“IMPROVING CARE WITH INTERACT FOR ASSISTED LIVING”

17th Annual HCANJ Assisted Living Conference

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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

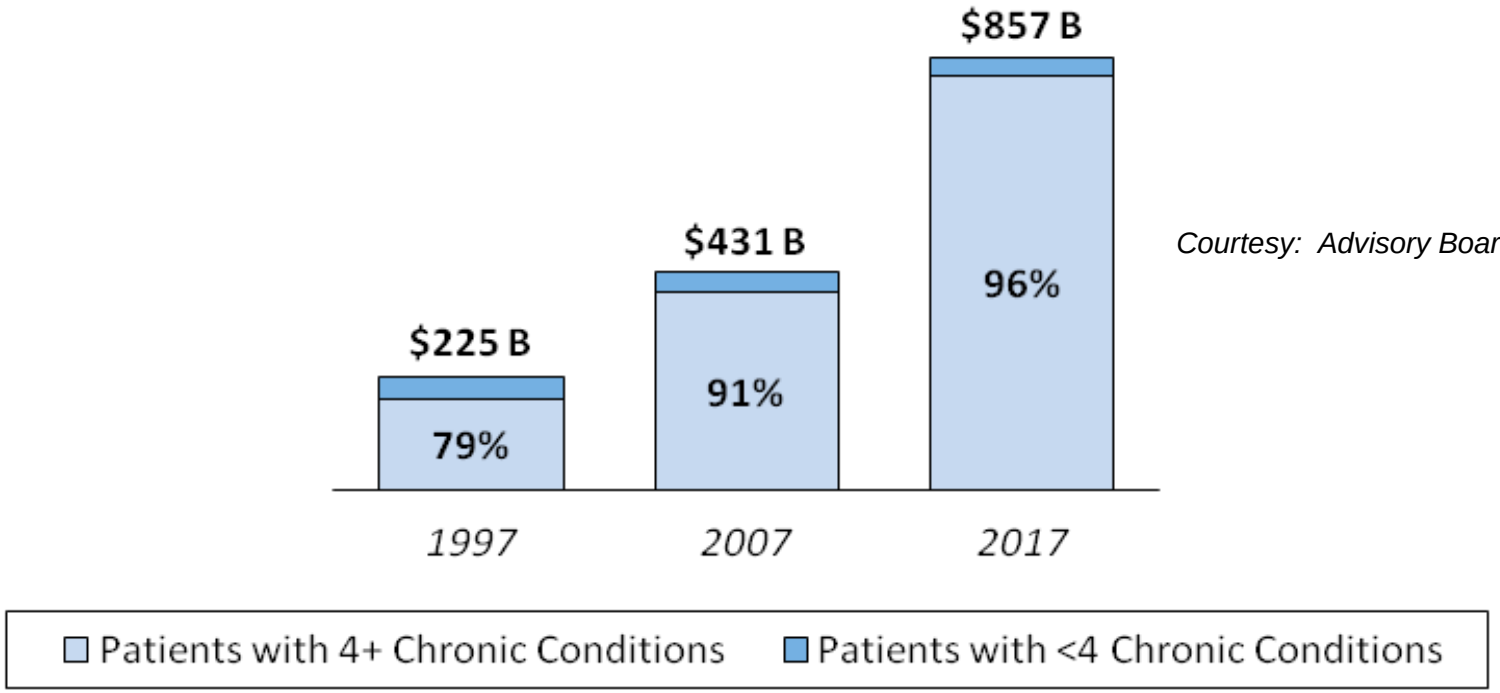
**Source: National Center for Health Statistics, 2010*

