“IMPROVING CARE WITH INTERACT FOR ASSISTED LIVING”

17th Annual HCANJ Assisted Living Conference

Patrice Evans, MBA, BSN, RN, CPHQ
Grant Site Manager – Brookdale
Bio/Disclosures

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is the CMS Grant Site Manager for Brookdale. She is a graduate of the State University of New at Buffalo and Mountainside Hospital School of Nursing with over 40 years of varied nursing experience. She currently holds a certification as a Certified Professional in Healthcare Quality. She has been a Skilled Nursing Home Administrator as well as an Executive Director of both Assisted Living and Independent Living communities for Brookdale. Her nursing career has allowed her to work in the acute, long-term, hospice and home-care fields. She has been with Brookdale since 2010.
Disclaimer Re: CMS Health Care Innovations Award

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• The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
Acknowledgements of Contributions to this Presentation

Kevin O’Neil, M.D. Chief Medical Officer Brookdale Senior Living
Practiced and taught geriatric medicine for over 30 years.
Clinical Professor in the Department of Aging Studies at the University of South Florida.
Certified by the American Board of Internal Medicine in both Internal Medicine and Geriatric Medicine.
Co-Director for the Center for Medicare Services (CMS) Health Innovations Challenge Grant for application of INTERACT in IL, AL, and HH settings.

Joseph G. Ouslander, M.D. Professor /Senior Associate Dean for Geriatric Programs
Interim Chair, Department of Integrated Medical Sciences
Charles E. Schmidt College of Medicine
Professor (Courtesy), Christine E. Lynn College of Nursing
Florida Atlantic University
Executive Editor, Journal of the American Geriatrics Society
OBJECTIVES

Describe the development of the INTERACT QI program for Assisted Living as it relates to the CMS Innovations Challenge grant

Identify the goals of the INTERACT Quality Improvement program and the 4 categories of INTERACT tools (http://Interact.fau.edu)

Identify strategies to prevent avoidable hospitalizations & improve the quality of resident care

Describe the role of direct care staff in identifying/reporting acute changes in resident condition

Identify barriers to the implementation of the INTERACT process and use of best practices

Discuss the tools of INTERACT as they relate to Advanced Directives/end of life care
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
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
Costs of Care are Unsustainable

Total Medicare Expenditures: 1997-2017


Courtesy: Advisory Board Company
Functional Limitations Exacerbate the Challenge

Average Annual Medicare Spending per person in 2006

Chronic Disease & Functional Limitations: $15,833
3 or More Chronic Conditions Only: $7,926
1-2 Chronic Conditions Only: $3,559
No Chronic Conditions: $2,245

Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use File
Why it matters - Going to the Hospital …

- Disrupts our resident’s/patient’s life
- May cause health complications
- Is difficult for families and friends
- Costs billions of dollars to Medicare and Medicaid each year
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\(^2\)

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

<table>
<thead>
<tr>
<th>Was the Hospitalization Avoidable?</th>
<th>Definitely/Probably YES</th>
<th>Definitely/Probably NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare A</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>Other</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>HIGH Hospitalization Rate Homes</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>LOW Hospitalization Rate Homes</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010
Why Assisted Living Providers Need To Focus

Courtesy: Advisory Board Company
Ineffective Transitions Lead to Poor Outcomes

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

Overview of QI Programs

“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

“Care Transition Program”
http://www.caretransitions.org

• Transition coach
• Trained volunteers
• Empowered patients and caregivers

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

• Advance care planning

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

• Social Worker coordinating Aging Resource Center Services at hospital discharge

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

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

“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

High Quality Care Transitions for
Older Adults & Caregivers

Courtesy: Joseph Ouslander, MD

Slide used with permission of Dr. Joseph Ouslander
CMS Health Innovation Challenge Grant

• 3-Year Grant - Awarded July 1, 2012 to University of North Texas Health Science Center in partnership with Brookdale Senior Living

• Goal is to revise and implement the INTERACT Program in skilled nursing, assisted living, and home care settings to reduce avoidable readmissions and emergency room transfers

• Quality Nurse Leaders will evaluate data and guide quality improvement programs

• Implementing electronic data exchange between healthcare providers

• Implementing in 67 Brookdale Communities (Florida/Texas/KS/Denver) during grant period and share lessons learned with acute and post-acute care partners

