53%
Medication Reconciliation Worksheet for Post-Hospital Care	47%
Stop and Watch Early Warning Tool	88%

Percentage of respondents agreeing that the tool is useful

For Communication Between AL and Hospital	
Assisted Living Capabilities List	69%
AL to Hospital Transfer Form	61%
AL to Hospital Transfer Data List	48%
AL Acute Care Transfer Checklist	53%
Hospital To Post Acute Care Transfer Form	47%
Hospital To Post Acute Care Data List	37%

Final Assisted Living Pilot Site Ratings (N=33*) Response rate varies from 26-33 participants

Identifying Residents who may be Appropriate for Hospice or Palliative/Comfort Care Orders

INTERACT Version 3.0 Tool

I. Residents with Selected Diagnoses who may be Appropriate for Hospice

Congestive Heart Failure

- Symptoms of CHF at rest *(New York Heart Association class IV)*
- Serum sodium level < 134 mmol/L or creatinine level > 2.0 mg/dL due to poor cardiac output
- Intensive care unit admission for exacerbation

Chronic Obstructive Pulmonary Disease

- Cor pulmonale *(right-sided heart failure associated with COPD)*
- Intensive care unit admission for exacerbation
- New dependence in two activities of daily living (ADLs) due to COPD symptoms
- Chronic hypercapnia *(PaCO2 > 50 mm Hg)*

Dementia

- Dependence in all ADLs, language limited to just a few words, and inability to ambulate
- Acute hospitalization *(especially for pneumonia or hip fracture)*
- Difficulty swallowing with recurrent aspiration
- Has feeding tube due to dementia or swallowing difficulty related to dementia

Cancer

- Poor physical performance status as a result of cancer *(dependence in multiple ADLs)*
- Multiple tumor sites
- Metastatic cancer involving liver or brain
- Bowel obstruction due to cancer
- Pericardial effusion due to cancer

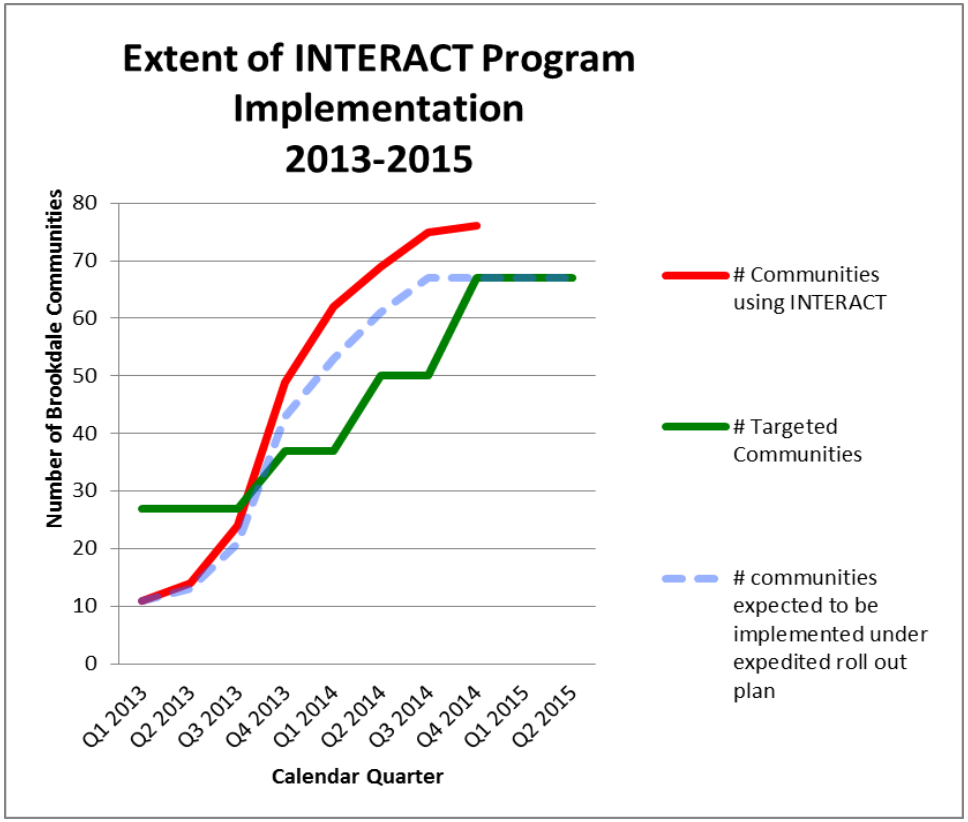
II. Residents at High Risk of Actively Dying who Should be Considered for Palliative or Comfort Care Orders *(if not already on Hospice)*

