Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

Third National Medicare Readmissions Summit
Mini-Summit III: Successful Provider Initiatives

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Goals For Today

- Provide a very brief background of the problem
- Review the purpose of the INTERACT II toolkit
- Give an overview of some key tools
- Share lessons learned
- Discuss INTERACT II in context of other initiatives

The INTERACT Interdisciplinary Team

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Gerri Lamb, RN, PhD, FAAN	Arizona State University
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Sanya Diaz, MD	Florida Atlantic University
Alice Bonner, RN, PhD	Center for Medicare and Medicaid Services
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IN COLLABORATION WITH PARTICIPATING NURSING HOMES

Hospitalizations of NH residents are common

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

N Engl J Med 2009; 360:1418-28

- **1 in 5** Medicare fee-for-service patients admitted to an acute hospital are re-admitted within 30 days
- In any six month period, more than 15% of long stay residents are hospitalized
  - O Intrator, J. Zinn, and V. Mor, "Nursing Home Characteristics and Potentially Preventable Hospitalizations" Journal of the American Geriatrics Society 52, no. 10(2004): 1730-1736

Hospitalization of Nursing Home Residents is Costly

In 2004 in NY, Medicare spent close to $200 million on hospitalization of long-stay NH residents for "ambulatory care sensitive diagnoses"

Grabowski et al, Health Affairs

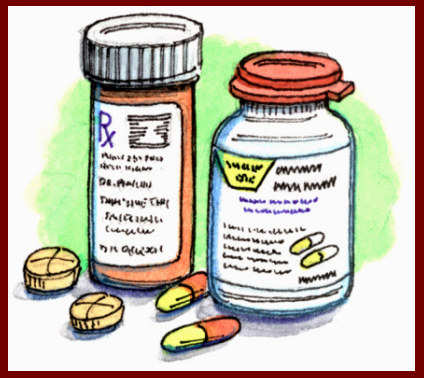
26: 1753-1761, 2007

Many Hospitalizations Are Avoidable

As many as 45% of admissions of nursing home residents to acute hospitals may be inappropriate

Saliba et al, J Amer Geriatr Soc 48:154-163, 2000

Improving Geriatric Care



A Toolkit to Improve Nursing Home Care by Reducing Avoidable Acute Care Transfers and Hospitalizations

The INTERACT II Tools, educational materials, and implementation strategies were developed by Drs. Joseph Ouslander, Gerri Lamb, Alice Bonner, and Ruth Tappen, and Laurie Herndon with input from a variety of direct care providers and national experts in a project supported by the Commonwealth Fund based at Florida Atlantic University.

Initial versions of the INTERACT Tools were developed by Dr. Ouslander and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a special study contract from CMS.

Purpose of Toolkit

- Aid in the early identification of a resident change of status
- Guide staff through a comprehensive resident assessment when a change has been identified
- Improve documentation condition
- Enhance around resident change in communication with other health care providers about a resident change of status

Design of Toolkit

- Dr. Ouslander “Simple Test”
- Feasible and efficient
- Part of the “way we do business”
- Acceptable to staff

What Is Missing Here?

Goals/language aimed at reducing ALL transfers

Why?