• Expected savings of more than $9 million
## Key Program Partners & Roles

<table>
<thead>
<tr>
<th>Organization</th>
<th>Main Role</th>
<th>Key Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of North Texas Health Science Center (UNTHSC)</td>
<td>Manages the grant and coordinates interactions between partners</td>
<td>Dr. Thomas Fairchild Shelby Bedwell</td>
</tr>
<tr>
<td>Brookdale Senior Living (BSL)</td>
<td>Coordinates transitional care and leads program dissemination</td>
<td>Dr. Kevin O’Neil Kim Estes RN</td>
</tr>
<tr>
<td>Florida Atlantic University (FAU)</td>
<td>Oversees the implementation INTERACT</td>
<td>Dr. Joe Ouslander Nancy Henry RN, ARNP</td>
</tr>
<tr>
<td>Loopback, LLC</td>
<td>Oversees integration of clinical data needed for rapid cycle learning</td>
<td>Neil Smiley Ron Trevino Shari Robertson</td>
</tr>
<tr>
<td>University of South Florida (USF)</td>
<td>Facilitates program implementation and dissemination</td>
<td>Kathryn Hyer</td>
</tr>
<tr>
<td>Florida Medical Quality Assurance, Inc. (FMQAI)</td>
<td>Provides input on reports and expertise on measures and data analytics</td>
<td>Amy Osborn</td>
</tr>
</tbody>
</table>
PROCESS

- Organization of the CMS Grant Team Summer 2012
- October to December 2012: Began a Review of the INTERACT version 2 tools & made recommendations for changes for AL and HH.
- External survey of tools conducted with NCAL/AALNA through December 2012
  - Stop & Watch tool
  - SBAR for AL Nurses
  - SBAR for Caregivers-AL
- December 2012: External survey conducted to gather additional feedback on tools. Goal of 30-40 survey participants for AL:
  - Internal experts: Brookdale Senior Living
- Pilot tools finalized Spring 2013 & training initiated August 2013
- Training of approx. 71 communities (Skilled/AL) completed in June 2014.
- May 2014: Initiated use of “select” Interact tools for Independent Living
Geriatrics is a TEAM Sport!

It’s a lot easier if we all pull together!
Interprofessional Team

Care Associates
Dining Services
Housekeeping
Maintenance
Administrative
Therapy
Nursing
Activities/Program Staff
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 assisted living 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
The goal of INTERACT is to improve care, **not** to prevent all hospital transfers

In fact, INTERACT can help with more rapid transfer of residents who need hospital care
Quality Improvement Tools
Communication Tools
Decision Support Tools
Advance Care Planning Tools
Communication

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

-George Bernard Shaw
Stop and Watch

Early Warning 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.

**STOP**

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

**WATCH**

- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less

- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toiling 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
2 SBAR Types for AL

**Nurse:** Situation/Background/Assessment/Request

**Caregiver or Supervisor:** Situation/Background/Appearance/Ready to Call

- **Situation:** What is going on with the resident?
- **Background:** What is the clinical background or context?
- **Assessment/Appearance:** What do I think the problem is?
- **Request/Ready to Call:** What do I think needs to be done for the resident?
Decision Support Tools

- Change of condition file cards
- Care paths
## Decision Support Tools

### INTERACT Assisted Living Version 1.0 Tools (cont'd)

<table>
<thead>
<tr>
<th>Tools</th>
<th>Use</th>
<th>Suggested Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision Support Tools</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute Change in Condition File Cards</strong></td>
<td>All assisted living licensed nursing staff and primary care clinicians • Provide guidance on when to communicate acute changes in status to MD, NP, and/or PA • Recommend placement at nurse's station or on med carts for quick reference</td>
<td>• 4” x 6” laminated cards put in a flip-chart or rolodex format for placement by nursing station phones, or • 4” x 6” laminated cards that can be kept in a file box near the phone at the nurses’ station, or • 4” x 6” laminated cards with hole punched in upper left corner and hooked onto the med carts</td>
</tr>
<tr>
<td><strong>Care Paths</strong></td>
<td>All assisted living licensed nursing staff and primary care clinicians • Educational tool and reference for guiding evaluation of specific symptoms that commonly cause acute care transfers</td>
<td>• 8.5” x 14” glossy prints for posters • 8.5” x 11” laminated, 3-hole punched for education for inclusion in a ring binder</td>
</tr>
</tbody>
</table>