- Frequent Emergency Room visits and/or hospitalizations over the last 6 months
- Sudden, major decline in functional status with no identified reversible causes
- Primary diagnosis of metastatic cancer with chronic pain and/or poor ADL function, not on chemotherapy
- Semi-comatose or comatose state with no identified reversible causes
- Inability or difficulty taking oral medicines
- Minimal oral intake *(or receiving continuous or intermittent IV hydration)*
- Mottling of extremities related to poor oral intake or volume depletion

Pilot Sites Conclusions

- ALF tools are rated as very useful
- Highest ranked tools are Communication tools (SBAR and Stop and Watch)
- Decision support and Advance Care Planning tools were well received
- ALFs with Electronic records were more likely to complain the INTERACT forms duplicate work
- Staff indicated improvements but admitted it was work to implement
- Many pilot sites used communication forms but did not enact QI process for full use of all tools

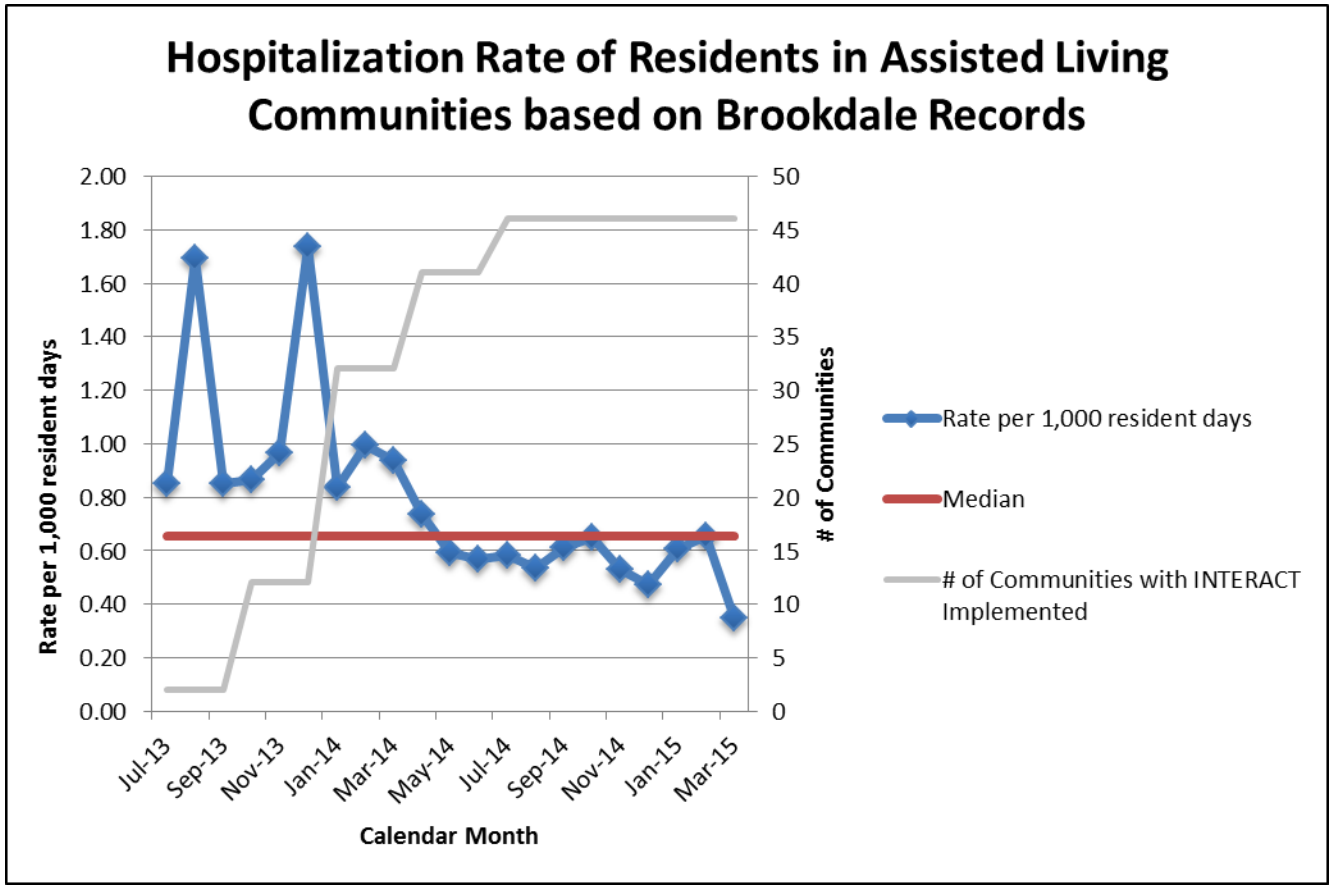
INTERACT Implementation



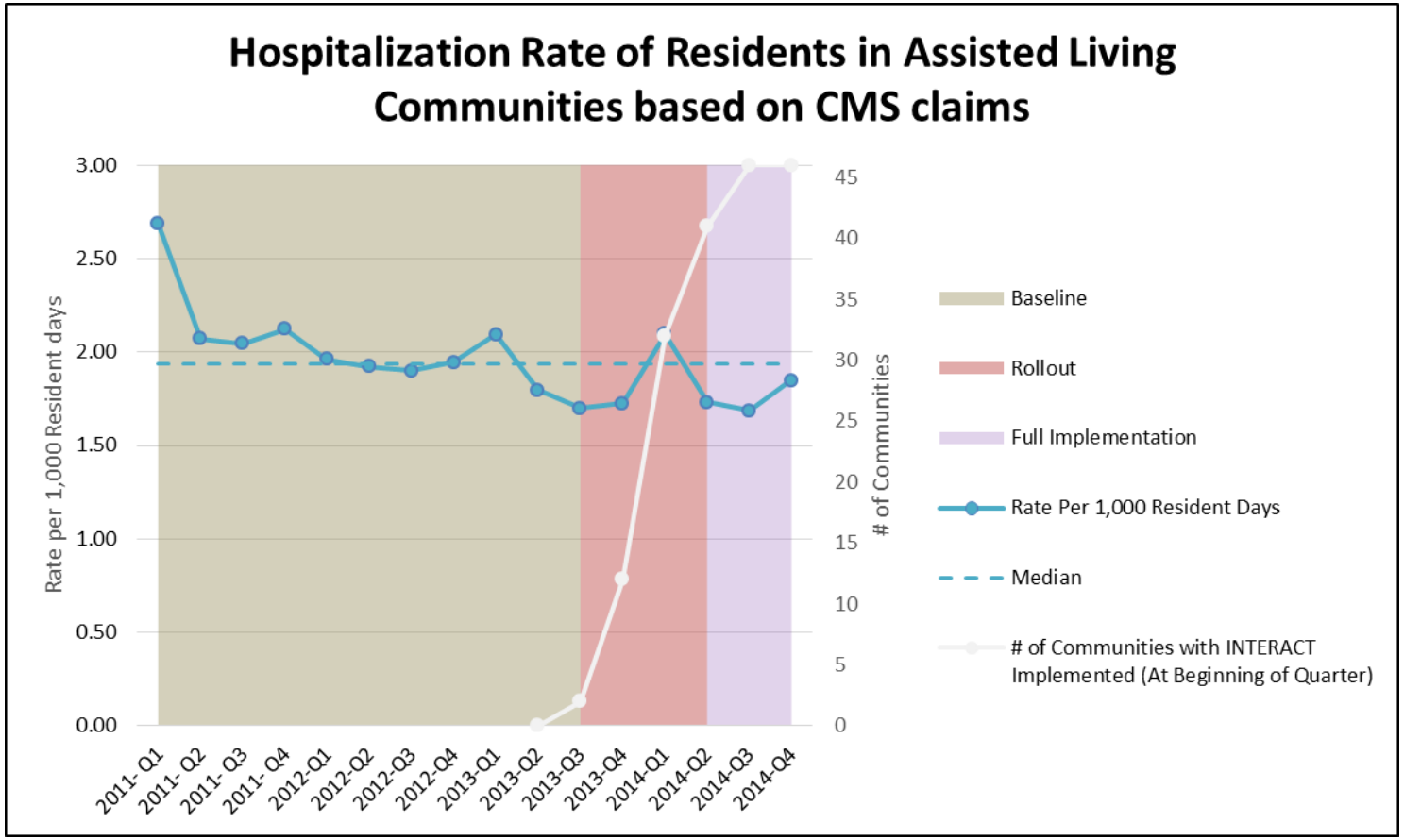
In God we trust; all others must bring data