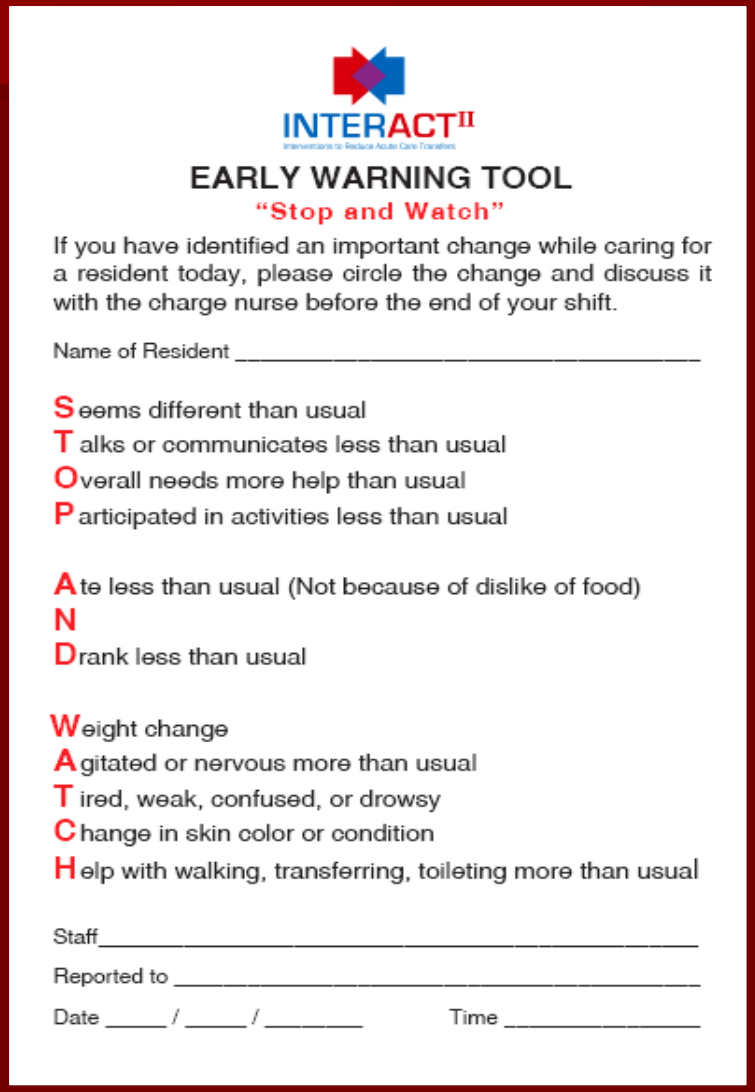
Organization of Tools in Toolkit

Communication Tools

Clinical Care Paths

Advance Care Planning Tools

Improving Communication Internally



INTERACT II

EARLY WARNING TOOL

"Stop and Watch"

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

Name of Resident _____

S eems different than usual
T alks or communicates less than usual
O verall needs more help than usual
P articipated in activities less than usual

A te less than usual (Not because of dislike of food)
N
D rank less than usual

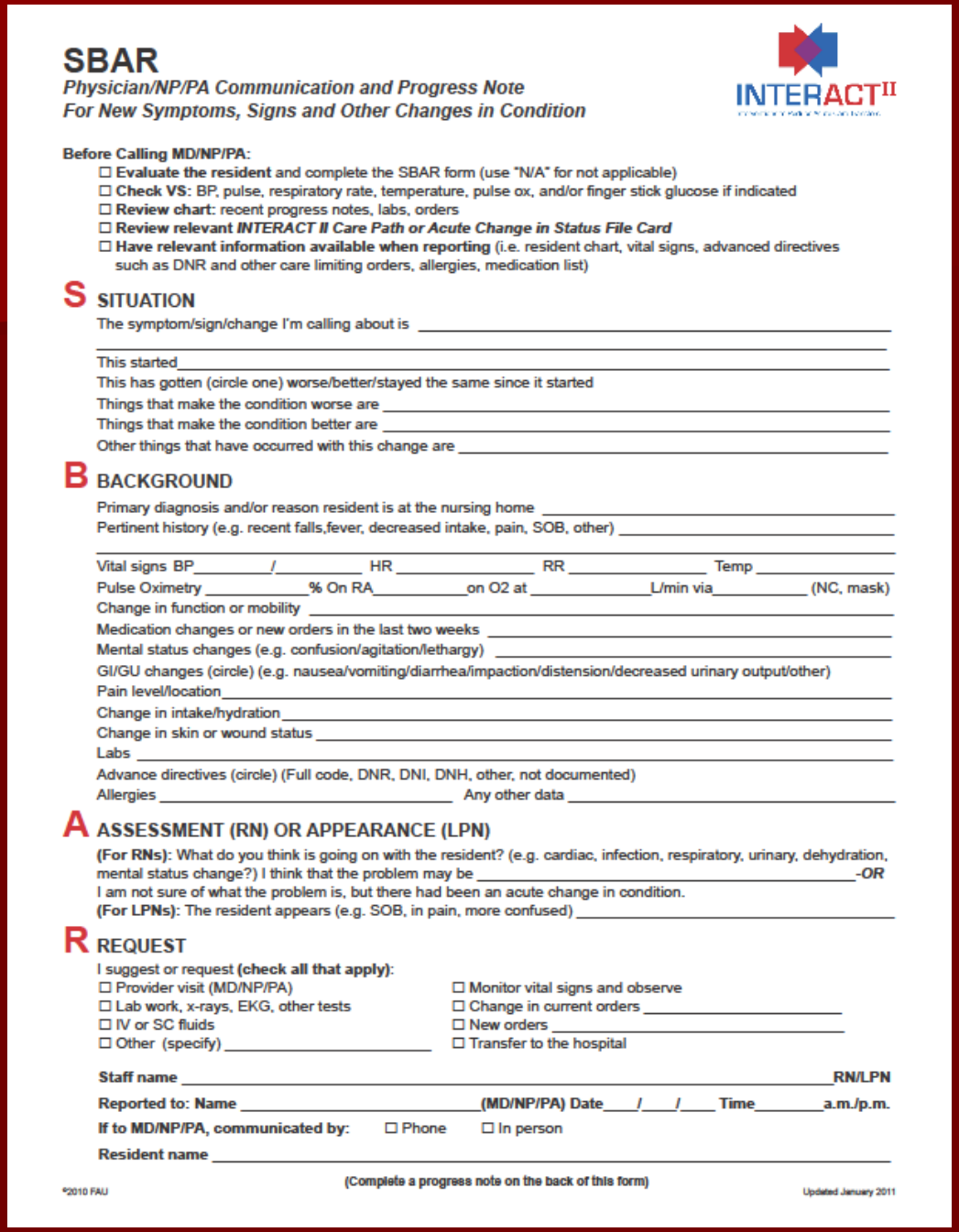
W eight change
A gitated or nervous more than usual
T ired, weak, confused, or drowsy
C hange in skin color or condition
H elp with walking, transferring, toileting more than usual

