A GUIDE OF INSIGHTS AND LESSONS LEARNED FOLLOWING EXPERIENCES WITH THE INTERVENTIONS TO REDUCE PREVENTABLE ACUTE CARE TRANSFERS IN NEW YORK (INTERACT NY) PROGRAM.
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INTRODUCTION
Interventions to Reduce Acute Care Transfers (INTERACT) is a quality improvement program designed to help long term care organizations reduce potentially preventable transfers of residents to hospitals. INTERACT helps long term care providers incorporate into practice new communication and advance care planning tools, care paths, and quality improvement tools and techniques. INTERACT also supports long term care managers and staff during program planning and implementation. INTERACT was tested among nursing homes with high transfer rates in Georgia and was associated with a 50% decreased hospitalization rate.\(^1\) It was later tested among 30 nursing homes in Florida, Massachusetts, and New York, where it was associated with a 17% reduction in hospitalization rate.\(^2\)

Not only do these results hold promise, but there are several other compelling reasons for health care providers to become engaged in reducing potentially preventable hospital transfers. From the health care system perspective, hospital care is much more expensive than nursing home care, so substantial savings may accrue if this program is implemented effectively.\(^3\) From the patient perspective, remaining in a long term care setting avoids the disruption of transitioning into and out of the hospital, avoids potential complications of care that occur in the hospital,\(^4,5\) and for nursing home residents, reduces the risk of losing one’s bed after temporarily vacating it.

In 2010–11 the Continuing Care Leadership Coalition (CCLC), a New York City metropolitan area long term care provider association, initiated an INTERACT collaborative quality improvement program among its members with support from a New York State health care workforce grant. INTERACT NY was implemented among 30 participating nursing facilities and some of their partner hospitals. One of the program’s goals was for facilities to share their experiences implementing INTERACT and their lessons learned. This guide was developed to assist organizations in setting up an INTERACT program, whether the organization is part of a quality improvement collaborative or considering utilizing the program outside of a collaborative structure, using the experience of INTERACT NY as a framework.

**HOW TO USE THIS RESOURCE**

*INTERACT Insights* is designed to assist members as they plan, implement, and sustain the INTERACT program. It is especially helpful for staff who have already completed an initial INTERACT NY training session and are familiar with the program. A References section on page 26 provides additional INTERACT information.
THE INTERACT NY EXPERIENCE
INTERACT NY consisted of an educational program for facility leadership and interdisciplinary staff related to the use of the INTERACT tools, hands-on implementation support, and data collection support for self-evaluation. Prospective participants agreed in advance to:

1. implement new strategies to promote quality improvement;
2. name administrative and clinical champions to coordinate facility staff training, implement INTERACT tools, and participate in scheduled learning sessions;
3. roll out one or more INTERACT tools in at least one post-acute care unit and one long term care unit;
4. allocate staff time (e.g., two hours per week for the champion role) to attend program meetings, conference calls, and other activities;
5. measure INTERACT tool utilization to achieve performance benchmarks; and
6. collect and submit program evaluation measures (e.g., hospital transfer reports) and other facility data.

The INTERACT NY educational program gave an overview of INTERACT, its evidence-based tools, and the implementation process. Most sessions consisted of a didactic component followed by peers sharing experiences and effective practices. A focus during each session was how to integrate INTERACT activities into each organization’s quality improvement processes and standard operating procedures. Other novel INTERACT NY activities included an in-person briefing for nursing home executives, and a high-fidelity patient simulator session that provided hands-on experience utilizing INTERACT tools, refining INTERACT skills, and correcting mistakes through debriefing. INTERACT NY also engaged hospitals and health systems by working with the Greater New York Hospital Association to hold a mid-year learning session for hospital staff, who also attended the patient simulation and debriefing session, as well as the final learning session. INTERACT NY went beyond the facility practice by engaging the union that represented frontline staff and working through a joint management-staff program, the Quality Care Community, to empower person-centered care in a program that trained more than 2,000 staff members.

Quotations throughout this document are from INTERACT NY participants during learning sessions.
INTERACT DEMONSTRATES SUCCESSFUL REDUCTION IN TRANSFERS

During INTERACT NY’s implementation in 2010 and 2011, there was a 10.6% reduction in hospital admissions per 1,000 resident-days. Among nursing homes with the greatest engagement in the program, there was a 14.3% reduction in hospital admissions per 1,000 resident-days. Among nursing homes with the highest rates of hospital admission pre-INTERACT NY (> 3.7 per 1,000 resident-days), there was a 27.2% reduction in hospital admissions per 1,000 resident-days. This data suggests that INTERACT is effective, especially among facilities with higher baseline rates of hospital transfers and greater commitment to the program.

