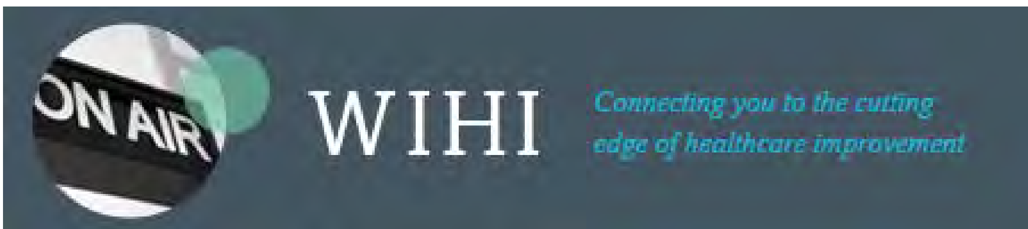
February 27, 2014



Mobilizing Skilled Nursing Facilities to Reduce Avoidable Rehospitalization: New Imperatives and New Models

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Madge Kaplan

Director of Communications
Institute for Healthcare Improvement

Madge Kaplan, IHI's Director of Communications, is responsible for developing new and innovative means for IHI to communicate the stories, leading examples of change, and policy implications emerging from the world of quality improvement — both in the U.S. and internationally. Prior to joining IHI in July 2004, Ms. Kaplan spent 20 years as a broadcast journalist for public radio – most recently working as a health correspondent for National Public Radio. Ms. Kaplan was the creator and Senior Editor of Marketplace Radio's Health Desk at WGBH in Boston, and was a 1989/99 Kaiser Media Fellow in Health. She has produced numerous documentaries, and her reporting has been recognized by American Women in Radio and Television, Pew Charitable Trusts, American Academy of Nursing and Massachusetts Broadcasters Association.

Marie Schall

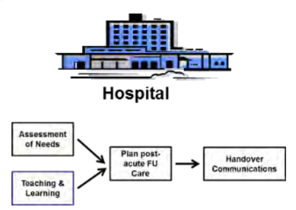
Institute for Healthcare Improvement

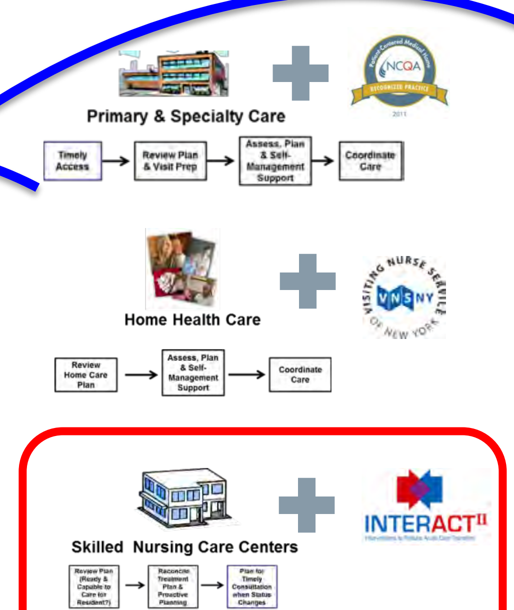
Marie W. Schall, MA, Director, Institute for Healthcare Improvement, directs innovation and improvement projects including the just completed STate Action on Avoidable Rehospitalizations (STAAR.) initiative - a four year effort supported by the Commonwealth Fund to improve transitions in care and reduce unnecessary hospitalizations. Ms. Schall has over 15 years of experience in guiding office practices in redesigning their care systems and in testing and developing innovations in office practices and other settings that span the continuum of care. She has also served as IHI's key liaison with the several major professional societies and organizations, including ABIM, AAFP, AMGA, and ACP. In addition, Ms. Schall is a senior faculty for IHI's Breakthrough Series College and leads the ongoing development of IHI's spread and scale-up methodology and programming. Prior to joining IHI in 1995, Ms. Schall designed and led improvement projects for PRONJ (the New Jersey Quality Improvement Organization) and was Director of Research for the Health Research and Educational Trust of New Jersey, a non-profit affiliate of the New Jersey Hospital Association.

Alternative or Supplemental Care for High-Risk Patients

Transition to Community Care Settings

Transition from Hospital to Home or other Care Setting





The Transitional Care Model (TCM)

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans

Key Changes for Improving Transitions into Skilled Nursing

1. Ensure SNF is ready and capable to care for the resident
2. Reconcile treatment plan and medications
3. Engage the resident and their family caregiver in a partnership to create an overall plan of care

http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx

Laurie Herndon

Massachusetts Senior Care Foundation

Laurie Herndon, GNP, is the Director for Clinical Quality at the Massachusetts Senior Care Foundation. In this role works she with nursing home owners, frontline providers, and colleagues from all sectors of health care to improve quality, innovation, and research in MA nursing facilities. Ms. Herndon is also a Gerontological Nurse Practitioner with 15 years of clinical experience in skilled nursing facilities. She has worked as a project consultant for a number of New England Quality Improvement Organizations on topics including Depression, Falls, and Medication Management. She has also consulted with the Massachusetts Board of Registration in Nursing on both practice and regulatory-related issues. Ms. Herndon has served as the Senior Project Coordinator on several INTERACT projects and in this role has trained facilities from across the country on how to implement INTERACT. INTERACT stands for Interventions to Reduce Acute Care Transfers, and is a quality improvement program that focuses on the management of acute changes in the conditions of patients residing in skilled nursing facilities.