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

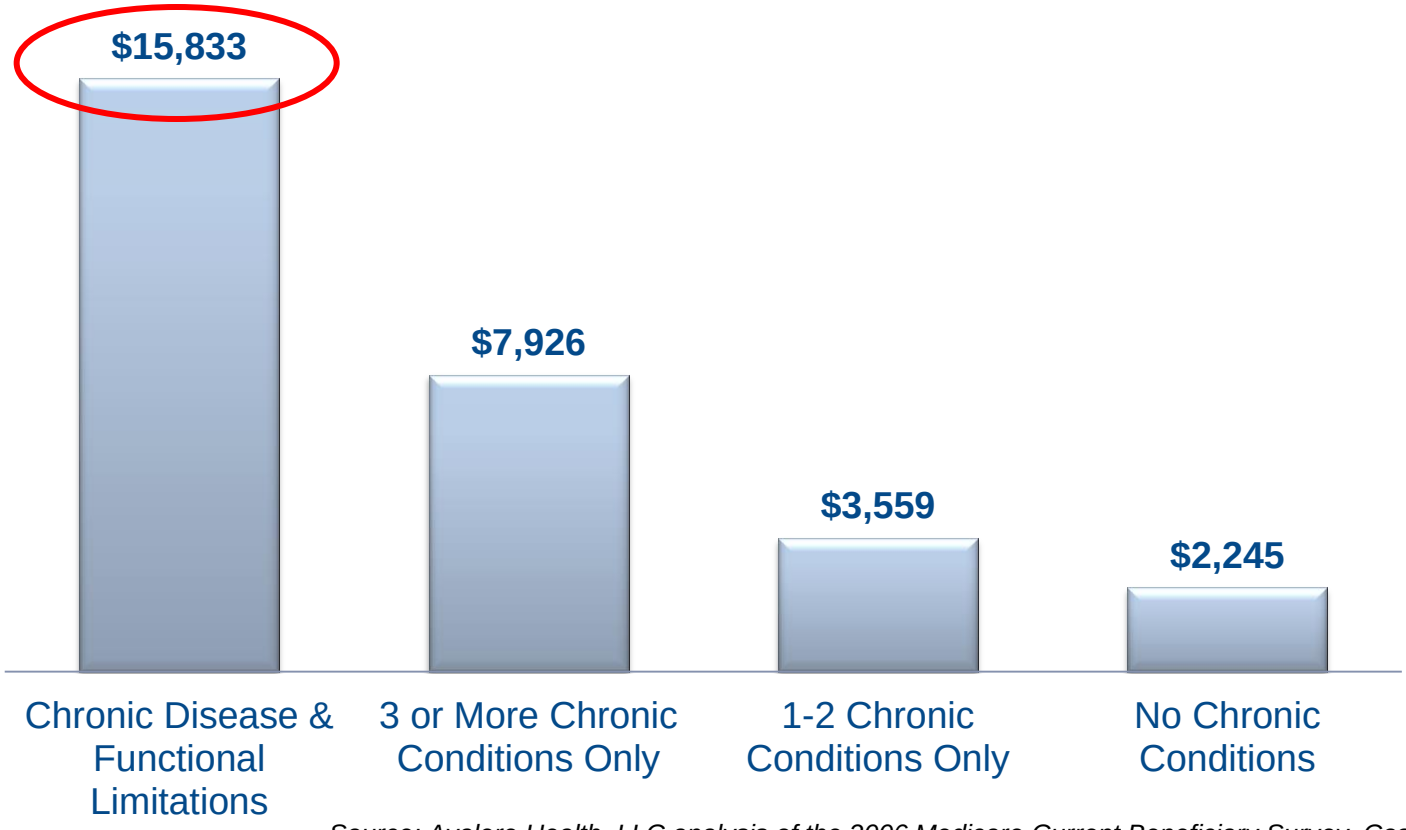


Courtesy: Advisory Board Company

Source: Thorpe K and Howard D, "The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity," Health Affairs, 379, August 2006; Innovations Center Futures Database; Health Care Advisory Board interviews and analysis.

Functional Limitations Exacerbate the Challenge

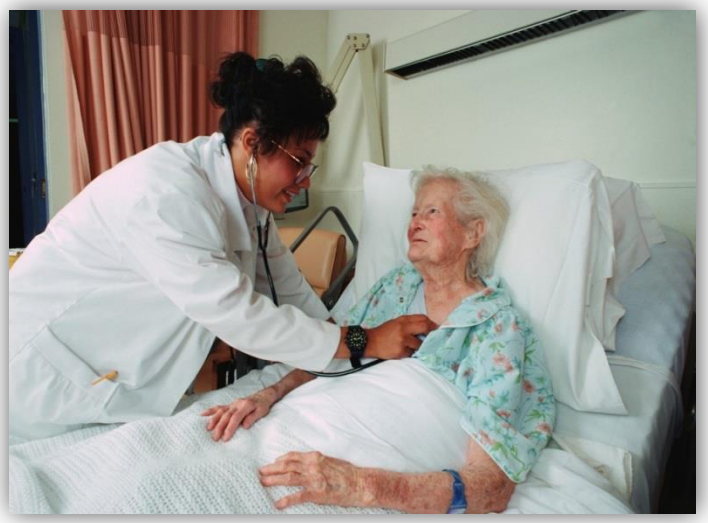
Average Annual Medicare Spending per person in 2006



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]

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

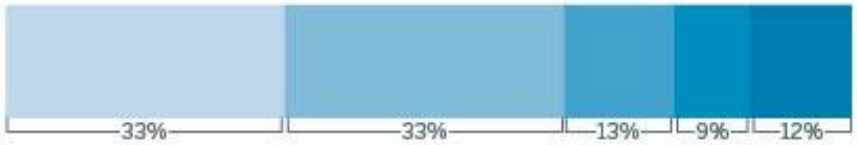
	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	**69%**	**31%**
Other	**65%**	**35%**
HIGH Hospitalization Rate Homes	**75%**	**25%**
LOW Hospitalization Rate Homes	**59%**	**41%**
TOTAL	**68%**	**32%**

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

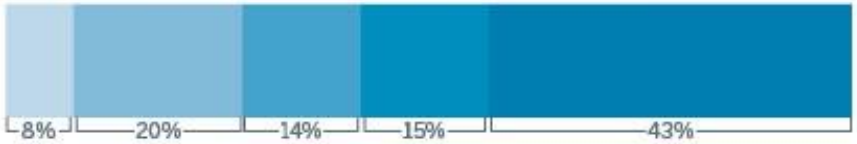
Why Assisted Living Providers Need To Focus

HIGH PATIENT COMPLEXITY DRIVING OUTSIZED PATIENT COSTS...

PERCENTAGE OF MEDICARE BENEFICIARIES



PERCENTAGE OF TOTAL MEDICARE SPENDING



NUMBER OF CONDITIONS:

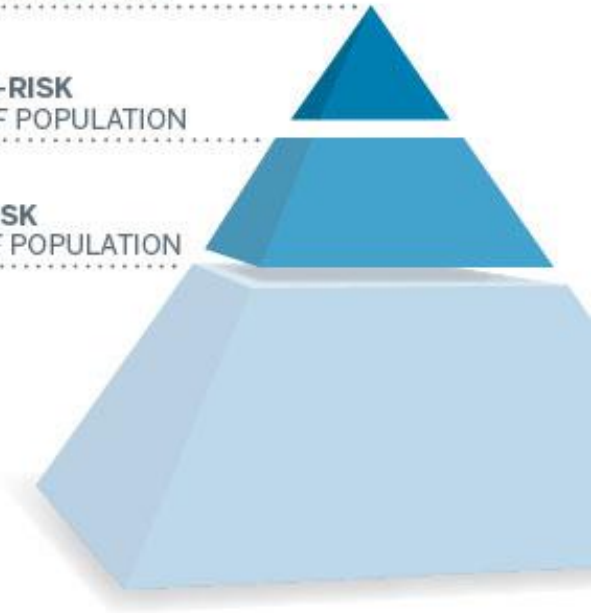
ZERO OR ONE | TWO OR THREE | FOUR | FIVE | SIX OR MORE

...REQUIRES CREATING THREE UNIQUE PATIENT POPULATIONS, WITH THREE COMPLEMENTARY CARE MODELS

1 **HIGH-RISK**
5% OF POPULATION

2 **RISING-RISK**
20% OF POPULATION

3 **LOW-RISK**
75% OF POPULATION



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

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

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

"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

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

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

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
  - External experts: National organizations (NCAL, AALNA, CEAL, ALFA, The Greenhouse Project, AMDA, Leading Age. Pioneer Network , AARP, and Advanced Practice Nurses).
- 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

Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 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 _____

SBAR

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?

