INTERACT II™ in AHT

Executive Interventions to Prevent Hospital Readmissions

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Executive Summary

> "Studies have shown facilities using INTERACT II tools reduced acute care transfers 17-24%."
>
> *2011 Commonwealth Fund Project Results*

The Challenge

Cuts are coming to hospitals for high readmission rates…and they're soon coming to skilled nursing facilities. MedPAC laid it out clearly in March of 2012: "we recommend reducing payments to SNFs with relatively high rates of re-hospitalizations. Avoidable re-hospitalizations of SNF patients increase Medicare's spending, expose beneficiaries to additional disruptive care transitions, and can result in hospital-acquired infections or other adverse health consequences."[1]

The Takeaway

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of changes in resident condition. The goal: reduce unplanned readmissions. This briefing will define INTERACT II and outline the opportunity with integrated, paperless tools.

The Bottom Line

Studies have shown facilities using INTERACT II tools reduced acute care transfers 17-24%.[2] You can:

- Put a dent in avoidable readmissions with INTERACT II tools integrated in AHT (two now, more to come)
- Measure your success using Outcomes Reporting in AHT
- Put INTERACT II data at the fingertips of all clinical staff in real time for smarter, faster decision making
- Enjoy the upside of efficient, paperless processes
- Market your success to local hospitals feeding you census

With Outcomes Reporting in American HealthTech, providers with great rates can show their competitive edge in reducing hospital readmissions and continuous quality improvement using data-driven proof.

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[1] http://www.medpac.gov/documents/Mar12_EntireReport.pdf

[2] 2011 Commonwealth Fund Project Results

Why Readmissions Matter

Approximately 23.5% of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted within 30 days at a cost to Medicare of $4.34 billion in 2006.[3] A substantial proportion of hospitalizations of nursing home residents may be preventable. Significant research in this area demonstrates that the inability to recognize and/or respond appropriately to changes in the resident's condition led to transfers to acute care hospitals.[4]

Quality of Life

Transfers between care settings take an incredible toll on residents and their families: both physically and emotionally. Hospitals geared toward treating the masses often lack specialized programs to meet the needs of frail, elderly patients. Skilled facilities in contrast have deep understanding of the complex conditions elders face: including depression, confusion, muscle weaknesses, catheters, falls, skin breakdown, and so much more. Keeping residents in settings where their needs are intimately understood by experts –at attractive price points to taxpayers—is a top national priority.

Financial Impact

Acute care transfers result in shortened Average Length of Stay and the opportunity cost of lost Medicare revenue. For example, in a 100 bed facility, with an average Medicare rate of $425 PPD the loss of 5 more Medicare beds and 20 patient days per month, shaves nearly half a million in revenue off the top line.

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[3] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2826971/

[44] Ouslander et al, 2000

INTERACT II

Definition

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute changes in resident condition. The program includes education and tools that are used throughout the life cycle of a resident's stay in skilled nursing – from admission to discharge. The goal is to reduce unplanned transfers to a hospital. INTERACT II programs have been paper-based…until now.

Results

Facilities nationwide are seeing promising results in readmission reductions with INTERACT II programs. Studies have shown facilities using the tools reduced acute care transfers 17-24%[5].

History

"The INTERACT Program and tools were 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 Center for Medicare and Medicaid Services. The current version of the INTERACT Program was designed by the INTERACT team, with input from many direct care providers and national experts in projects based at Florida Atlantic University and supported by The Commonwealth Fund."[6]

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[5] 2011 Commonwealth Fund Project Results

[6] http://www.interact2.net/

INTERACT II Tools “101”

American HealthTech is incorporating INTERACT II tools directly into workflows within the software. First up: Stop and Watch as well as the SBAR tool are integrated and paperless in AHT, with more tools to come.

Tools	*Use*
Early Warning Tool “Stop and Watch”	Certified Nursing Assistants: ▪ Regular evaluation of and recognition of changes in residents ▪ Report changes to licensed nurses ***Now integrated in American HealthTech***
SBAR Communication Tool and Progress Note	All nursing home licensed nursing staff: ▪ Evaluation and communication of acute changes to MD, NP, PA ▪ Documentation of evaluation and communications ***Now integrated in American HealthTech***
Change in Condition Cards	All nursing home licensed nursing staff: ▪ At nurses’ station for quick reference ▪ Guides when to communicate changes to MD, NP, and/or PA ▪ Laminate file cards for a file box (or spiral bound) at the nurses’ station or med cart
Resident Transfer Form	All nursing home licensed nursing staff and emergency room staff: ▪ Standardized form completed at the time of acute care transfer
Acute Care Transfer Envelope with Checklist	All nursing home staff at time of transferring residents to acute care: ▪ Complete the checklist on the front of the envelope ▪ Place copies of all documents in the envelope ▪ Send with the resident to the acute care facility
Quality Improvement Tool For Review of Acute Care Transfers	Nursing home staff involved in quality improvement or performance improvement committees; medical director, medical staff: ▪ Used for facility-based quality improvement focused on reducing the number of avoidable acute care transfers.