Staff _____

Reported to _____

Date ____ / ____ / _____ Time _____

- CNAs
- Rehab
- Dietary
- Housekeeping
- Activities



SBAR

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

INTERACT II

Before Calling MD/NP/PA:

- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Review chart:** recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____

_____

This started_____

This has gotten (circle one) worse/better/stayed the same since it started

Things that make the condition worse are _____

Things that make the condition better are _____

Other things that have occurred with this change are _____

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____

Pertinent history (e.g. recent falls,fever, decreased intake, pain, SOB, other) _____

_____

Vital signs BP_____/_____ HR _____ RR _____ Temp _____

Pulse Oximetry _____% On RA_____on O2 at _____L/min via_____ (NC, mask)

Change in function or mobility _____

Medication changes or new orders in the last two weeks _____

Mental status changes (e.g. confusion/agitation/lethargy) _____

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)

Pain level/location_____

Change in intake/hydration _____

Change in skin or wound status _____

Labs _____

Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)

Allergies _____ Any other data _____

A ASSESSMENT (RN) OR APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____-*OR*
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The resident appears (e.g. SOB, in pain, more confused) _____

R REQUEST

I suggest or request **(check all that apply)**:

- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ IV or SC fluids
- ☐ Other (specify) _____
- ☐ Monitor vital signs and observe
- ☐ Change in current orders _____
- ☐ New orders _____
- ☐ Transfer to the hospital

Staff name _____ **RN/LPN**

Reported to: Name _____ **(MD/NP/PA) Date**____/____/____ **Time**_____ **a.m./p.m.**

If to MD/NP/PA, communicated by: ☐ Phone ☐ In person

Resident name _____

(Complete a progress note on the back of this form)

Updated January 2011

- Nurses Notes
- Rapid Response Teams
- "Warm Handoffs"
- Warfarin Management

INTERACT II

Interventions to Reduce Acute Care Transfers

ACUTE CARE TRANSFER DOCUMENT CHECKLIST

RESIDENT NAME _____

COPIES SENT WITH RESIDENT (Check all that apply):

These documents should ALWAYS accompany patient:

____ Resident Transfer Form
____ Face Sheet
____ Current Medication List or Current MAR
____ Advance Directives
____ Care limiting Orders
____ Out of hospital DNR
____ Bed hold policy