SBAR

SBAR Communication Form

and Progress Note for RN/LPN/LVNs in Assisted Living

INTERACT Assisted Living* V1.0 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

- ☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, and finger stick glucose for diabetes
- ☐ **Review Record:** Recent progress notes, labs, orders
- ☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated *(nurses only)*
- ☐ **Have Relevant Information Available when Reporting**
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are _____

This started on ____/____/____ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom ***worse*** are _____

Things that make the condition or symptom ***better*** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode *(if applicable)* _____

Other relevant information _____

BACKGROUND

Resident Description

This resident is in the facility for: ☐ Long-Term Care ☐ Respite ☐ Other: _____

Primary diagnoses _____

Other pertinent history *(e.g. medical diagnosis of CHF, DM, COPD)* _____

Medication Alerts

☐ Changes in the last week *(describe)* ☐ Resident is on blood thinners warfarin/coumadin: Result of last INR _____ Date ____/____/____

Resident is on: ☐ Hypoglycemic medication (s) / Insulin ☐ Digoxin

Allergies _____

Pharmacy name _____ Phone (_____) _____

Vital Signs

BP _____ Pulse _____ (or Apical HR _____) RR _____ Temp _____ Weight _____ lbs *(date ____/____/____)*

For CHF, edema, or weight loss: last weight before the current one was _____ on ____/____/____

Blood Sugar *(Diabetics)* _____

Pulse Oximetry *(if indicated)* _____% on ☐ Room Air ☐ O_2 (_____)

Resident Name _____

(continued)

SBAR Communication Form

and Progress Note for Caregivers in Assisted Living

INTERACT Assisted Living* V1.0 Tool

This form is for caregivers who are not licensed nurses (RN/LPN/LVN). There is another INTERACT tool for licensed nurses.

Before Calling the Nurse/Supervisor:

- ☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, and finger stick glucose for diabetes
- ☐ **Have Relevant Information Available when Reporting**
  (i.e. resident record, vital signs, advance directives such as DNR / POLST and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are _____

This started on ____/____/____ Since this started has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom ***worse*** are _____

Things that make the condition or symptom ***better*** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Other relevant information _____

BACKGROUND

Resident Description

This resident is in the facility for: ☐ Long-Term Care ☐ Respite ☐ Other: _____

Medication Alerts

☐ Changes in the last week *(describe)* ☐ Resident is on blood thinners warfarin/coumadin: Result of last INR _____ Date ____/____/____

Resident is on: ☐ Hypoglycemic medication (s) / Insulin ☐ Digoxin

Allergies _____

Pharmacy name _____ Phone (_____) _____

Vital Signs

BP _____ Pulse _____ RR _____ Temp _____

Pain: ☐ No ☐ Yes (describe location, intensity) _____

Pulse Oximetry *(if indicated)* _____% on ☐ Room Air ☐ O_2 (_____)

Resident Evaluation

1. Mental Status Changes *(compared to baseline; check all that you observe)*

- ☐ Decreased consciousness *(sleepy, lethargic)*
- ☐ Increased confusion *(disoriented)*
- ☐ New or worsening behavioral symptoms
- ☐ Unresponsiveness
- ☐ Other symptoms or signs of delirium *(e.g. inability to pay attention, disorganized thinking)*

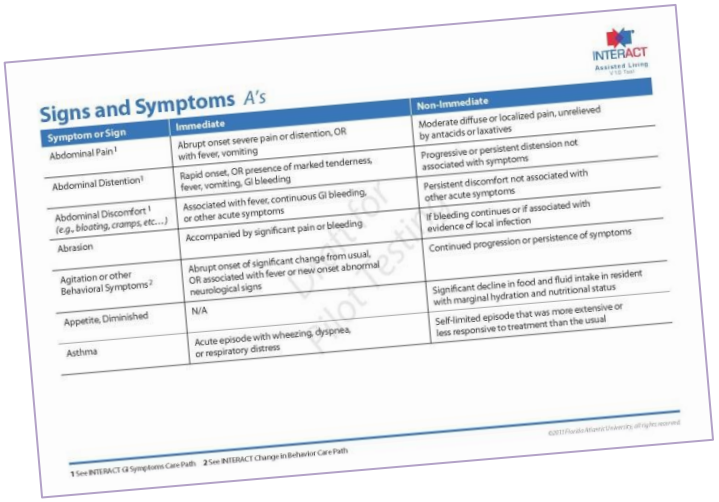
Describe symptoms or signs _____

Resident Name _____

(continued)

Decision Support Tools

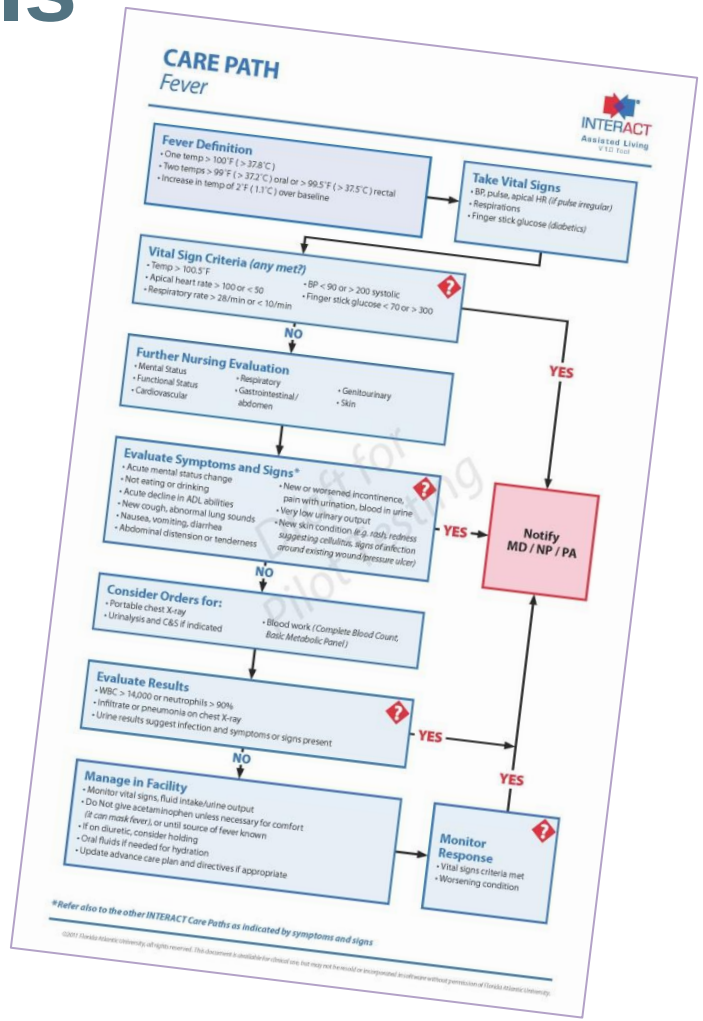
- Change of condition file cards
- Care paths