-Edward Deming

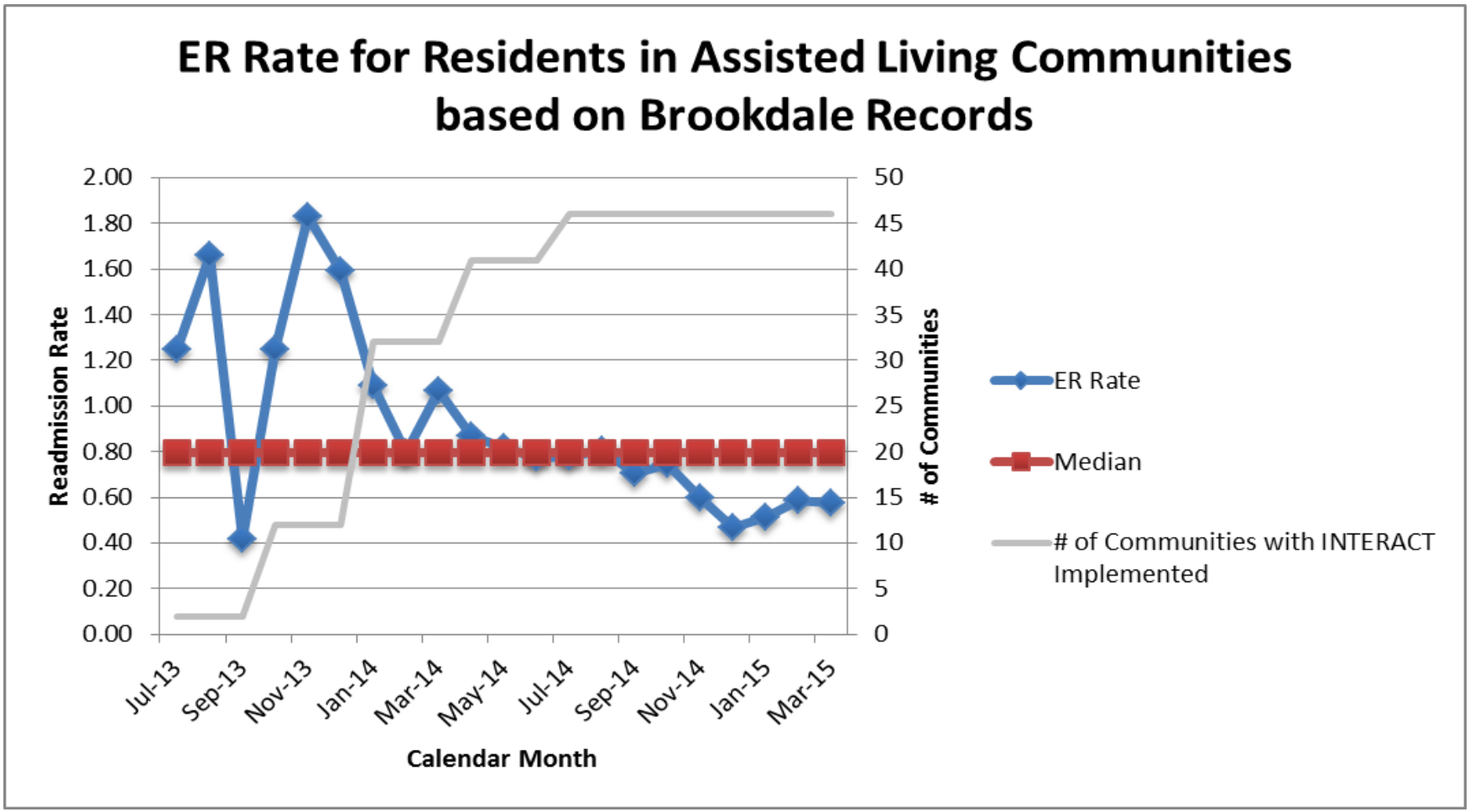
Assisted Living: Hospitalization Rate



AL Hospitalization Rate: CMS Claims



Emergency Room Transfer Rates



Engaging Hospitals

1. **Create** a list of all hospitals your facility sends patients to/or receives patients from.
2. **Identify** the 'readmissions champion' for each hospital.
3. **Host** or join a 'cross-continuum' or Community Care Transitions Working Group or Coalition.
4. **State** your facility's goals to reduce avoidable hospital transfers, admissions, and readmissions, and link that to the hospitals' goals in readmission reduction.
5. **Describe** the set of quality improvements underway in your facility through INTERACT and other initiatives.
6. **Ask** the hospital to be an active partner in your INTERACT improvements.