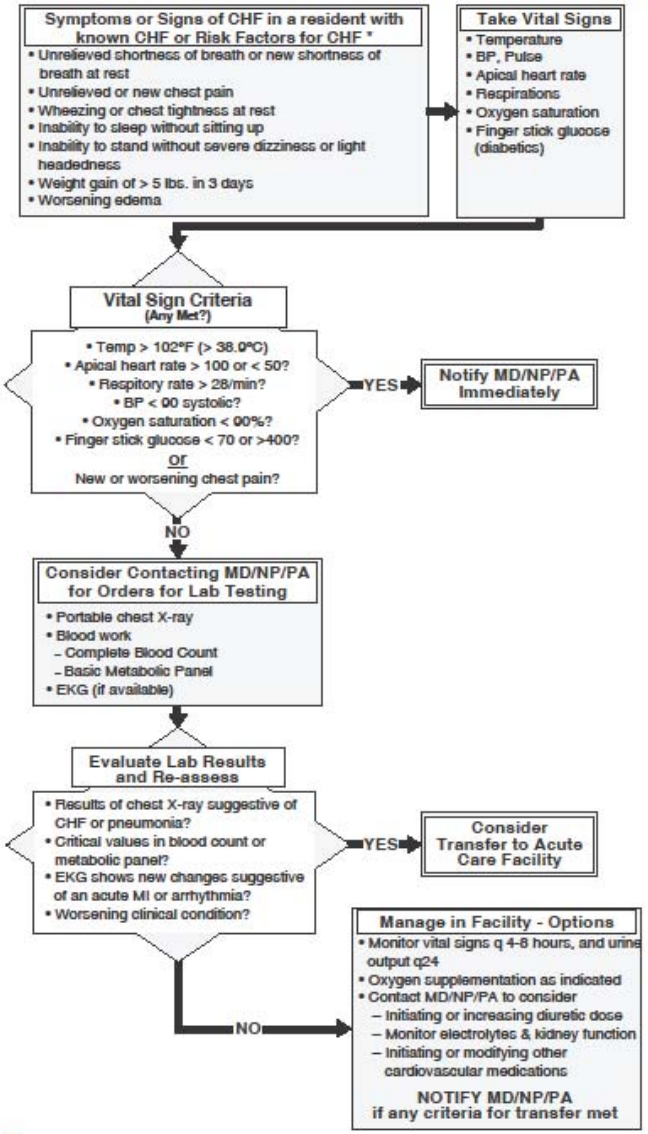
Send these documents IF INDICATED:

____ SBAR/Nurse's Progress Note
____ Most Recent History & Physical and any recent hospital discharge summary
____ Recent MD/NP/PA Orders related to Acute Condition
____ Relevant Lab Results
____ Relevant X-Rays
____ PERSONAL BELONGINGS SENT WITH RESIDENT:
____ Eyeglasses ____Hearing Aid ___ Dental Appliance
____ Other (specify)

Signature of ambulance staff accepting envelope:_____

(Please make a copy and keep this for your records in the nursing home)