Overview of the INTERACT Quality Improvement Program

Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources

Communication Tools

Decision Support Tools

Advance Care Planning Tools

Quality Improvement Tools

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The INTERACT
Quality Improvement Program: Building Evidence

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project

Joseph G. Ouslander, MD,†‡ Gerri Lamb, PhD, RN, FAAN,§ Ruth Tappen, EdD, FAAN,‡ Laurie Herndon, MSN, GNP,‖ Sanya Diaz, MD,* Bernard A. Roos, MD,†#** David C. Grabowski, PhD,†† and Alice Bonner, PhD, RN‡‡*

A substantial proportion of hospitalizations of nursing home (NH) residents may be avoidable. Medicare payment reforms, such as bundled payments for episodes of care and value-based purchasing, will change incentives that favor hospitalization but could result in care quality problems if NHs lack the resources and training to identify and manage acute conditions proactively. Interventions to Reduce Acute Care Transfers (INTERACT) II is a quality improvement intervention that includes a set of tools and strategies designed to assist NH staff in early identification, assessment, communication, and documentation about changes in resident status. INTERACT II was evaluated in 25 NHs in three states in a 6-month quality improvement initiative that provided tools, on-site education, and teleconferences every 2 weeks facilitated by an experienced nurse practitioner. There was a 17% reduction in self-reported hospital admissions in these 25 NHs from the same 6-month period in the previous year. The group of 17 NHs rated as engaged in the initiative had a 24% reduction, compared with 6% in the group of eight NHs rated as not engaged and 3% in a comparison group of 11 NHs. The average cost of the 6-month implementation was $7,700 per NH. The projected savings to Medicare in a 100-bed NH were approximately $125,000 per year. Despite challenges in implementation and caveats about the accuracy of self-reported hospitalization rates and the characteristics of the participating NHs, the trends in these results suggest that INTERACT II should be further evaluated in randomized controlled trials to determine its effect on avoidable hospitalizations and their related morbidity and cost. **J Am Geriatr Soc 59:745–753, 2011.**

Key words: hospitalizations; nursing home residents

From the *Charles E. Schmidt College of Medicine, Florida Atlantic University, Boca Raton, Florida; †Geriatrics Institute, Miller School of Medicine, University of Miami, Miami, Florida; ‡Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, Florida; §College of Nursing and Healthcare Innovation, Arizona State University, Tucson, Arizona; ‖Massachusetts Senior Care Foundation, Boston, Massachusetts; #Geriatric Research, Education, and Clinical Center, Bruce W. Carter Veterans Affairs Medical Center, Miami, Florida; **Stein Gerontological Institute, Miami Jewish Health Systems, Miami, Florida; ††Harvard Medical School, Boston, Massachusetts; and ‡‡Bureau of Health Care Safety and Quality, Massachusetts Department of Public Health, Boston, Massachusetts.

Address correspondence to Joseph G. Ouslander, Charles E. Schmidt College of Medicine, Florida Atlantic University, 777 Glades Rd., Bldg. 71, Boca Raton, FL 33431-0991. E-mail: joseph.ouslander@fau.edu

DOI: 10.1111/j.1532-5415.2011.03333.x

Hospitalization of nursing home (NH) residents, although often essential for safe and high-quality care of acute conditions, can result in many iatrogenic complications, morbidity, and excess healthcare expenditures. Up-to-date national data on the frequency of hospitalization of NH residents are difficult to obtain. The rate of hospitalization of residents in Georgia NHs in a 15-month period in 2006/07 varied from 0 to 4.81 per 1,000 resident days.[1] A recent study that includes a state-by-state analysis reported that, of people admitted to skilled nursing facilities in 2006, 23.5% were hospitalized within 30 days.[2] In addition to being common, previous research suggests that a substantial proportion of hospitalizations of NH residents may be avoidable.[1–10] Reforms to the Medicare fee-for-service system, such as pay-for-performance (or value-based purchasing) and bundling of payments for episodes of care,[11–17] have the potential to mitigate financial incentives that currently favor hospitalization of NH residents.[18,19] However, changing the financial incentives could also result in inadequate care if NHs do not have the infrastructure to manage residents with acute changes in clinical condition, including clinical practice tools, adequate numbers of NH staff (especially licensed practical and registered nurses) with training in the assessment and management of acute changes in status, primary care clinicians to use the tools, and rapid access to ancillary services such as diagnostic testing,

rican Geriatrics Society 0002-8614/11/$15.00

Commonwealth Fund Project Results

Facilities	Mean Hospitalization Rate per 1000 resident days		Mean Change	p value	Relative Reduction in All-Cause Hospitalizations
	Pre intervention	During Intervention			
All INTERACT facilities (N = 25)	3.99	3.32	- 0.69	0.02	17%
Engaged facilities (N = 17)	4.01	3.13	- 0.90	0.01	24%
Not engaged facilities (N = 8)	3.96	3.71	- 0.26	0.69	6%

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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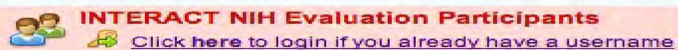
www.interact2.net

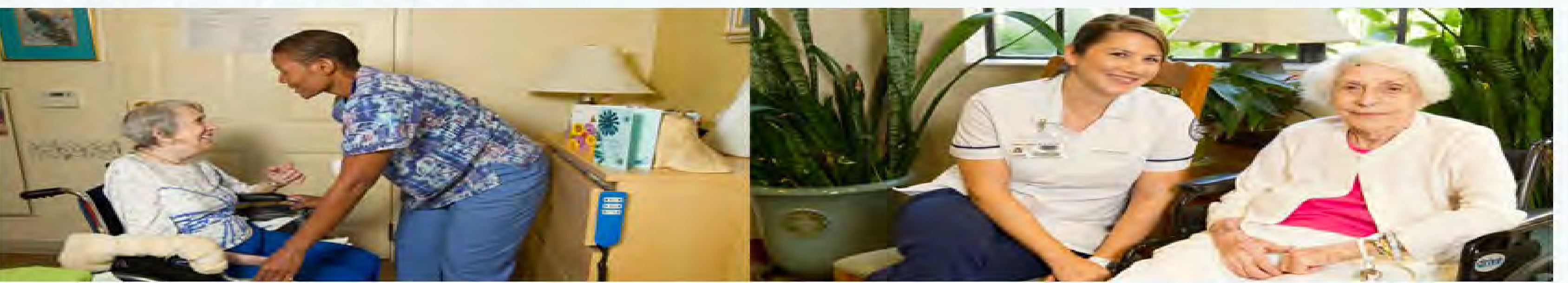
Interventions to Reduce Acute Care Transfers

Home · About INTERACT · INTERACT Tools · Educational Resources · Links to Other Resources · Project Team · Contact Us

What is INTERACT?