- 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

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
# Vital Signs

**Vital Signs** *(report why vital signs were taken)*

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Report Immediately*</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Systolic BP &gt; 200 mmHg or &lt; 90 mmHg</td>
<td>Diastolic BP &gt; 90 mmHg</td>
</tr>
<tr>
<td></td>
<td>Diastolic BP &gt; 115 mmHg</td>
<td>New irregular pulse</td>
</tr>
<tr>
<td></td>
<td>Resting pulse &gt; 100, &lt; 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respirations &gt; 18, &lt; 10/minute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral temp &gt; 100.5 F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxygen saturation &lt; 90%</td>
<td></td>
</tr>
<tr>
<td>Weight Loss</td>
<td>way to be added.</td>
<td>New onset of anorexia with or without weight loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5% or more within 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% or more within 6 months</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>&gt; 5 lbs in one week in resident with CHF</td>
<td>&gt; 5 lbs in one week in resident with other volume overload state</td>
</tr>
<tr>
<td></td>
<td></td>
<td>chronic renal failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Unless these values are stable and known by the primary care clinician*
Lab Tests/Diagnostic Procedures

### Laboratory Tests / Diagnostic Procedures
(report why the test or procedure was done)

<table>
<thead>
<tr>
<th>Test / Procedure</th>
<th>Report Immediately*</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count</td>
<td>- WBC &gt; 14,000 &lt;br&gt; - Hemoglobin (Hb) &lt; 8 &lt;br&gt; - Hematocrit &lt; 24 &lt;br&gt; - Platelets &lt; 50,000</td>
<td>WBC &gt; 10,000 without symptoms or fever</td>
</tr>
<tr>
<td>Chemistry</td>
<td>- Blood urea/nitrogen (BUN) &gt; 60 mg/dl &lt;br&gt; - Calcium (Ca) &gt; 12.5 mg/dl &lt;br&gt; - Potassium (K) &lt; 3.0, &gt; 6.0 mg/dl &lt;br&gt; - Sodium (Na) &lt; 125, &gt; 155 mg/dl &lt;br&gt; - Blood glucose &gt; 300 mg/dl or &lt; 70 mg/dl (diabetic)</td>
<td>- Glucose consistently &gt; 200 mg/dl &lt;br&gt; - Hb A1c (any value) &lt;br&gt; - Albumin (any value) &lt;br&gt; - Bilirubin (any value)</td>
</tr>
<tr>
<td>Consult Reports</td>
<td>Consultant report recommending immediate action or changes in management</td>
<td>Routine consultant report recommending routine action or changes in resident’s management</td>
</tr>
<tr>
<td>Drug Levels</td>
<td>Levels above therapeutic range of any drug &lt;br&gt; (hold next dose)</td>
<td>Any therapeutic or low level</td>
</tr>
<tr>
<td>INR (International Normalized Ratio)</td>
<td>- INR &gt; 6 IU/s (hold warfarin)</td>
<td>- INR 3-6 IU/s (hold warfarin)</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Abnormal result in resident with signs and symptoms possibly related to urinary tract infection or urosepsis (e.g. fever, burning sensation, pain in suprapubic or flank area)</td>
<td>Abnormal result in resident with no signs or symptoms</td>
</tr>
<tr>
<td>Urine Culture</td>
<td>&gt; 100,000 colony count with a urinary pathogen with symptoms</td>
<td>Any growth with no symptoms</td>
</tr>
<tr>
<td>X-ray</td>
<td>New or unsuspected finding &lt;br&gt; (e.g. fracture, pneumonia, CHF)</td>
<td>Old or long-standing finding, no change</td>
</tr>
</tbody>
</table>

*Unless these values are stable and known by the primary care clinician.
Checklists
PDSA Cycle

- On-going review of processes and practices
- Evaluating the Process/Outcomes
Quality Improvement Tool

Quality Improvement Tool
For Review of Acute Care Transfers

The INTERACT QI Tool is designed to help your team analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

Resident ___________________________ Age ___________________________
Date resident moved into the facility ___________ / ___________ / ___________
Major reason for move in: ___________________________