“Stop and Watch”

INTERACT II

EARLY WARNING TOOL

“Stop and Watch”

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident ______________________________

Seems different than usual
T alks or communicates less than usual
Overall needs more help than usual
Participated in activities less than usual

Ate less than usual (Not because of dislike of food)
N
Drank less than usual

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

Staff______________________________________
Reported to ________________________________
Date _____ / _____ / _______ Time _____________

Because front-line staff spend time with residents constantly, they are invaluable contributors to the readmission prevention process. While they may not have the skill level to assess a condition, they certainly can help identify behaviors and subtle changes:

- “Jim didn’t talk as much as usual today…” *(Housekeeper)*
- “Jim seemed to need a little more help than normal…” *(CNA)*
- “Jim’s skin color wasn’t normal today…” *(LPN)*
- “Jim is always at bingo but not for the past two days…” *(Activities)*
- “Jim just doesn’t look right today.” *(CNA)*

These are such valuable snippets of information for busy nurses; and just about any role can contribute. Bits and pieces added together might be just enough information that signals a nurse to do a more thorough assessment that leads to a physician-guided intervention, and ultimately a prevented hospital visit.

Now in American HealthTech

Stop and Watch is now integrated into Smart Charting in American HealthTech.

Situation, Background, Assessment and Request (SBAR)

SBAR-type instruments have been around for many years across the healthcare spectrum. In hospital settings, for example, they are used to notify higher-level decision makers about a change in patient condition.

Value of SBAR

In skilled care settings, the SBAR tool helps nurses get organized in order to communicate succinctly and effectively with a physician or nurse practitioner. The answers nurses provide in the tool help physicians and nurse practitioners differentiate between patients that need to be transferred to higher levels of care vs. patients that can stay and benefit from targeted skilled care—in a systematic, organized way.

In American HealthTech, the SBAR is now integrated. By answering simple, intuitive questions, a nurse can complete an SBAR in minutes.

Components

- ***Situation***. What are we calling about? When did it start? Describes the change in condition.
- ***Background***. Great for a physician who doesn't know a patient. Describes diagnoses, vitals, pain, mobility, and much more.
- ***Assessment*** (RN) or Appearance (LPN). Nurses give their valuable input as to what they think is going on and assist the physician in decision-making.
- ***Request.*** What is the next step? Can be either what the nurse suggests or what the doctor orders.

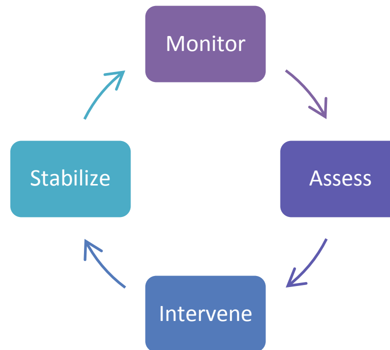
Now in American HealthTech

SBAR is now integrated in American HealthTech.

Care Paths

Care Paths, along with other INTERACT II tools, will be integrated into American HealthTech in coming releases.

A Care Path offers guidance to nurses about what to monitor and suggested interventions. It's basically a closed loop cycle:



Because nurses tend to work in silos, care paths are vital tools for team coordination. The inputs of many team members feed care paths that are then put at the fingertips of those who can intervene. Automation that aggregates an ongoing 360° picture of a resident across many disciplines results in more timely and accurate care interventions.

The top 6 common reasons that residents return to the hospital include:

- Dehydration
- Fever
- Mental status change
- Congestive heart failure
- Lower respiratory infections
- Urinary tract infection

About the Author

Maria's 28 years of experience in nursing and elder care includes administration, direct care nursing, and care management. Adept in regulatory compliance and quality improvement, Maria serves as an expert consultant on standards of care in nursing home operations, and is a frequent presenter on clinical and leadership topics. As a Vice President of AANAC, she helped develop an MDS certification program. She is a member of the nursing informatics committee for HIMSS has and currently serves on a technical expert panel for CMS on the CARE Tool, a uniform health and functional assessment instrument that could potentially span all of post-acute care. Maria co-authored the books "The Consumer's Guide to Colorado Nursing Homes" and "The Softer Side of MDS." She holds undergraduate degrees in Nursing and Business as well as a Master's Degree in Health Care Informatics from the University of Colorado.

About AmericanHealthTech

American HealthTech is **Your Ultimate Connectivity Partner,** connecting caregivers, partners, and healthcare networks to drive higher outcomes in the new era of post-acute care. Coast to coast, a fifth of the nation's providers depend on AHT daily for innovations that free hands to care for others. For more information, visit www.healthtech.net.

About INTERACT II

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