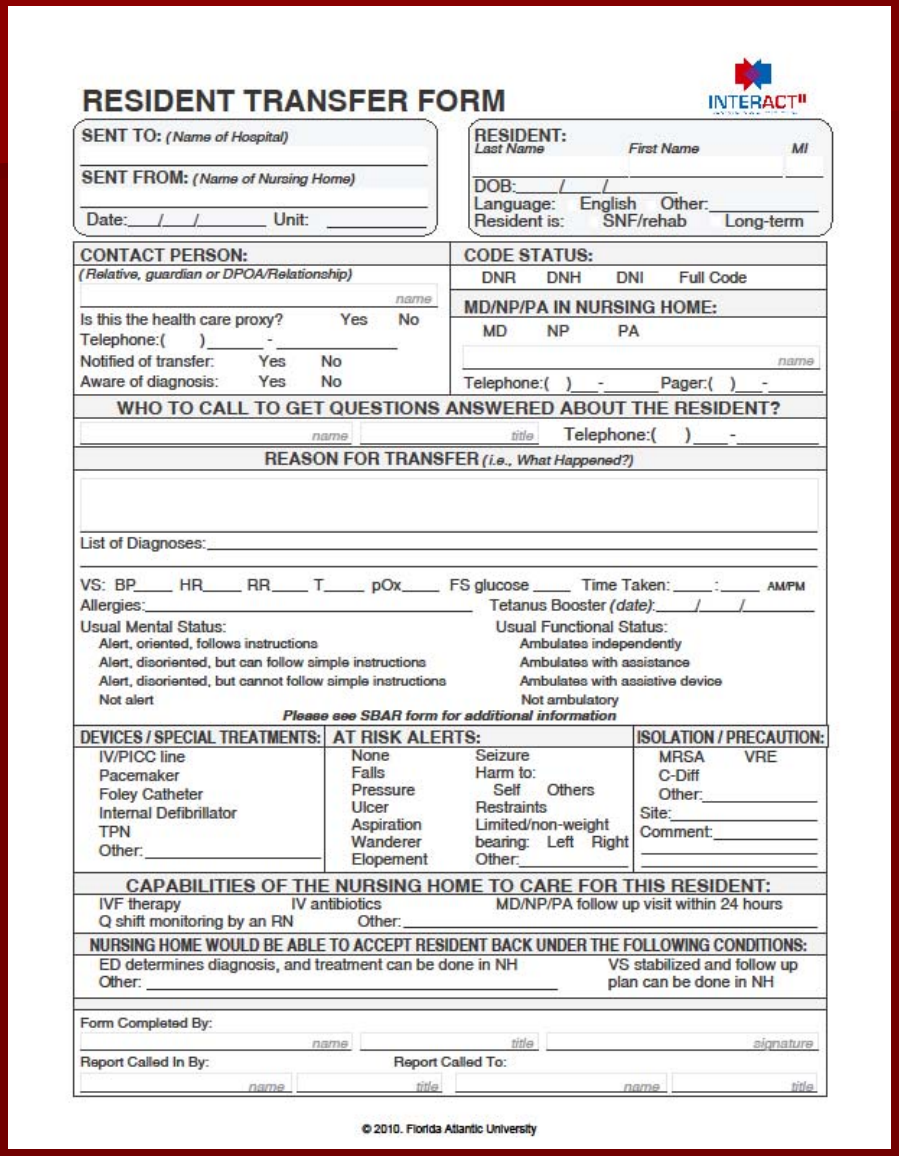
CARE PATH: *Symptoms of Congestive Heart Failure (CHF)*



INTERACT II

* Risk Factors for CHF: Hypertension, Diabetes, Coronary Artery Disease, Valvular Heart Disease (e.g. aortic stenosis)

Communication Across Settings



RESIDENT TRANSFER FORM

INTERACT II

SENT TO: *(Name of Hospital)*

SENT FROM: *(Name of Nursing Home)*

Date:___/___/_____ Unit: _____

RESIDENT: *Last Name* *First Name* *MI*

DOB:____/____/_____

Language: English Other:_____

Resident is: SNF/rehab Long-term

CONTACT PERSON:

(Relative, guardian or DPOA/Relationship)

name

Is this the health care proxy? Yes No

Telephone:( )_____-_____

Notified of transfer: Yes No

Aware of diagnosis: Yes No

CODE STATUS:

DNR DNH DNI Full Code

MD/NP/PA IN NURSING HOME:

MD NP PA

name

Telephone:( )___-_____ Pager:( )___-_____

WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?

name *title* Telephone:( )___-_____

REASON FOR TRANSFER *(i.e., What Happened?)*

List of Diagnoses:_____

VS: BP____ HR____ RR____ T____ pOx____ FS glucose ____ Time Taken: ____:____ AM/PM

Allergies:_____ Tetanus Booster *(date)*:____/____/_____

Usual Mental Status:

- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, but cannot follow simple instructions
- Not alert

Usual Functional Status:

- Ambulates independently
- Ambulates with assistance
- Ambulates with assistive device
- Not ambulatory

Please see SBAR form for additional information

DEVICES / SPECIAL TREATMENTS:

- IV/PICC line
- Pacemaker
- Foley Catheter
- Internal Defibrillator
- TPN
- Other:_____

AT RISK ALERTS:

- None
- Falls
- Pressure Ulcer
- Aspiration
- Wanderer
- Elopement
- Seizure
- Harm to: Self Others
- Restraints
- Limited/non-weight bearing: Left Right
- Other:_____

ISOLATION / PRECAUTION:

MRSA VRE

C-Diff

Other:_____

Site:_____

Comment:_____

CAPABILITIES OF THE NURSING HOME TO CARE FOR THIS RESIDENT:

IVF therapy IV antibiotics MD/NP/PA follow up visit within 24 hours

Q shift monitoring by an RN Other:_____

NURSING HOME WOULD BE ABLE TO ACCEPT RESIDENT BACK UNDER THE FOLLOWING CONDITIONS:

ED determines diagnosis, and treatment can be done in NH

VS stabilized and follow up plan can be done in NH

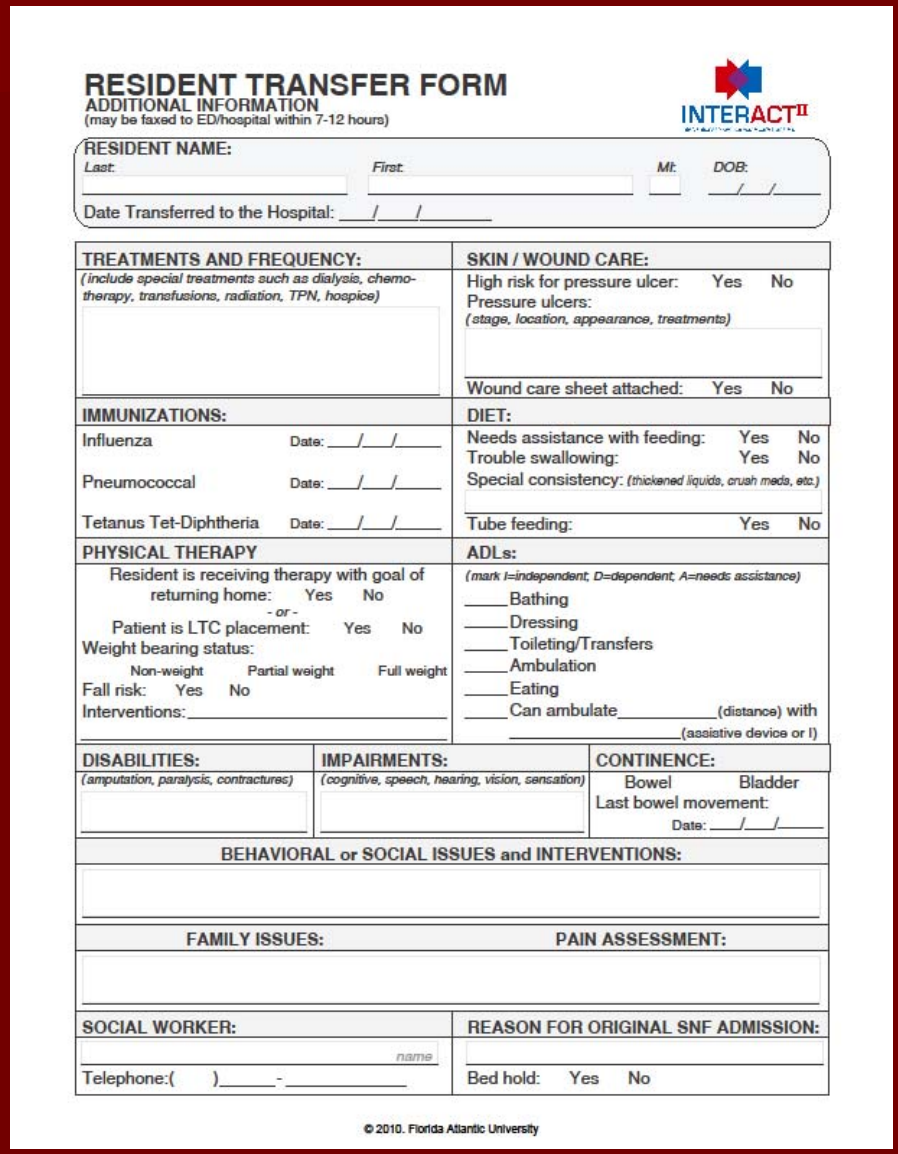
Other: _____

Form Completed By:

name *title* *signature*

Report Called In By: Report Called To:

name *title* *name* *title*



RESIDENT TRANSFER FORM

ADDITIONAL INFORMATION

(may be faxed to ED/hospital within 7-12 hours)