Signs and Symptoms *A's*

Symptom or Sign	Immediate	Non-Immediate
Abdominal Pain[1]	Abrupt onset severe pain or distention, OR with fever, vomiting	Moderate diffuse or localized pain, unrelieved by antacids or laxatives
Abdominal Distention[1]	Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding	Progressive or persistent distension not associated with symptoms
Abdominal Discomfort[1] (e.g., bloating, cramps, etc....)	Associated with fever, continuous GI bleeding, or other acute symptoms	Persistent discomfort not associated with other acute symptoms
Abrasion	Accompanied by significant pain or bleeding	If bleeding continues or if associated with evidence of local infection
Agitation or other Behavioral Symptoms[2]	Abrupt onset of significant change from usual, OR associated with fever or new onset abnormal neurological signs	Continued progression or persistence of symptoms
Appetite, Diminished	N/A	Significant decline in food and fluid intake in resident with marginal hydration and nutritional status
Asthma	Acute episode with wheezing, dyspnea, or respiratory distress	Self-limited episode that was more extensive or less responsive to treatment than the usual

1 See INTERACT GI Symptoms Care Path 2 See INTERACT Change in Behavior Care Path



CARE PATH
Fever

Fever Definition
- One temp > 100°F (> 37.8°C)
- Two temps > 99°F (> 37.2°C) oral or > 99.5°F (> 37.5°C) rectal
- Increase in temp of 2°F (1.1°C) over baseline

Take Vital Signs
- BP, pulse, apical HR *(if pulse irregular)*
- Respirations
- Finger stick glucose *(diabetics)*

Vital Sign Criteria *(any met?)*
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Finger stick glucose < 70 or > 300

NO / YES

Further Nursing Evaluation
- Mental Status
- Functional Status
- Cardiovascular
- Respiratory
- Gastrointestinal / abdomen
- Genitourinary
- Skin

Evaluate Symptoms and Signs*
- Acute mental status change
- Not eating or drinking
- Acute decline in ADL abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Abdominal distension or tenderness
- New or worsened incontinence, pain with urination, blood in urine
- Very low urinary output
- New skin condition *(e.g. rash, redness suggesting cellulitis, signs of infection around existing wound/pressure ulcer)*

YES → **Notify MD / NP / PA**

NO

Consider Orders for:
- Portable chest X-ray
- Urinalysis and C&S if indicated
- Blood work *(Complete Blood Count, Basic Metabolic Panel)*

Evaluate Results
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

YES / NO

Manage in Facility
- Monitor vital signs, fluid intake/urine output
- Do Not give acetaminophen unless necessary for comfort *(it can mask fever)*, or until source of fever known
- If on diuretic, consider holding
- Oral fluids if needed for hydration
- Update advance care plan and directives if appropriate

Monitor Response
- Vital signs criteria met
- Worsening condition

YES

*Refer also to the other INTERACT Care Paths as indicated by symptoms and signs

Decision Support Tools

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

INTERACT Assisted Living V 1.0 Tool

Tools	Use	Suggested Formats
Decision Support Tools		
Acute Change in Condition File Cards	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	• 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
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**	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	• 8.5" x 14" glossy prints for posters • 8.5" x 11" laminated, 3-hole punched for education for inclusion in a ring binder

Change in Condition File Cards

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

INTERACT Assisted Living V 1.0 Tool

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)*

INTERACT Assisted Living V 1.0 Tool

Vital Sign	Report Immediately*	Non-Immediate
Blood Pressure Pulse Respiratory Rate Temperature	• Systolic BP > 200 mmHg or < 90 mmHg • Diastolic BP > 115 mmHg • Resting pulse > 100, < 50 • Respirations > 28, < 10/minute • Oral temp > 100.5 F • Oxygen saturation < 90%	• Diastolic BP > 90 mmHg • New irregular pulse
Weight Loss		• New onset of anorexia with or without weight loss • 5% or more within 30 days • 10% or more within 6 months
Weight Gain		• > 5 lbs in one week in resident with - CHF - chronic renal failure - other volume overload state

*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)

INTERACT Assisted Living V 1.0 Tool

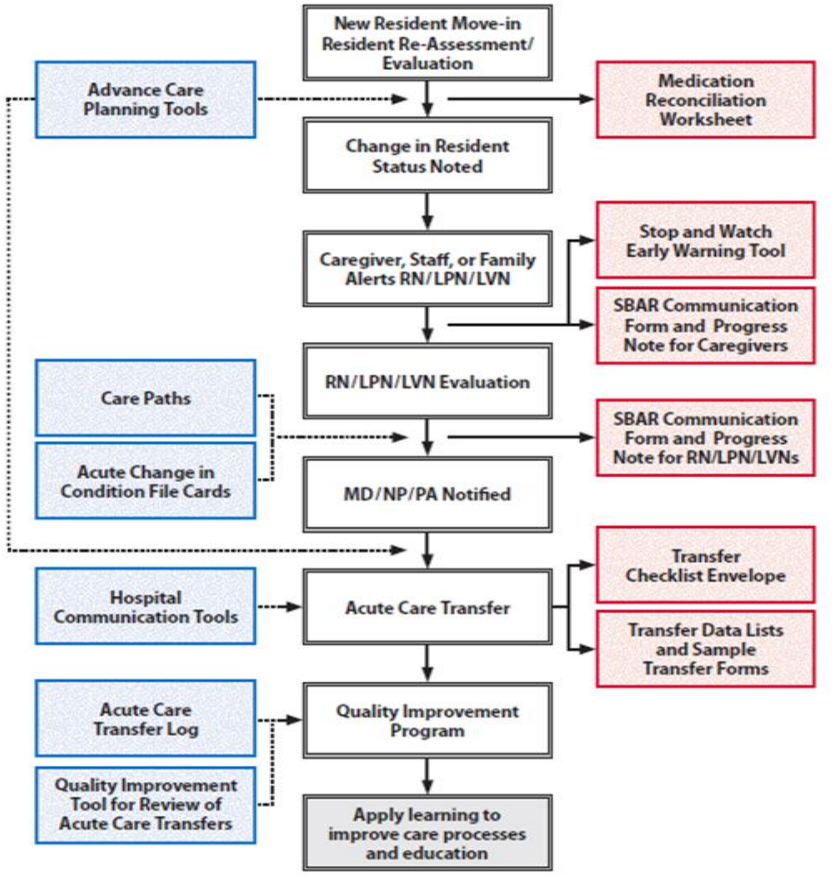
Test/Procedure	Report Immediately*	Non-Immediate
Complete Blood Count	• WBC > 14,000 • Hemoglobin (Hb) < 8 • Hematocrit < 24 • Platelets < 50,000	WBC > 10,000 without symptoms or fever
Chemistry	• Blood/urea/nitrogen (BUN) > 60 mg/dl • Calcium (Ca) > 12.5 mg/dl • Potassium (K) < 3.0, > 6.0 mg/dl • Sodium (Na) < 125, > 155 mg/dl • Blood glucose > 300 mg/dl or < 70 mg/dl *(diabetic)*	• Glucose consistently > 200 mg/dl • Hb A1c *(any value)* • Albumin *(any value)* • Bilirubin *(any value)* • Cholesterol *(any value)* • Triglycerides *(any value)* • Other chemistry values
Consult Reports	Consultant report recommending immediate action or changes in management	Routine consultant report recommending routine action or changes in resident's management
Drug Levels	Levels above therapeutic range of any drug *(hold next dose)*	Any therapeutic or low level
INR *(International Normalized Ratio)*	• INR > 6 IUs *(hold warfarin)*	• INR 3-6 IUs *(hold warfarin)* • PT *(in seconds)* 2x control *(hold warfarin)*
Urinalysis	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)*	Abnormal result in resident with no signs or symptoms
Urine Culture	>100,000 colony count with a urinary pathogen with symptoms	Any growth with no symptoms
X-ray	New or unsuspected finding *(e.g. fracture, pneumonia, CHF)*	Old or long-standing finding, no change