Engaging Hospitals in Your Program

INTERACT

Engaging Hospitals Checklist

1. **Create** a list of all hospitals your facility sends patients to or receives patients from.

2. **Identify** the 'readmissions champion' for each hospital. You can most easily discover who is leading the readmissions effort at local hospitals by reaching out to one of the leaders listed below. They will know who is the organizational lead for readmissions for example, the:
   a. Chief Quality Officer
   b. Chief Medical Officer
   c. Chief Nursing Officer
   d. Director of Case Management
   e. Director of Quality

3. **Host** or join a 'cross-continuum' or Community Care Transitions Working Group or Coalition. Start by inviting the hospitals in your area to your facility to see your capabilities first hand. Also, attend cross-continuum team meetings hosted by your local hospitals. It is optimal to meet in person to form and strengthen relationships, but start with one person and one phone call if needed.

4. **State** your facility's goals to reduce avoidable hospital transfers, admissions, and readmissions, and link that to the hospitals' goals in readmission reduction. Lead with a brief set of numbers:
   a. The average number of patients you receive from the hospital each month
   b. The current 30-day readmission rate among those patients
   c. Your facility's goal to reduce preventable and unnecessary hospital transfers

5. **Describe** the set of quality improvements underway in your facility through INTERACT and other initiatives.

6. **Ask** the hospital to be an active partner in your INTERACT improvements.
   a. Post the INTERACT® **NH Capabilities** List in the ER and at floor case manager workstations
   b. Educate ER staff and inpatient teams about relevant INTERACT forms and tools
   c. Encourage ER physicians to review your transfer forms and consider returning the resident to NH if safe and appropriate based on the **NH Capabilities Checklist**
   d. Develop a process to ensure INTERACT forms are sent from the ER to the patient care units
   e. Improve hand-off communication between hospital and NH using 'Warm Hand-Offs' (in-person communication)
   f. Engage in regular readmission reviews to identify improvement opportunities

Engaging With Hospitals: $V=\frac{Q+S}{\$}$

- Identify your champions and co-champions
- Share your capabilities
- Demonstrate your value with data
- Participate on transition teams and coalitions
- Determine projects to pursue
- Hardwire continuous quality improvement structure

Ensure Leadership Buy-in

- Create a feeling of urgency
- Build your team
- Have a clear vision
- Communicate for buy-in
- Empower action
- Create short-term wins
- Don’t let up
- Make changes stick

Source: Kotter JP, Leading Change

Impact: Acute and PAC Providers

- Strategic planning
- Identifies opportunities for synergistic alliances
- Increases care coordination with hospitals and communities
- Positions the PAC provider to be a viable hospital partner
- Aligns internal operations with ACA and hospital Initiatives

Project Impact: Medicare Population

Assist organizations in the development of processes that:

- Improve clinical post-acute care outcomes for Medicare population
- Decreases risk of inappropriate hospital readmissions and ER transfers
- Improves continuity of care from acute to post-acute care
- Reduce cost and health care expenditures through increased efficiency and operational capacity
- Provides methods to hold post-acute care and long-term care providers accountable for performance

Project Impact: Public Health

Addresses Accountable Care Act and Triple Aim Guidelines to:

- Improve Patient Experience
- Improve Quality of Healthcare
- Decrease Medical Cost

- Reduces:
  - Silos in Healthcare
  - Healthcare Expenditures
  - Medical Errors
- Increases Internal and External Accountability for PAC and LTC Providers
- Develops Relationships between Public Health and Senior Long-Term Healthcare Providers

What We Have Learned…

- Importance of Leadership & Communication
- Role of Champions/Co-Champions is critical
- Sustaining gains & training new staff
- Integrating QI/tools into the culture
- Opportunities with staff turnover
- Family/Caregiver education on INTERACT is important
- Advanced Care Planning discussions make a difference
- Involve all staff in quality improvement
- Critical role of the Transition Teams

Resources

- National Transitions of Care Coalition: www.ntocc.org
- Institute for Healthcare Improvement: www.ihi.org
- INTERACT QI Program: www.interact.fau.edu
- Care Transitions Program SM, University of Colorado (Eric Coleman, MD): www.caretransitions.org
- American Medical Director Association: Transitions of Care Clinical Practice Guideline at www.amda.com

“ Alone we can do so little;
together we can do so much.”

—Helen Keller

Questions?