INTERACT II

RESIDENT NAME:

Last: *First:* *MI:* *DOB:*

Date Transferred to the Hospital: ___/___/_____

TREATMENTS AND FREQUENCY:

(include special treatments such as dialysis, chemo-therapy, transfusions, radiation, TPN, hospice)

SKIN / WOUND CARE:

High risk for pressure ulcer: Yes No

Pressure ulcers:

(stage, location, appearance, treatments)

Wound care sheet attached: Yes No

IMMUNIZATIONS:

Influenza Date: ___/___/_____

Pneumococcal Date: ___/___/_____

Tetanus Tet-Diphtheria Date: ___/___/_____

DIET:

Needs assistance with feeding: Yes No

Trouble swallowing: Yes No

Special consistency: *(thickened liquids, crush meds, etc.)*

Tube feeding: Yes No

PHYSICAL THERAPY

Resident is receiving therapy with goal of returning home: Yes No

- or -

Patient is LTC placement: Yes No

Weight bearing status:

Non-weight Partial weight Full weight

Fall risk: Yes No

Interventions:_____

ADLs:

(mark I=independent; D=dependent; A=needs assistance)

____Bathing

____Dressing

____Toileting/Transfers

____Ambulation

____Eating

____Can ambulate_____(distance) with _____(assistive device or I)

DISABILITIES:

(amputation, paralysis, contractures)

IMPAIRMENTS:

(cognitive, speech, hearing, vision, sensation)

CONTINENCE:

Bowel Bladder

Last bowel movement:

Date: ___/___/_____

BEHAVIORAL or SOCIAL ISSUES and INTERVENTIONS:

FAMILY ISSUES:

PAIN ASSESSMENT:

SOCIAL WORKER:

name

Telephone:( )_____-_____

REASON FOR ORIGINAL SNF ADMISSION:

Bed hold: Yes No

QUALITY IMPROVEMENT TOOL

INTERACT II

The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

Section 1: BACKGROUND INFORMATION

Resident's Last Name	First Name	Age	Unit/Room #

a. Date of ***most recent*** admission to nursing home: _____/_____/_____

b. Resident hospitalized in the past 12 months? ☐ No ☐ Yes **If yes, list dates and reasons below:**

_____

_____

_____

_____

Section 2: DESCRIBE THE ACUTE CHANGE IN CONDITION THAT LED TO TRANSFER

Date the change in condition first noticed: _____/_____/_____

a. **Check *all* that apply:**

CHANGE IN:
- ☐ Appetite/intake
- ☐ Behavior
- ☐ Function
- ☐ Skin or a wound

NEW CONDITION:
- ☐ Bleeding
- ☐ Breathing difficulty or SOB
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fall
- ☐ Pain (new or worsened)
- ☐ Other (specify)

_____

NEW SYMPTOM(S)/SIGNS OF:
- ☐ Altered mental status
- ☐ Congestive heart failure
- ☐ Dehydration
- ☐ Fever
- ☐ Lower respiratory infection
- ☐ Urinary tract infection

OTHER CHANGE:
- ☐ Abnormal lab value(s)
- ☐ Abnormal vital signs
- ☐ Family concern
- ☐ Other (specify)

_____

b. Briefly describe the symptom, sign or change in condition that led to the transfer:

_____

_____

_____

_____

Section 3: EVALUATION AND MANAGEMENT

a. **Check *all* that apply:**

TOOLS USED:
- ☐ Stop and Watch
- ☐ SBAR Progress Note
- ☐ Care Path
- ☐ Change in Condition Cards

MEDICAL EVALUATION:
- ☐ Telephone only
- ☐ On-site visit - MD
- ☐ On-site visit - NP or PA

TESTING:
- ☐ Blood tests
- ☐ Urinalysis or culture
- ☐ Xray
- ☐ Other (specify)

INTERVENTIONS:
- ☐ New medication
- ☐ IV or SC fluids
- ☐ Other (specify)

b. Briefly describe how the symptoms, signs, or change was evaluated and managed before hospital transfer:

_____

_____

c. Was advanced care planning (e.g. DNR, DNH, palliative or hospice care) discussed? ☐ No ☐ Yes

d. Was the resident transferred to the hospital? ☐ No **(skip to Section 5)** ☐ Yes **(complete Sections 4 and 5)**

Section 4: TRANSFER INFORMATION

Date of transfer: _____/_____/_____ Day (circle): M T W Th F Sa Sn Time of transfer: _____:_____ a.m./p.m.