*Unless these values are stable ***and*** known by the primary care clinician

Checklists

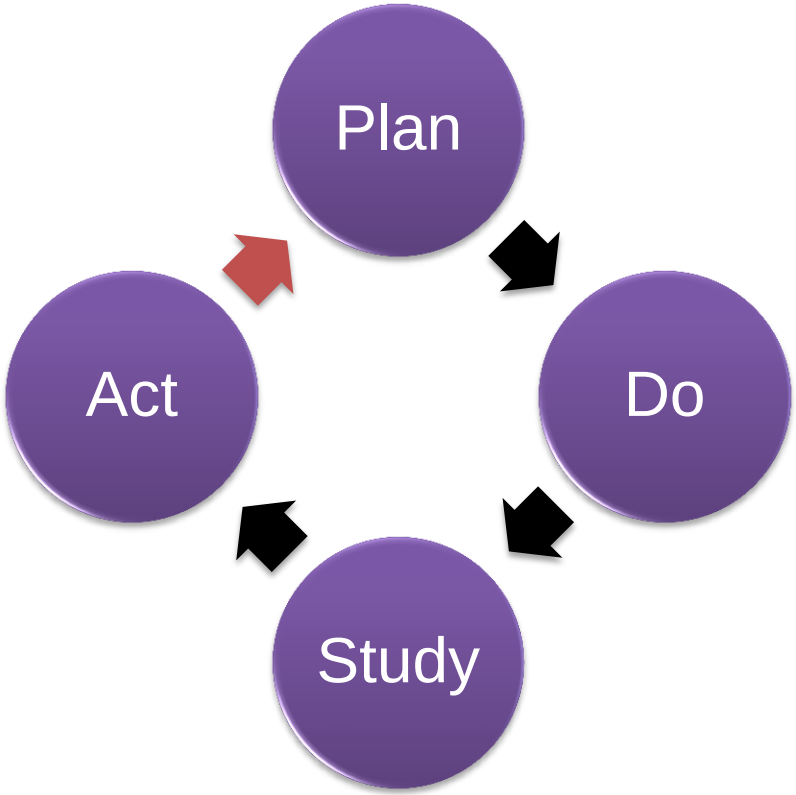
Using the INTERACT Assisted Living Version 1.0 Tools *In Every Day Care*

INTERACT Assisted Living V1.0 Tool

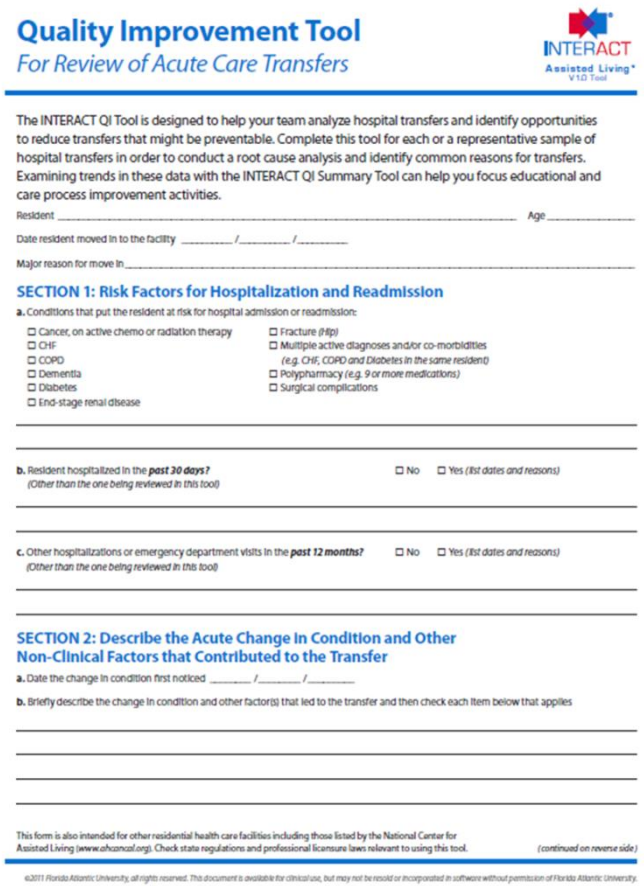


PDSA Cycle

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



Quality Improvement Tool



Quality Improvement Tool

For Review of Acute Care Transfers

INTERACT Assisted Living* V1.0 Tool

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 in to 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. 9 or more medications)*
- ☐ Surgical complications

b. Resident hospitalized in the ***past 30 days?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

c. Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

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 factor(s) that led to the transfer and then check each item below that applies

