The INTERACT® Hospitalization Tracking Tool
LeadingAge Washington
Annual Meeting and Conference

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Qualis Health Washington

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• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day
• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington
• QIOs: the largest federal network dedicated to improving health quality at the community level
The Role of Skilled Nursing Facilities in Care Transitions

Patients admitted to SNF for rehab/recovery are often sicker and have higher needs than those who go directly home

- Already at higher risk for readmission

SNF are a key component in successful transitions

- What are the tools/skills/processes necessary to:
  - Quickly and appropriately identify and respond to changes in condition
  - Communicate effectively with MDs and hospital providers
  - Track progress on QI initiatives and continuously improve

SNF Motivations

- Reduce resident and family suffering
- Become a preferred provider for local hospital referrals
- Decrease workload associated with transitioning and readmitting residents
- Increase professional satisfaction and morale
- Penalties for readmissions, value-based purchasing on their way—a reality for hospitals, soon for others
- Prepare to participate in payment reform initiatives (ACOs, bundled payments, commercial payer rates)
“Drivers” of Poor Transitions

Lack of patient and family activation
• Health literacy
• Self-management skills & tools
• Motivation, locus of control

Lack of standard and known processes
• Patient discharge, hand-over
• Internal work flow

Lack of information transfer
• Especially cross-setting
• Delays, inaccuracies, missing information

Two Approaches to Interventions

System changes
– Hardwiring standard and reliable processes
– Benefit: Broad reach for all patients, all payers, all units
– Challenge: Improving and sustaining processes is hard work!

Targeted population interventions
– Usually chronic condition-specific (like HF)
– Coaching, case management
– Benefit: care based on identified risk
– Challenge: narrow focus, may not move overall readmit rate

The INTERACT® Program is a system/culture change intervention
Acknowledgement

- The INTERACT® Program and Tools were initially developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare & Medicaid Services (CMS).
- The current version of the INTERACT® Program was developed by the INTERACT® interdisciplinary team under the leadership of Dr. Joseph G. Ouslander, MD with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by The Commonwealth Fund.

The INTERACT® Program

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources
- The program is located at http://interact2.net
- Includes an excel program for tracking readmissions and reporting outcomes
**Differences with the INTERACT® Program**

- Facilities using the INTERACT® Program components are focused on improving the quality of care for patients and reducing hospital readmissions
- Use of INTERACT® tools provide nursing staff guidelines for assessment and intervention to identify changes in condition sooner
- INTERACT® tools assist facilities to identify and provide for educational needs of staff
- Use of evidence-based, standardized tools allows for clear, comprehensive communication and coordination across all settings, particularly during transfers

**INTERACT® Design and Purpose**

- Improve care and reduce the frequency of potentially avoidable acute care transfers of nursing home residents
- Minimize risks associated with hospitalization
- Improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities
- Target is avoidable transfers, NOT to prevent all transfers
- More rapid transfer of residents who do need hospital care
The INTERACT® Program

Organization of Tools

- Quality Improvement Tools
- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools
Quality Improvement Tools

- Hospitalization Rate Tracking Tool (Calculating Hospitalization Rates)
- Acute Care Transfer Log
- Quality Improvement Tool for Review of Acute Care Transfers
- Quality Improvement Summary

Quality Improvement Tool for Review of Acute Care Transfers
Quality Improvement Tool for Review of Acute Care Transfers

The INTERACT QI Tool is designed to help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete the 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.

SECTION 1: Describe Resident Characteristics

Name: __________________________
Date of most recent admission to acute care hospital: ___________
Length of stay: ___________

A. Major diagnosis or admission: __________________________
B. Conditions that put resident at risk for hospital admission or readmission:
- [ ] Pneumonia
- [ ] CHF
- [ ] Comorbidities (e.g., HTN, DM, COPD, CHF)
- [ ] Other:

- No
- Yes (for dates and reasons)

C. Resident hospitalized in the past 30 days? __________________________
D. Resident hospitalized in the past 12 months? __________________________

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

A. Describe the condition that caused the transfer: __________________________
B. Briefly describe the change, symptoms, or other factors that led the transfer and then check each item below that applies.
- [ ] Other:

Purpose

• Review each transfer to understand the reasons for transfer
• Identify possible opportunities to prevent avoidable transfers

When to Use

• Within 24-48 hours after transfer
• Representative sample of transfers to look for common patterns & identify improvements
Quality Improvement Tool

Who
– Incorporate into existing QI process
– Form an acute care transfer team
– If one staff person, they interview CNAs, nurses & other staff
– Include rehab and support staff (dietary, activities)
– Family members may have important contribution

Quality Improvement Tool

• Root Cause Analysis: The Rest of the Story
• Demographics
• What happened?
• Contributing factors
• Attempts to manage in SNF
• Avoidable?
• Staff thoughts about this
• “Ah ha” moments
• Should have returned sooner?

• Opportunities for improvement
• Online version coming
• Cross continuum review of cases
Quality Improvement Tool

**Helpful Tips**
- Complete all sections of the tool
- Complete each section in order
- Involve staff who participate in processes covered by the review
- Be specific when describing improvement next steps

Quality Improvement Summary Worksheet
QI Summary Worksheet

- Moves the focus from individual QI Tools (one patient) to patterns across all QI Tools (multiple patients)
- Allows patterns to begin to form
- Focuses improvement activities
- Unfortunately not often used – a missed opportunity!