INTERACT (**I**nterventions to **R**educe **A**cute **C**are **T**ransfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.





What is the purpose of INTERACT?

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

INTERACT Project Team Section
Click here to login if you already have a username

Announcements

- INTERACT Hospitalization Rate Tracking Tool for 2014 now available 1/9/2014
- INTERACT eCurriculum on Medline University 6/18/2013
- Information about the eINTERACT Certification Panel and Process is available at http://www.einteract.info/vendors.html 6/21/2013
- Licenses for INTERACT v3.0 for Nursing Homes for EHRs and HIT are now available 6/24/2013

Publications Related to INTERACT

- Measurement of Potentially Preventable Hospitalizations, Long Term Quality Alliance, 2012
- Reducing Unnecessary Hospitalizations - N Engl J Med 2011
- INTERACT Evaluation - J Amer Geriatr Soc 2011
- INTERACT and the EMR Ann LTC 2011
- Avoidable Hospitalizations - J Amer Geriatr Soc 2010

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Annette Crawford

Stafford Healthcare

Annette Crawford has been a licensed nursing home administrator since 1989. She has managed Stafford Healthcare at Ridgemont, located in Port Orchard, WA, for 11 years. The campus includes a 21-bed Transitional Care Unit, 75-bed Residential Care Unit, and a 46-unit Independent Retirement facility. Ms. Crawford is also the co-founder of the Kitsap County Cross Continuum Care Transitions Project (KC4TP), which began In March 2012. In support of the CMS Partnership for Patients initiative, KC4TP's mission is to improve safety, quality of care, and the patient's satisfaction as they experience care transitions within Kitsap County. Initiatives implemented by KC4TP have been supported and recognized by Qualis Health, the Institute for Healthcare Improvement, the National Transitions of Care Coalition, and the Colorado Foundation for Medical Care. Annette Crawford was honored to review and contribute to the newly-updated IHI How-To Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations.

KC4TP Commitment to INTERACT implementation:

- 9 of 10 Kitsap SNFs agree to implementation
- Qualis Health develops tool for monitoring
- Hospital hosted INTERACT Trainings
- Case Reviews using QA Improvement Tool
- INTERACT Advance Care Planning Sessions

KC4TP INTERACT IMPLEMENTATION MONITOR/MEASURE

Communication Tools	Not Implemented	Trialed or Small Test of Change	Implemented but not Reliable, Consistent Process	Consistently Implemented, Standard Reliable Process	Audit or Other Evidence of Implementation	Process & Outcome Measurements Tracked
Early Warning Tool "Stop and Watch" Pocket Card and Report						
SBAR Communication Tool and Progress Note						
Change in Condition File Cards						
Resident Transfer Form						
Acute Care Transfer Envelope with Checklist						
Quality Improvement Tool For Review of Acute Care Transfers						
Acute Care Transfer Log						
Care Paths						
Mental Status Change						
Fever						
Symptoms of Lower Respiratory Infection						
Symptoms of CHF						
Symptoms of UTI						
Dehydration						
Advance Care Planning Tools						
Identifying Residents to Consider for Palliative Care and Hospice – Pocket Card						
Advance Care Planning Communication Guide – File Cards						
Comfort Care Order Set – File Cards						
Educational Information						
Advance Care Plan Tracking Form						

Adapted by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, from materials provided by XXXXXXXX and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
ID/WA-C8-QH-810-06-12

INTERACT Implementation Checklist

INTERACT
Version 3.0 Tool

This checklist is intended to assist organizations in determining the degree to which the INTERACT **Quality Improvement Program** is being implemented. INTERACT Implementation requires all of these key components, not just using selected INTERACT Tools.

Facility Name ______________________ **Date** ______/______/______

Contact ______________________ **Tel** (______) ______________

INTERACT Implementation and Care Processes	Yes	No
Strong Leadership Support		
Incorporate INTERACT into overall QI program	Y	N
Allocate time for education and implementation activities	Y	N
INTERACT tools visible and accessible for everyday care	Y	N
Appointment of Champions and a Team		
Champion in place with time allocated	Y	N
Co-champion in place with time allocated	Y	N
Interdisciplinary team meets regularly to discuss implementation and outcomes	Y	N
Staff Education		
Required staff education on INTERACT	Y	N
Required INTERACT overview in new staff orientation	Y	N
Tracking and Trending Hospital Transfer Rates		
All unplanned admissions	Y	N
30-day readmissions	Y	N
Emergency room visits without admission	Y	N
Observation stays	Y	N
Quality Improvement Activities		
Perform root cause analyses using the INTERACT Quality Improvement or similar tool	Y	N
Summarize root cause analyses data and use results to focus care process improvements and education	Y	N
In-person meetings with local hospitals in a cross-continuum team focused on reducing preventable hospital transfers	Y	N