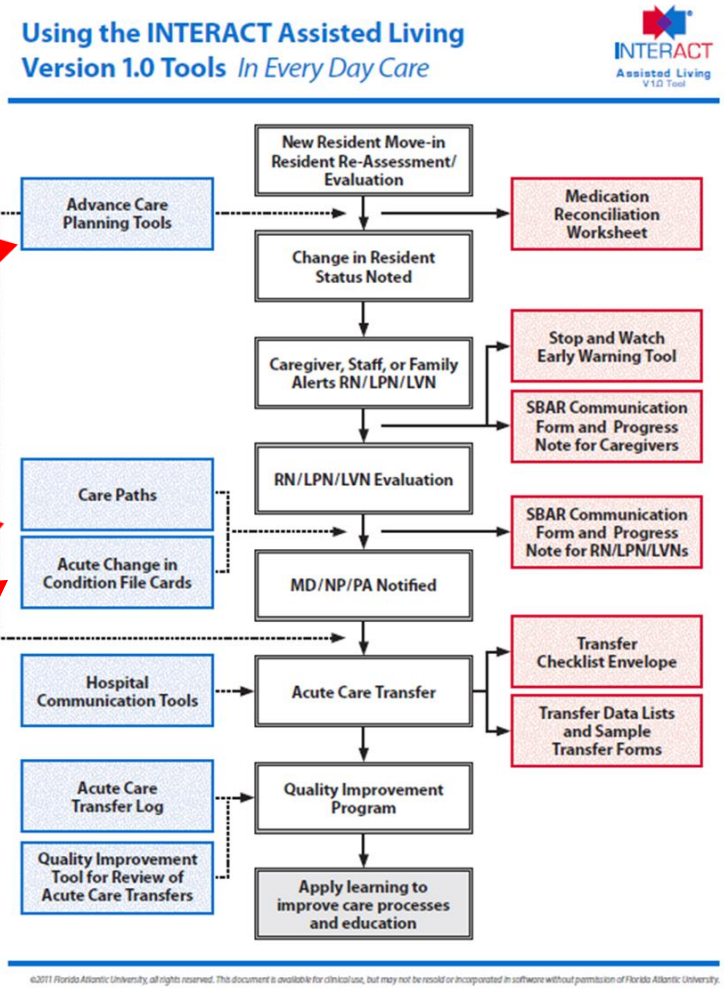
This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living (*www.ahcancal.org*). Check state regulations and professional licensure laws relevant to using this tool. *(continued on reverse side)*

Advanced Care Planning

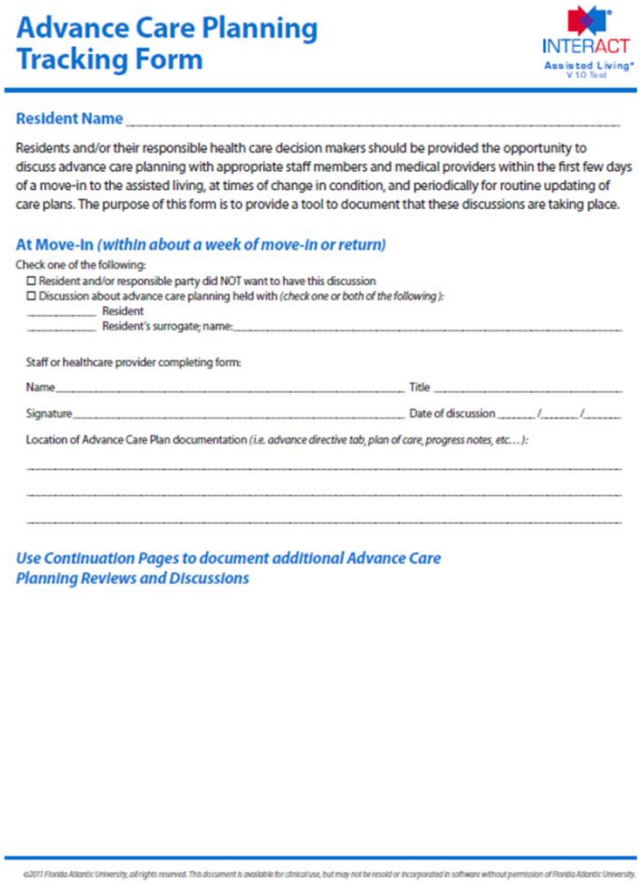
- Advance Care Planning Tracking Form
- Advance Care Planning Communication Guide
- Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders
- Comfort Care Order Set

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

INTERACT Assisted Living* V 1.0 Tool

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 notes, etc…)*:

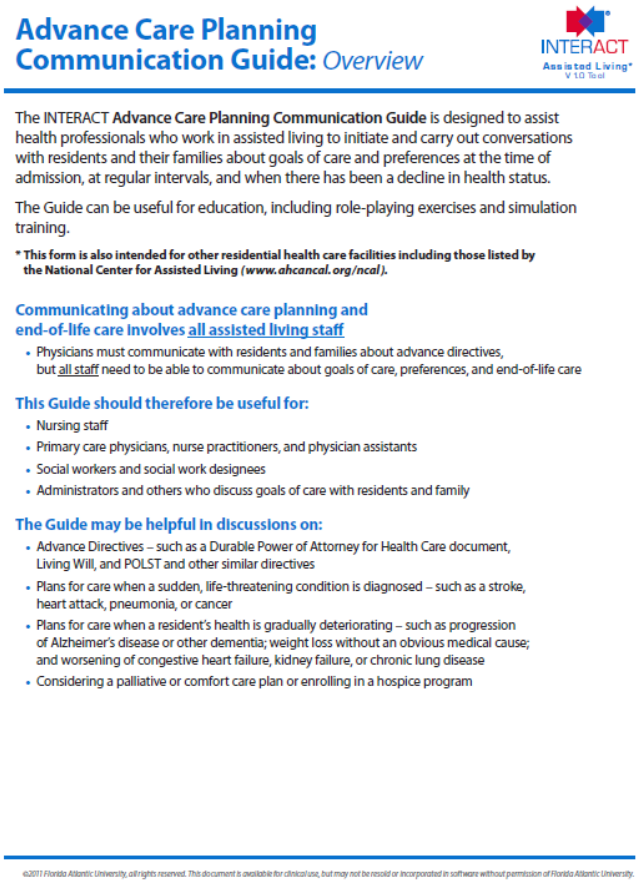
_____

_____

_____

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

ACP Communication Guide



Advance Care Planning Communication Guide: *Overview*

INTERACT Assisted Living* V 1.0 Tool

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/ncal)*.**

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

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

Quality Improvement Tools	
Hospitalization Rate Tracking Tool - Excel template	34%
Tracking Tool Instructions	57%
Tracking Tool Trouble Shooting	45%
Acute Care Transfer Log - Worksheet	61%
Calculating Hospitalization Rate	48%
Quality Improvement Tool for Review of Acute Care Transfers	66%
Quality Improvement Summary - Worksheet	59%

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%

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

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Medication Reconciliation Worksheet for Post-Hospital Care	47%
Stop and Watch Early Warning Tool	88%