SECTION 1: Risk Factors for Hospitalization and Readmission

a. Conditions that put the resident at risk for hospital admission or readmission
   - Cancer, on active chemo or radiation therapy
   - CHF
   - COPD
   - Dementia
   - Diabetes
   - End-stage renal disease
   - Fracture hip
   - Multiple active diagnoses and/or co-morbidities
   (e.g., CHF, COPD and Diabetes in the same resident)
   - Polypharmacy (e.g., Frequent medications)
   - Surgical complications

b. Resident hospitalized in the past 30 days? (Check all that apply)
   - No
   - Yes (list dates and reasons)

SECTION 2: Describe the Acute Change in Condition and Other Non-Clinical Factors that Contributed to the Transfer

a. Date the change in condition first noticed ___________ / ___________ / ___________

b. Briefly describe the change in condition and other factors that led to the transfer and then check each item below that applies

This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living (www.assistedliving.org). Check state regulations, and use the form at various sites to understand a resident's hospitalization.

35 | Enriching the lives of those we serve with compassion, respect, excellence and integrity.
Advanced Care Planning

• Advance Care Planning Tracking Form
• Advance Care Planning Communication Guide
• Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders
• Comfort Care Order Set
Advance Care Planning

- ACP should occur at some time shortly after admission
- Decisions should be reviewed regularly and at times of acute changes in condition
ACP Tracking Form

Advance Care Planning Tracking Form

Resident Name
Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of a move-in to the assisted living, at times of change in condition, and periodically for routine updating of care plans. The purpose of this form is to provide a tool to document that these discussions are taking place.

At Move-In (within about a week of move-in or return)
Check one of the following:
☐ Resident and/or responsible party did NOT want to have this discussion
☐ Discussion about advance care planning held with (check one or both of the following):
   Resident
   Resident’s surrogate name:

Staff or healthcare provider completing form:
Name: ______________________ Title: ______________________
Signature ______________________ Date of discussion: _______/_____/______

Location of Advance Care Plan documentation (i.e. advance directive, tab, plan of care, progress note, etc.):

Use Continuation Pages to document additional Advance Care Planning Reviews and Discussions

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Advance Care Planning Communication Guide: Overview

The INTERACT Advance Care Planning Communication Guide is designed to assist health professionals who work in assisted living to initiate and carry out conversations with residents and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health status.

The Guide can be useful for education, including role-playing exercises and simulation training.

* This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living (www.ahcancal.org/nclal).

Communicating about advance care planning and end-of-life care involves all assisted living staff:
- Physicians must communicate with residents and families about advance directives, but all staff need to be able to communicate about goals of care, preferences, and end-of-life care

This Guide should therefore be useful for:
- Nursing staff
- Primary care physicians, nurse practitioners, and physician assistants
- Social workers and social work designees
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:
- Advance Directives – such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives.
- Plans for care when a sudden, life-threatening condition is diagnosed – such as a stroke, heart attack, pneumonia, or cancer.
- Plans for care when a resident’s health is gradually deteriorating – such as progression of Alzheimer’s disease or other dementia, weight loss without an obvious medical cause, and worsening of congestive heart failure, kidney failure, or chronic lung disease.
- Considering a palliative or comfort care plan or enrolling in a hospice program.

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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.
INTERACT AL Tools

Do you think this INTERACT AL is a useful tool?

Percentage of respondents agreeing that the tool is useful

<table>
<thead>
<tr>
<th>Quality Improvement Tools</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization Rate Tracking Tool - Excel template</td>
<td>34%</td>
</tr>
<tr>
<td>Tracking Tool Instructions</td>
<td>57%</td>
</tr>
<tr>
<td>Tracking Tool Trouble Shooting</td>
<td>45%</td>
</tr>
<tr>
<td>Acute Care Transfer Log - Worksheet</td>
<td>61%</td>
</tr>
<tr>
<td>Calculating Hospitalization Rate</td>
<td>48%</td>
</tr>
<tr>
<td>Quality Improvement Tool for Review of Acute Care Transfers</td>
<td>66%</td>
</tr>
<tr>
<td>Quality Improvement Summary - Worksheet</td>
<td>59%</td>
</tr>
</tbody>
</table>

Percentage of respondents agreeing that the tool is useful

<table>
<thead>
<tr>
<th>Communication Tools</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBAR Communication Form and Progress Note for RN/LPN/LVNs in AL/HH</td>
<td>70%</td>
</tr>
<tr>
<td>SBAR Communication Form and Progress Note for Caregiver in AL/HH</td>
<td>53%</td>
</tr>
<tr>
<td>Medication Reconciliation Worksheet for Post-Hospital Care</td>
<td>47%</td>
</tr>
<tr>
<td>Stop and Watch Early Warning Tool</td>
<td>88%</td>
</tr>
</tbody>
</table>

Final Assisted Living Pilot Site Ratings (N=33*) Response rate varies from 26-33 participants
Do you think this INTERACT AL is a useful tool?