INTERACT Tool Use	Implemented on ALL Units	Implemented on Some Units
Stop and Watch	☐	☐
SBAR Form and Progress Note	☐	☐
Change in Condition File Cards	☐	☐
Care Paths	☐	☐
Transfer Forms or Transfer Data Lists	☐	☐
Nursing Home Capabilities List	☐	☐
Transfer Document Checklist	☐	☐
Medication Reconciliation Worksheet	☐	☐
Advance Care Planning Tracking Form	☐	☐
Other Advance Care Planning Tools	☐	☐

Outcomes of INTERACT Implementation	Yes	No
Improved Communication		
Between nursing staff	Y	N
Between nursing staff and medical care providers	Y	N
With the hospital	Y	N
Improved Nursing Evaluation		
Earlier identification of acute changes in condition	Y	N
More comprehensive evaluation of acute changes in condition	Y	N
Improved Documentation		
More structured and relevant progress notes	Y	N
Reduced Hospitalization Rates		
All unplanned admissions	Y	N
30-day readmissions	Y	N
Emergency room visits without admission	Y	N
Observation stays	Y	N
Improved QI Processes		
Better understanding of preventable transfers	Y	N
Targeted educational activities based on root cause analyses	Y	N
Targeted care process changes based on root cause analyses	Y	N
Better Hospital Relationships		
Improved referral patterns	Y	N

Comments on Implementation

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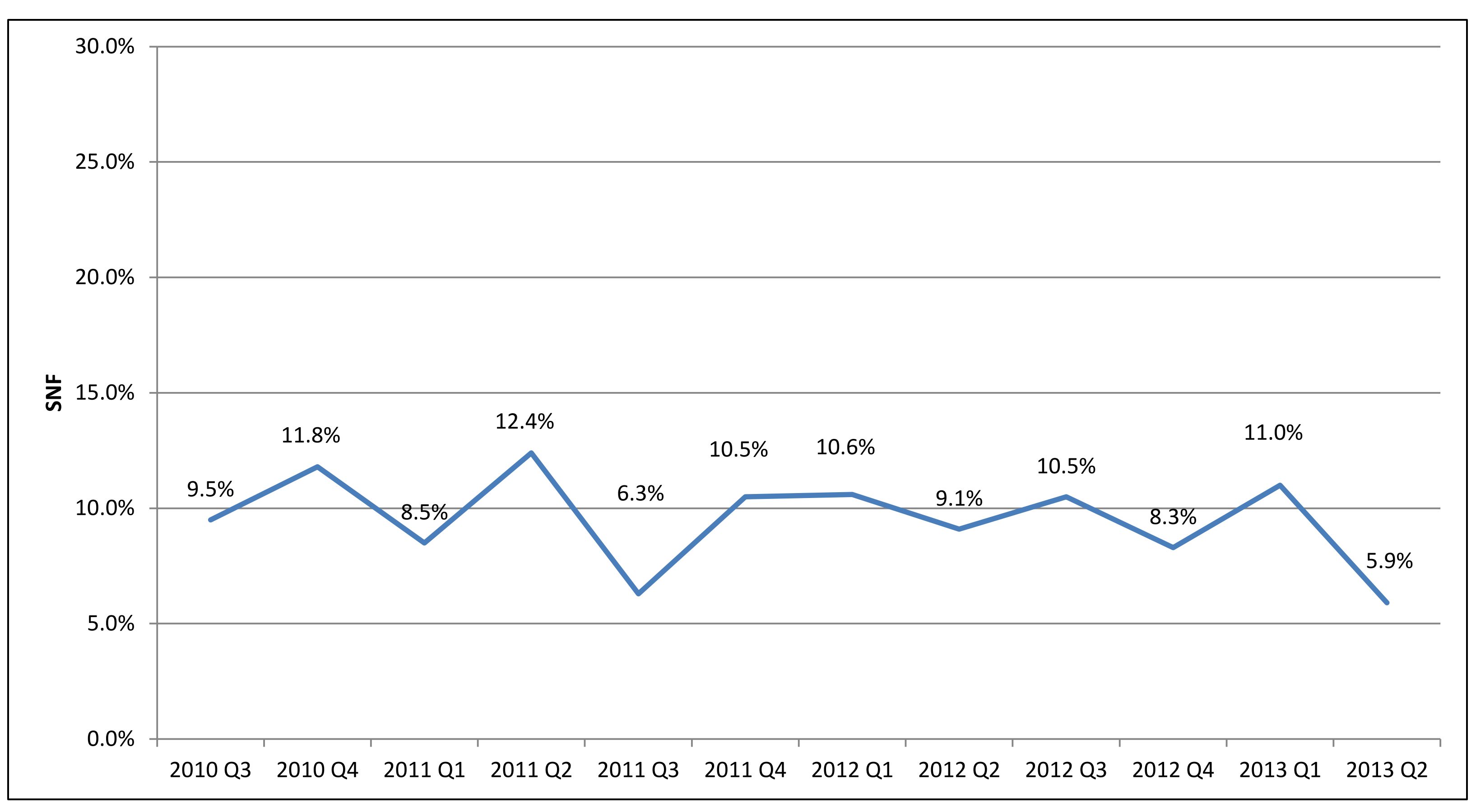
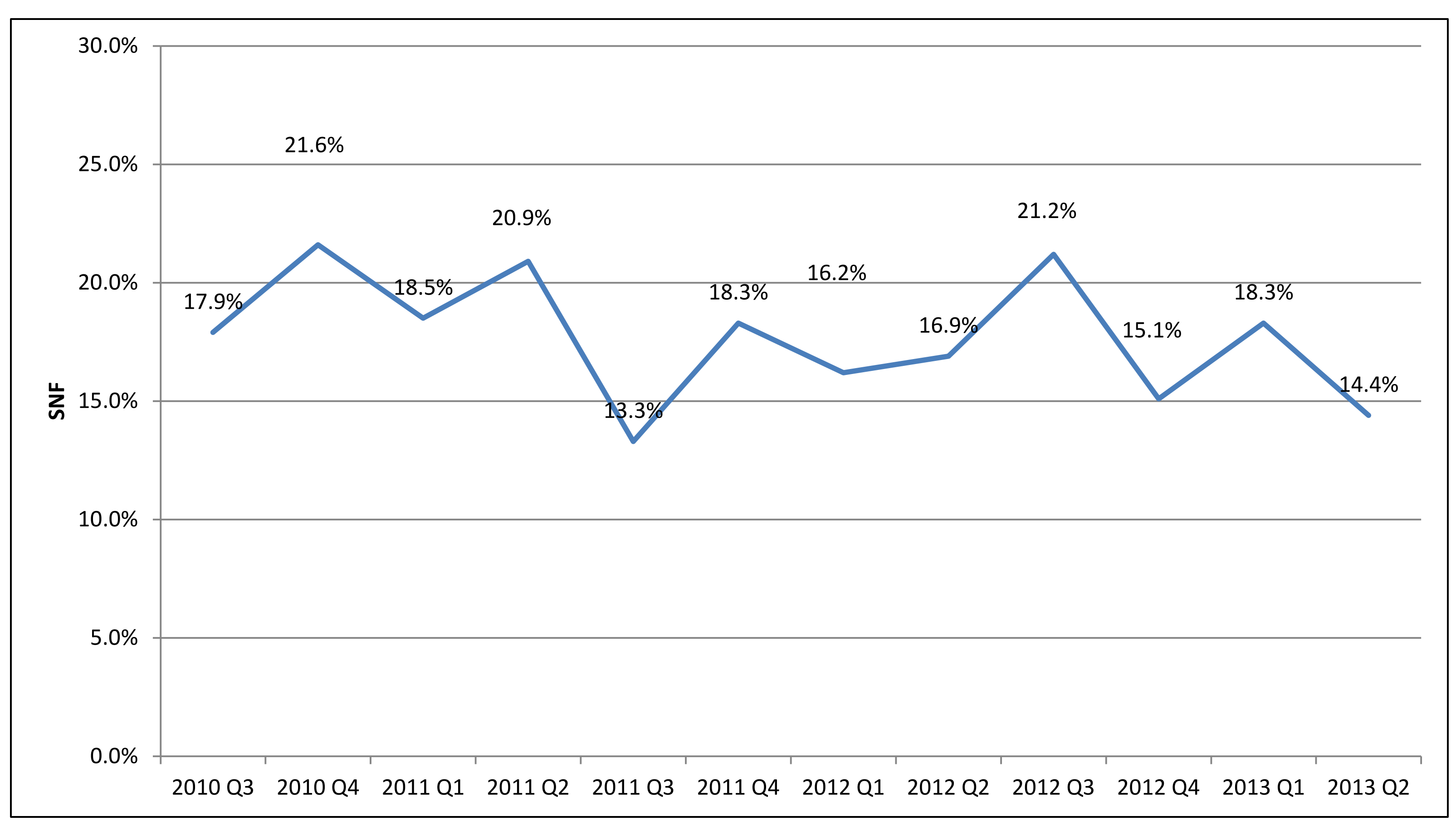
Hospital Readmission Rate by Initial Discharge Destination
Returning from **Initia**l Post Acute Setting