Percentage of respondents agreeing that the tool is useful

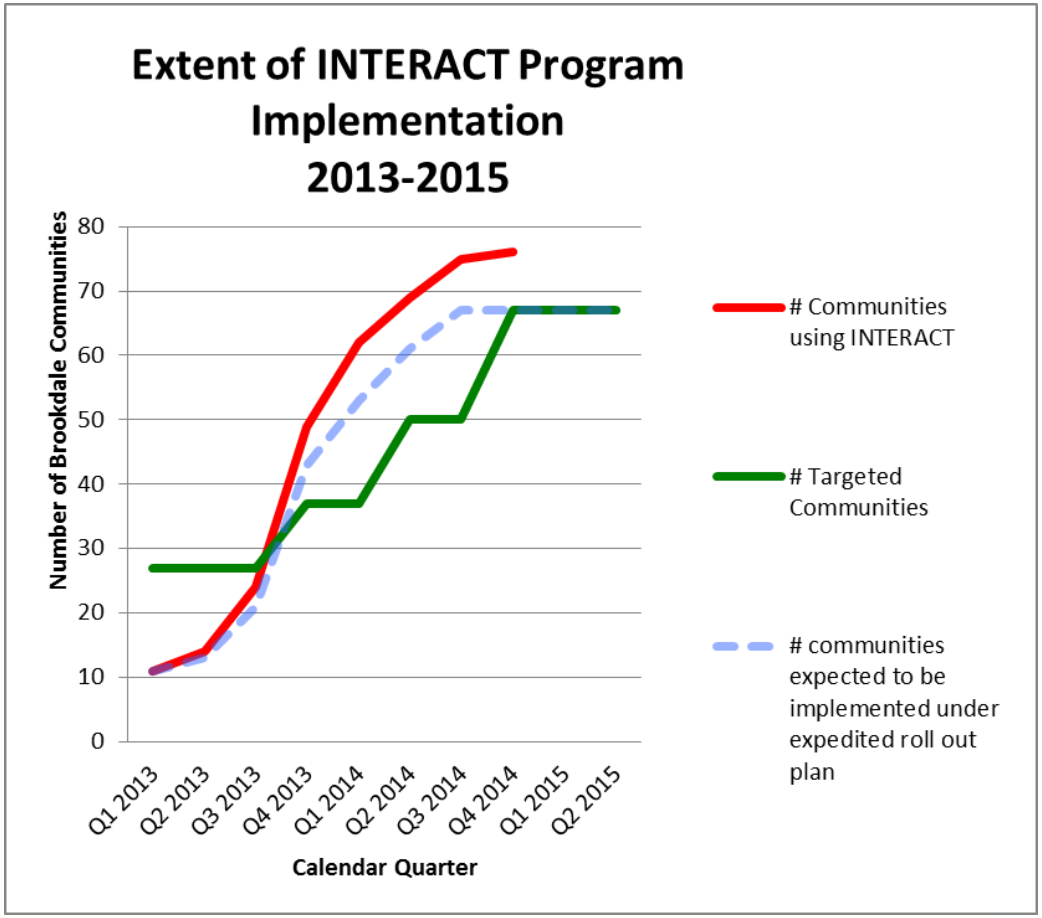
For Communication Between AL and Hospital	
Assisted Living Capabilities List	69%
AL to Hospital Transfer Form	61%
AL to Hospital Transfer Data List	48%
AL Acute Care Transfer Checklist	53%
Hospital To Post Acute Care Transfer Form	47%
Hospital To Post Acute Care Data List	37%