MD authorizing transfer: ☐ Primary MD ☐ Covering MD ☐ Other (_____)

a. What contributed to the transfer? **(Check *all* that apply):**

- ☐ Abnormal vital signs
- ☐ Abnormal lab(s)
- ☐ Injury
- ☐ Worsening condition despite intervention
- ☐ MD insisted on transfer
- ☐ Resident preference or insistence
- ☐ Family preference or insistence
- ☐ Other (specify)

b. Briefly describe the main reason(s) for transfer:

_____

_____

Section 5: OPPORTUNITIES FOR IMPROVEMENT

a. After review of how the new symptoms, signs, or other change were evaluated and managed, has your team identified any opportunities for improvement? ☐ No ☐ Yes **If yes, describe briefly**

_____

_____

_____

b. In retrospect, does your team think this transfer might have been prevented?

☐ No ☐ Yes **If yes, check all that apply and describe briefly**

- ☐ The new sign, symptom, or other change might have been detected earlier
- ☐ The condition might have been managed safely in the facility without transfer
- ☐ Advance directives and/or palliative or hospice care could have been discussed
- ☐ Other (specify)

_____

_____

_____

_____ _____/_____/_____

Name of person completing form **Date of completion**

The QI Review and Process Improvement

- Internal Processes
  - Missing early warning signs
- Cross Continuum Processes
  - 7 day readmits
  - Primarily cardiac diagnosis

ACUTE CARE TRANSFER LOG

INTERACT II

Facility Name ______________________________ Month/Year ________/________

Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

*Hosp = Hospital
H = Home
O = Other

* S = Skilled (Medicare Part A)
LT = Long-term (Medicaid, private pay)
O = Other (e.g. managed care)

Building Evidence

- CMS Pilot
  - 50% reduction of hospitalization in 3 NHs with high baseline rates
  - 36% reduction in hospitalizations rated as potentially avoidable
- Commonwealth Fund Project
  - 17% reduction all facilities
  - 24% reduction in highly engaged facilities
- Practice Change Fellowship
  - 100+MA facilities
  - Data from ~30

Anecdotal Evidence

"I love this project!

I love that it's short on rhetoric and theory and focuses on tools and I especially love the flexibility you've given facilities to tailor it to their needs"

INTERACT Champion

Lessons Learned

- Commonwealth Fund Project training and implementation strategy effective
- Others have implemented on their own
- Leadership matters
- Front lines are where it happens: The Champion is KEY
- Relationships matter
  - Medical Director
  - Nurse Practitioners
- Important foundation for relationship with the hospital

Lessons Learned

- It can be done
- Allow 3 months to get started
- Anticipate questions
- Promote as integrated set of tools
- Anticipate enthusiasm
- Be ready for refining and critical thinking at 12-18 months
  - Ex. Cross Continuum Team ⟶
  - Transfer Form ⟶
  - Post Acute Checklist

INTERACT II in Context of Other Initiatives

- MA Statewide Strategic Plan for Care Transitions
- STAAR Project
- Cross Continuum Teams
- MOLST/POLST
- Accountable Care Organizations
- Universal Transfer Form
- Blue Cross Blue Shield of MA
- MA Department of Public Health
- CMS Care Transitions in 10th Scope of Work
  - INTERACT listed in “Resources for Providers”

Highlight critical role of SNFs

Find Out More

- www.interact2.net
- Coming Soon: Online curriculum

Resources

"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
J Am Geriatr Soc 59:745–753, 2011

Massachusetts Strategic Plan for Care Transitions
http://www.patientcarelink.org/uploadDocs/1/Strategic-Plan-for-Care-Transitions_2-11-2010-(2).pdf

State Action on Avoidable Rehospitalizations (STAAR)
http://www.ihi.org/IHI/Programs/StrategicInitiatives/StateActiononAvoidableRehospitalizationsSTAAR.htm

MOLST
http://www.molst-ma.org/

Care Transitions QIOSC
http://www.cfmc.org/caretransitions/provider_resources.htm

Thank You!!!