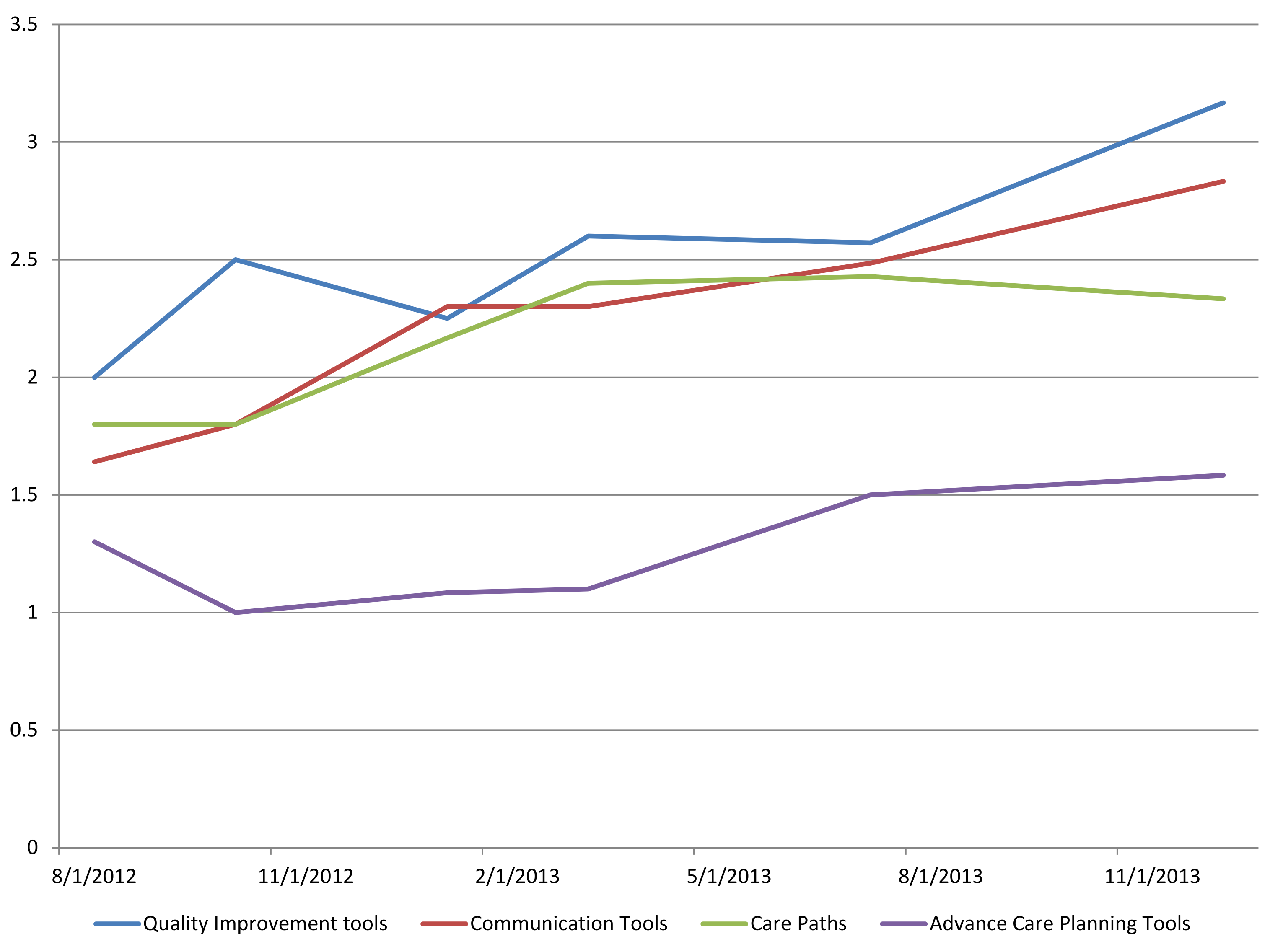


Patients discharged to a SNF and readmitted from the SNF

Hospital Readmission Rate by Initial Post Acute Destination Returning from **ANY** Post Acute Setting



Patients discharged to a SNF and readmitted from any care setting


Implementation Progress by Tool Type
3.5
3
2.5
2
1.5
1
0.5
0
8/1/2012
11/1/2012
2/1/2013
5/1/2013
8/1/2013
11/1/2013
Quality Improvement tools
Communication Tools
Care Paths
Advance Care Planning Tools

David Gifford

American Health Care Association

David Gifford, MD, MPH, is the Senior Vice President of Quality and Regulatory Affairs at the American Health Care Association, the largest association in the country representing long term and post-acute care facilities. He helped create the department that assists providers in their quality improvement efforts and works with Administration officials on regulations and policies impacting the profession. Dr. Gifford also serves on the Board of the Advancing Excellence in America's Nursing Homes campaign. He is a former Director of the Rhode Island Department of Health and Chief Medical Officer for Quality Partners of Rhode Island where he directed CMS' national nursing home-based quality improvement effort.

AHCA Quality Initiative Goals

Safely reduce 30-day hospital readmissions by 15% by 2015

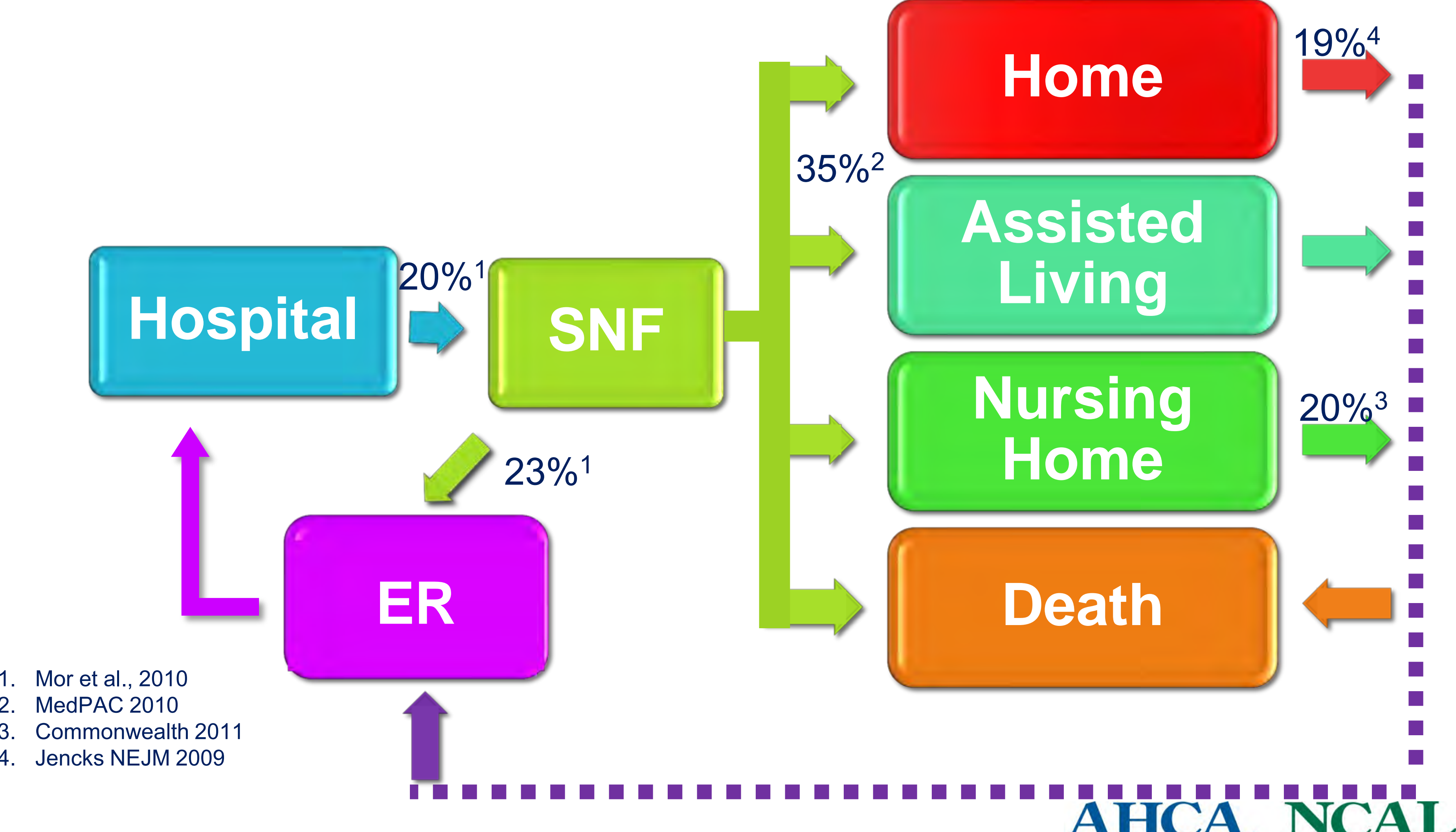
Reduce nursing staff turnover by 15% by 2015