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

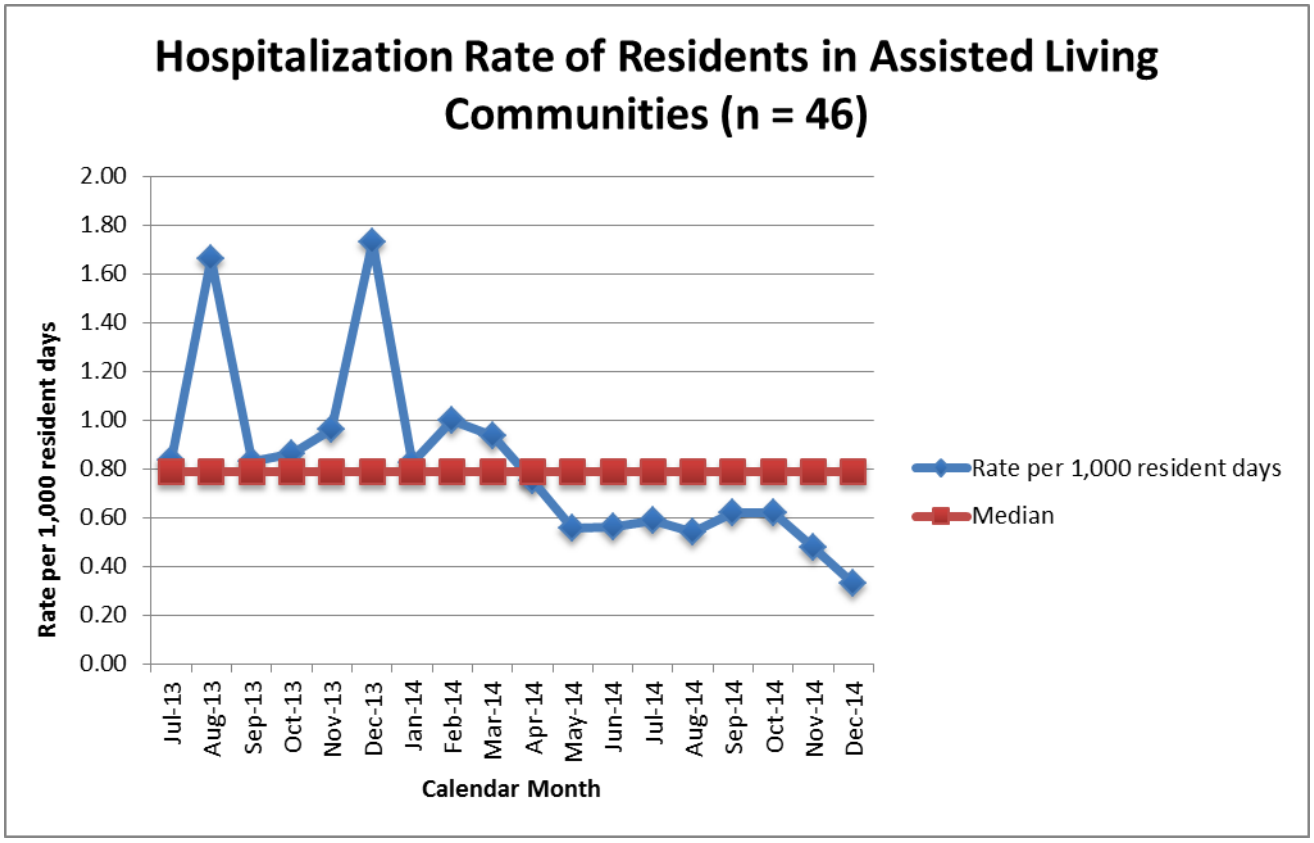
Pilot Sites Conclusions

- 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

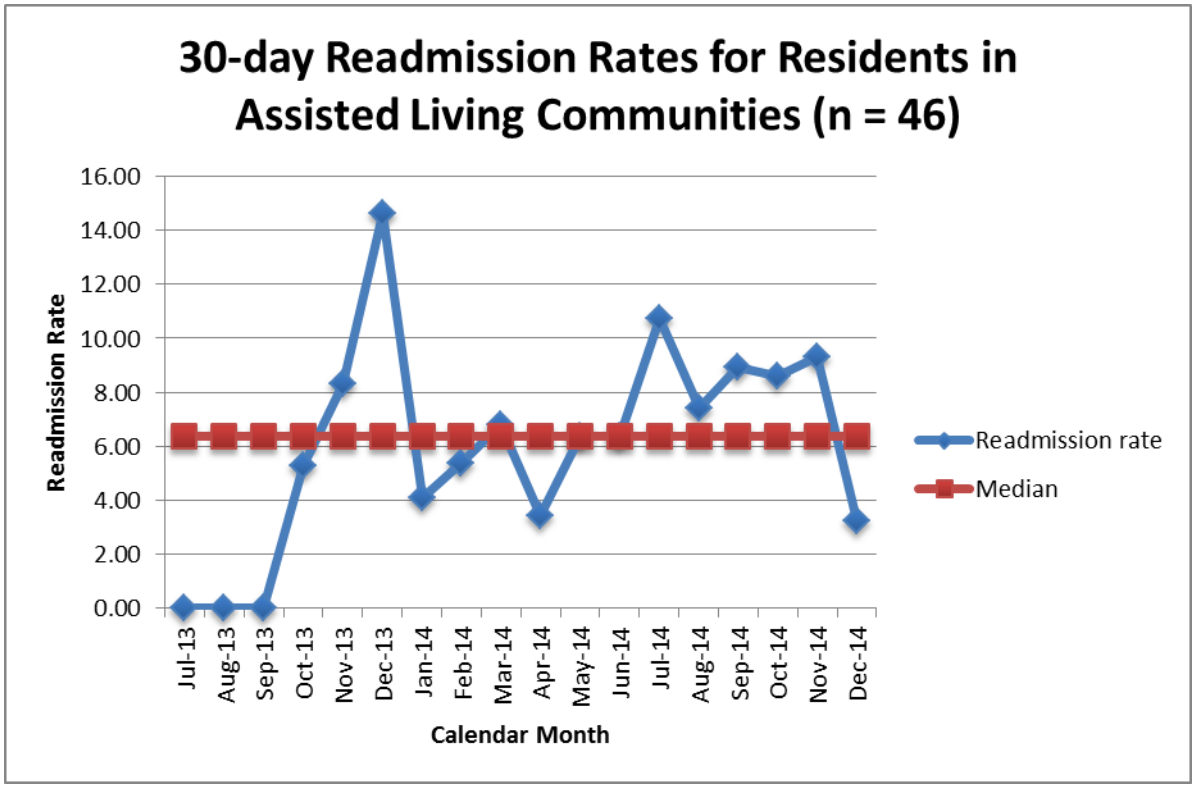
INTERACT Implementation



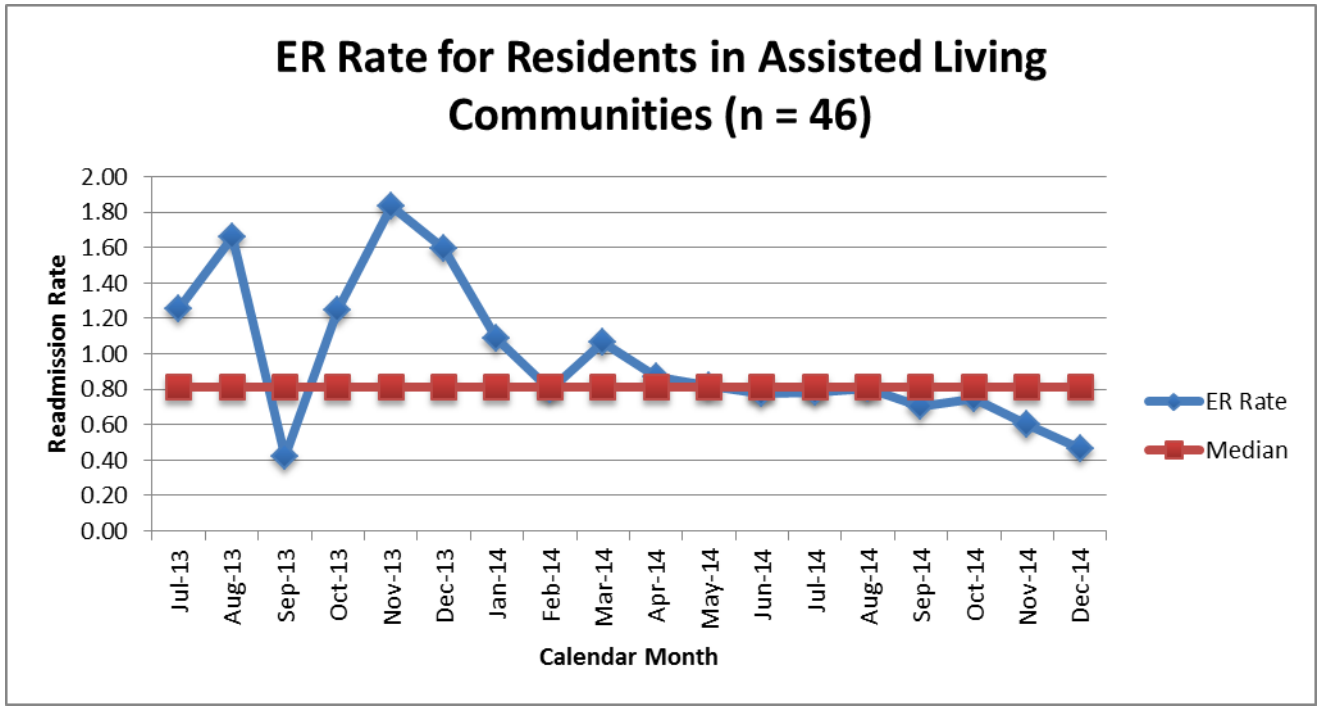
Hospitalization Rate



Readmission Rate



Emergency Room Transfers



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