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<td>88%</td>
</tr>
</tbody>
</table>

Percentage of respondents agreeing that the tool is useful

<table>
<thead>
<tr>
<th>For Communication Between AL and Hospital</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living Capabilities List</td>
<td>69%</td>
</tr>
<tr>
<td>AL to Hospital Transfer Form</td>
<td>61%</td>
</tr>
<tr>
<td>AL to Hospital Transfer Data List</td>
<td>48%</td>
</tr>
<tr>
<td>AL Acute Care Transfer Checklist</td>
<td>53%</td>
</tr>
<tr>
<td>Hospital To Post Acute Care Transfer Form</td>
<td>47%</td>
</tr>
<tr>
<td>Hospital To Post Acute Care Data List</td>
<td>37%</td>
</tr>
</tbody>
</table>
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

Extent of INTERACT Program Implementation 2013-2015

- # Communities using INTERACT
- # Targeted Communities
- # Communities expected to be implemented under expedited roll out plan
Hospitalization Rate

Hospitalization Rate of Residents in Assisted Living Communities (n = 46)
Readmission Rate

30-day Readmission Rates for Residents in Assisted Living Communities (n = 46)
Emergency Room Transfers

ER Rate for Residents in Assisted Living Communities (n = 46)
Challenges/Opportunities

- Turnover
- Lack of support by Leadership
- Lack of embracing the process as part of the culture – a “just more paperwork” attitude
Success Stories

Those communities that have embraced the process believe they have a more focused communication throughout their community (associates to the nurse) and the feedback they have received from their physicians also allows for more organized and complete information to the physician at the time of the call/fax.

We were able to provide the associates with supportive documentation of a recent case where an associate completed a stop and watch form, submitted it to the charge nurse, the charge nurse initiated the SBAR, assessed the resident, communicated this information to the doctor, labs and urinalysis were ordered and ultimately it was determined she had a severe UTI that we were able to successfully treat in house without the need of a transfer to an acute care setting/ER.
I had a resident that was showing signs and symptoms of pneumonia, using SBAR, continued to decline and was able to send him to our skilled unit for care avoiding hospitalization.

I have a resident that keeps a stop and watch book for herself so she can update nurses on any condition change with other residents.

Our Program Assistant noticed that a resident was coughing each time she would have a drink. She reported via Stop and Watch which resulted in speech therapy and diagnosis of aspiration. Diet was altered and she is doing much better.
• Able to analyze each hospital visit thoroughly, provide a more well-rounded care to the resident, and identify the need for staff training to reduce # of transfers or to be aware of preventative measures. Staff reports that they love the stop and watch tools and the SBAR form.

I will hold an in-service on interact training for all existing and new hires the month of August, since we have recently hired quite a few new employees and to refresh the program for our existing employees. The QI meetings being held every 2 weeks in conjunction with our CCM meeting has seemed to make quite a difference in keeping our residents out of the hospitals. We had only 1 transfer in May and 0 in June. The meetings really keep the lines of communication open between myself and staff, as well as Home Health and Therapy. We can all brainstorm and come up with ideas to help keep our residents safe and healthy in our community. All in the program has been a positive in our community.
• Also, the benefit I am seeing is the improvement in communication with the ER doctors and staff. Also, it is helpful to newer nurses to find the right path to take to figure out what to look for. It is also a great reminder for the older nurses to use the paths.

• “We have found that family use of the Stop & Watch tool to be helpful in giving them a voice in their loved one’s care. They feel that no matter what time of day they visit, and whether the nurse is present or not, they have a tool available to them to express a medical concern and know it will be followed up on. We have a small table in our lobby with the Stop & Watch box with the trifold pamphlet as well as the booklet for them to fill out a slip. First thing in the door and last before they leave.”
What We Have Learned…

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

• Paper versions of the INTERACT Tools are available at:
  – www.interact.fau.edu or www.interact2.net
• Electronic versions of the INTERACT Tools are only available from authorized providers
• Theconversationproject.org
“Alone we can do so little; together we can do so much.”

—Helen Keller