Increase customer satisfaction to 90% by 2015

Safely reduce the off-label use of antipsychotics by 15% by the end of 2013

QualityInitiative.ahcancal.org

Use of Long Term Care Services



State Avg 30d SNF Rehospitalizations

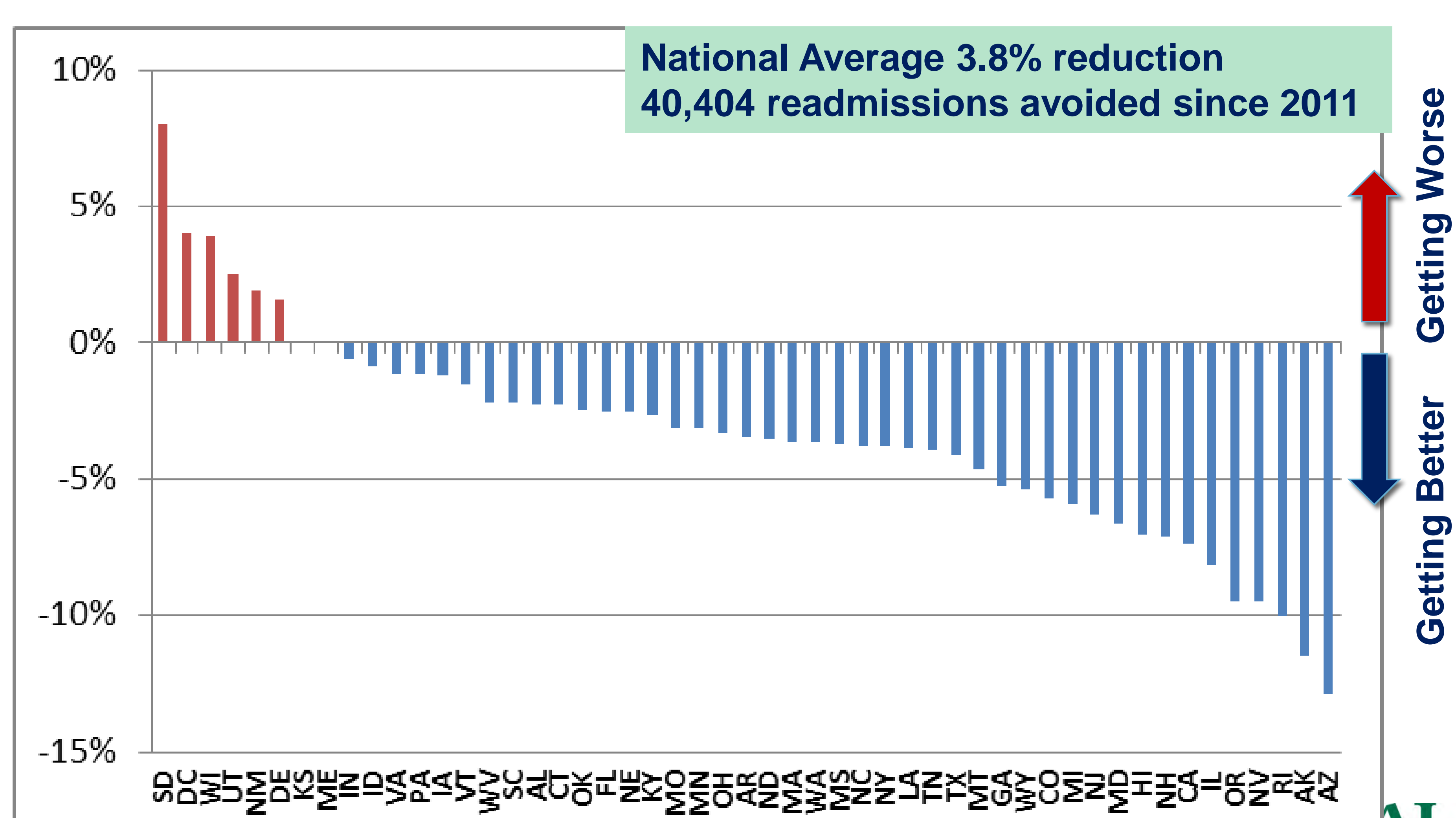
State Avg 30d SNF Rehospitalizations

25
20
15
10
5
0

Nat Avg

HI ID UT CO MT SD VT ND WY NH ME MN AK NM WA OR MA NE WI IA AZ NV CA KS CT AL MI PA IN OH US TN RI SC VA NC WV NY GA MD TX KY DE IL MO FL NJ DC AR OK MS LA

Change in State Average Rehospitalization 2011 to 2013 Q3



AMERICAN HEALTH CARE ASSOCIATION NATIONAL CENTER FOR ASSISTED LIVING

SNF Change in Rehospitalization 2011 Q4 to 2013 Q2

Number of facilities

1000
500
0
-500
-1000

Getting Better
Getting Worse

887
528
385
352
297
244
176
-354
-435
-556
-595
-576
-517
-830

(-)30% & more
(-)25->30%
(-)20->25%
(-)15->20%
(-)10->15%
(-)05->10%
(-)00->05%
(+)00-<05%
(+)05-<10%
(+)10-<15%
(+)15-<20%
(+)20-<25%
(+)25-<30%
(+)30% & more

Percent Change Range(2011Q4-2013Q3)

Where Can I Get Data on My Rates?