QI Summary Worksheet

- **Step 1:** Number and timeframe of individual QI Tools in the summary
- **Step 2:** Compares across categories
  - Resident characteristics
  - Changes in condition
  - Actions taken
  - Hospital transfers and contributing factors
  - Potentially preventable?
- **Step 3:** Summarizes common factors
Measurement of Hospital Transfer Rates

• **Excel spreadsheet tracking tool**
• **Tracking outcomes**
  – Hospitalization rates
  – Readmission rates (30-day)
  – ER rates
  – Observation stay rates
• **Tracking other variables**
  – Long stay vs. rehab, payer type, etc
  – Process measures – adherence to clinical practice guidelines and INTERACT® tools

Root Cause Analysis (RCA)

• Identifies causal factors leading to acute care transfers
• Shows what efforts were made to treat and keep
• Highlights common patterns
• Identifies possible gaps in either facility processes or staff knowledge
Implications of RCA

- Identifies system-wide or process improvement opportunities
- Guides educational efforts both for initial orientation and continuing in-services
- Determines interventions needing implementation – i.e. which tools

Common Reasons for Transfers

- Resident characteristics or condition
- Acute change and other factors
- Actions prior to transfer
- Characteristics of the transfer
Examples of Reports

<table>
<thead>
<tr>
<th>Admissions by Day of Week</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

**Percent of all Admissions**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

100%
### Source of Admissions

The 5 places from which our nursing home most frequently admits residents with recent hospital stay

<table>
<thead>
<tr>
<th>Percent of all Admissions</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>n/a</td>
</tr>
<tr>
<td>80%</td>
<td>n/a</td>
</tr>
<tr>
<td>60%</td>
<td>n/a</td>
</tr>
<tr>
<td>40%</td>
<td>n/a</td>
</tr>
<tr>
<td>20%</td>
<td>n/a</td>
</tr>
<tr>
<td>0%</td>
<td>n/a</td>
</tr>
<tr>
<td>Not recorded</td>
<td>0</td>
</tr>
</tbody>
</table>

### Admissions by Health Plan

for the 5 plans for which you admit the most residents

<table>
<thead>
<tr>
<th>Percent of all Admissions</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>n/a</td>
</tr>
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<tr>
<td>60%</td>
<td>n/a</td>
</tr>
<tr>
<td>40%</td>
<td>n/a</td>
</tr>
<tr>
<td>20%</td>
<td>n/a</td>
</tr>
<tr>
<td>0%</td>
<td>n/a</td>
</tr>
<tr>
<td>Not recorded</td>
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<tr>
<td>40%</td>
<td>n/a</td>
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<tr>
<td>20%</td>
<td>n/a</td>
</tr>
<tr>
<td>0%</td>
<td>n/a</td>
</tr>
<tr>
<td>Not recorded</td>
<td>0</td>
</tr>
</tbody>
</table>
Transfers by Time of Day

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Number of Transfers</th>
<th>Percent of all Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning (7am--noon)</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Afternoon (noon--7pm)</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Evening (7pm--midnight)</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Night (midnight--7am)</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Not recorded</td>
<td>0</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Transfers by Clinician

for the 5 clinicians who order the most transfers

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Number of Transfers</th>
<th>Percent of all Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning (7am--noon)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Afternoon (noon--7pm)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Evening (7pm--midnight)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Night (midnight--7am)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Not recorded</td>
<td>0</td>
<td>n/a</td>
</tr>
</tbody>
</table>
### Transfers by Outcome

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number of Transfers</th>
<th>Percent of all Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED visit only</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Admitted, inpatient</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Admitted, observation</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Admitted, status uncertain</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>Not recorded</td>
<td>0</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Transfers by Sign/Symptom

- Abnormal labs or test results: 0%
- Altered mentation: 0%
- Altered mental status: 0%
- Atrial fibrillation: 0%
- Blood loss: 0%
- Chest pain: 0%
- Cough: 0%
- Delirium: 0%
- Diabetic complication: 0%
- Dysrhythmia: 0%
- Fever: 0%
- High blood pressure: 0%
- Hypotension: 0%
- Infection: 0%
- Intraabdominal bleed: 0%
- Intoxication: 0%
- Kidney failure: 0%
- Liver failure: 0%
- Malnutrition: 0%
- Nausea: 0%
- Nausea/vomiting: 0%
- Nervous system abnormality: 0%
- Obstructive jaundice: 0%
- Paralysis: 0%
- Pneumonia: 0%
- Septic shock: 0%
- Shock: 0%
- Stroke: 0%
- Trauma: 0%
- Ulcers: 0%
- Unknown: 0%
- Other sign/symptom: 0%
- Not recorded: 0%
### Status on Admission to Nursing Home

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
<th>Nov-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Acute Care</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td>Chronic Long Term Care (non-Medicare)</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
</tr>
<tr>
<td>All Residents</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
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</tr>
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</table>

### Questions about Application

- What are you doing with your Tracking Tool Reports?
- Who is doing root cause analysis on each transfer?
- When and how?
Discussion

Data - What is Happening?

30-Day Readmission Rates

- Post-Acute Care Readmissions
- Chronic Long Term Care (non-Medicare) Readmissions
- All Residents Readmissions
Other Options for Tracking Tool Use

- Think about current use in your facility – how might you expand that capacity?
- What other uses could you find for your reports?
  - Feedback to staff
  - Implications for staff training
  - Reporting to administration/regional/corporate
- What sorts of information would you like to be tracking over time?
- What else can you think of for your reports from your data?

Follow-Up Action

Based on the discussion today, will you

- Review the QI Tool for individual cases and the QI Summary Tool?
- Share the tools with your team and discuss their use?
- Consider implementation of these tools as a PDSA Cycle?
- Consider additional implementation if you are already using one or both of the tools
Round Table Discussion and Sharing

Questions?

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For more information:
www.QualisHealthMedicare.org/Transitions

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