- Use Long Term Care Trend Tracker
  - See Appendix for OnPoint-30 risk adjusted measure from PointRight
  - www.ltctrendtracker.com
- Real-time internal data collection & analysis
  - Advancing Excellence free INTERCT excel tracking tool
  - www.nhqualitycampaign.org/star_index.aspx?controls=HospitalizationsIdentifyBaseline

Search

Advancing Excellence in America's Nursing Homes

Making nursing homes better places to live, work and visit.

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Getting Started

Explore Goals

Process Goals:
- Consistent Assignment
- Hospitalizations
- Person Centered Care
- Staff Stability

Clinical Outcome Goals:
- Infections
- Medications
- Mobility
- Pain
- Pressure Ulcers

Hospitalizations

Explore Goal | Identify Baseline | Examine Process | Improve | Leadership | Monitor & Sustain | Celebrate

Now that you know what you want to improve, it's important to identify your starting point or baseline. Download the data tracking tool and collect data for a month or so to determine your starting point.

Safely Reduce Hospitalizations Tracking Tool

This tool calculates rates for 30-day Readmission, Hospital Admissions, Transfers to Emergency Only, and Transfers Resulting in Observation Stay. This tool also has features that allow you to track patterns and processes affecting your hospital transfers.
AE_SafelyReduceHospitalizationsTrackingTool_v3.0_5-21-13.xls

This tool has been updated to be compatible with Excel 2010. If you are using Excel 2010 and still experience issues, please email help@nhqualitycampaign.org.

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Institute for Healthcare Improvement

Description

A not-for-profit organization founded in 1991 and based in Cambridge, Massachusetts, the Institute for Healthcare Improvement (IHI) is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide. IHI works with health care providers and others to accelerate the measurable and continual progress of health care systems toward safety,... ...More

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3	WIHI: Testing,Testing Is This P...	1:02:06	5/17/12	WIHI is an exciting new au...		FREE
4	WIHI: Pursuing the Triple Aim ...	1:23:04	5/3/12	WIHI is an exciting new au...		FREE
5	WIHI: You Can't Improve What ...	1:00:04	4/19/12	WIHI is an exciting new au...		FREE
6	WIHI: Going, Going, Green Em...	58:59	4/5/12	WIHI is an exciting new au...		FREE
7	WIHI: What Can You Learn in 9...	58:59	3/22/12	WIHI is an exciting new au...		FREE
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10	WIHI: The Social Imperative to ...	58:18	2/9/12	WIHI is an exciting new au...		FREE
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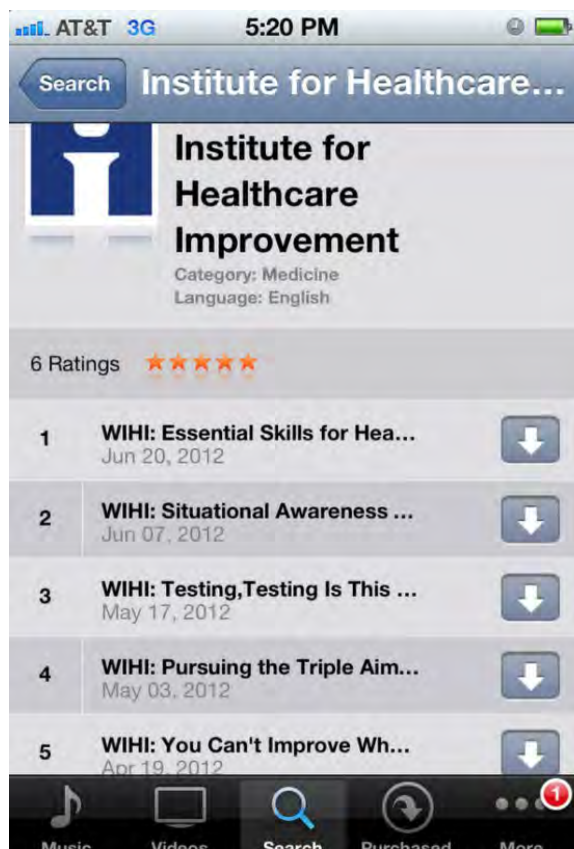

Reducing Avoidable Readmissions by Improving Conditions in Care
April 23-24 San Diego, CA

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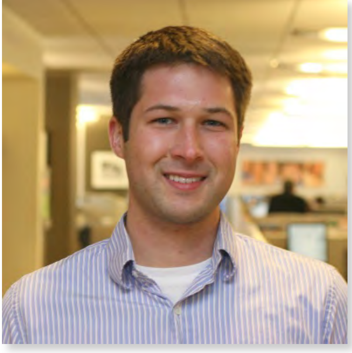

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March 13, 2014

- **How High, How Low? Shared Decision Making Amidst Shifting (Hypertension) Guidelines**

Produced in collaboration with the
Journal of the American Medical Association (JAMA)

March 27, 2014

- **High Risk, High Cost Patients**

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