Also during INTERACT NY’s implementation, participating facilities found that INTERACT tools fulfilled their purpose of keeping nursing home residents out of the hospital by identifying opportunities to prevent unnecessary transfers, facilitating advance care planning discussions, improving communication among care team members, and improving communication between hospital and nursing home partners. With regard to advance care planning, participants noted that resident and family preferences, as well as ethnicity and culture, affect hospital transfer decisions and use of palliative care.

Even when residents could not be treated in the nursing home and were transferred to the hospital, INTERACT tools assisted via early identification, communication, and assessment of significant changes in a resident’s status. Communication improved because participants were providing hospitals the same information for each patient in a more standardized way. Participants also noted that tracking residents who were at risk of going to the hospital, but ultimately stayed in the nursing home, helped safely improve care.

HOW DOES INTERACT ALIGN WITH OTHER NURSING HOME REQUIREMENTS AND INITIATIVES?

INTERACT is primarily a quality improvement program that is consistent with Federal and State nursing home regulations. Because it also assists long term care organizations in improving care coordination, both within and between organizations, while focusing on reducing preventable hospitalizations, INTERACT is consistent with
“INTERACT improves quality of care and a resident’s experience in the nursing home.”
Federal goals to improve care quality and reduce health care system costs. Additionally, INTERACT is aligned with nursing home requirements related to the new annual Quality Indicator Survey (QIS) process and the Quality Assurance and Performance Improvement (QAPI) program. INTERACT NY participants have been successful in integrating INTERACT evidence-based practices into their QAPI processes required under Section 6102(c) of the Affordable Care Act (ACA). This directly affects readiness in the QIS arena and has an impact on documentation on the Minimum Data Set (MDS) 3.0.

Under QIS, a Stage 1 calculation driven by MDS 3.0 documentation for one of the Quality of Care and Quality of Life Indicators—QP058 regarding Hospitalization within 30 days—will trigger a Stage 2 review, which is used to assess compliance with a broad range of potential deficiencies if the rate exceeds a 15% threshold. In New York State, INTERACT is consistent with State Department of Health Medical Direction and Medical Care Guidelines, the State Nursing Home Quality Pool, and with regional and statewide programs such as the NYS Gold STAMP (Success Through Assessment, Management, and Prevention) Program to Reduce Pressure Ulcers. Finally, INTERACT resources can be used as part of an organization's corporate compliance program, as the U.S. Department of Health and Human Services Office of Inspector General has recognized in the annual Work Plan that nursing homes with high rates of unnecessary hospitalizations have potential quality issues.
“INTERACT improves resident and family and staff satisfaction.”
IMPLEMENTING INTERACT
WHICH STAFF SHOULD PARTICIPATE IN INTERACT?

To optimize INTERACT implementation and maximize sustainability, strong support from facility leadership is required. In particular, medical and nursing director involvement is vital, since the INTERACT tools require nursing and medical knowledge and a familiarity with clinical practice in the nursing home setting. Facilities should try to engage all the stakeholders who will be part of the process from the project’s beginning. Then one or more champions should be identified and be involved with leaders in selecting a core team. Early engagement of frontline staff, office clinicians, hospital providers, managers, community members, patients, and family members can be very helpful. Having direct care staff on the core team is extremely helpful with engaging frontline staff. Finally, partnerships with acute care facilities should be developed, if not already present.

PLANNING TIPS

Planning refers to the initial and iterative process that will guide the organization’s direction and priorities regarding INTERACT. Some planning tips shared by those who have implemented INTERACT NY are:

1. As in all quality improvement initiatives, a plan for measurable and realistic target outcomes, short-term and long-term timelines, and appropriate accountabilities should be developed. Clear processes for implementation and evaluation should be in place.

2. INTERACT leaders should recognize that organizational change takes time. In fact, INTERACT NY was implemented over 13 months. Over such a long time it is important to keep momentum going with regularly scheduled meetings (weekly or every other week during the planning period). Once implemented, project leaders should consider developing a sustainability plan.

3. Less formal discussions, such as brown bag lunches with unit staff, may provide a relaxed environment conducive to brainstorming, problem-solving, and planning.

4. When planning a new process, it is important to make sure its implementation is consistent with the facility’s organizational Policies and Procedures and the way the facility provides care.
It is also valuable for planning to integrate INTERACT implementation with the facility’s quality improvement activities, since many INTERACT tools and processes are concordant with quality improvement priorities.

**TIPS FOR IMPLEMENTING INTERACT**

Effective initial implementation of INTERACT is critical to its long-term sustainability. In other words, if it fails or stagnates at the very beginning, it will not “take hold,” making it difficult to build support for the program. Some tips for implementation are as follows:

1. As with all quality improvement initiatives, take a gradual approach to implementation. Facilities should start with one or two pilot units, and then when successful expand to additional units. Similarly, facilities should start with one INTERACT tool, and then when successful expand to include additional tools.
2. Demonstrate the usefulness of the tools and make them visible in everyday practice in the facility. Memos can be used to increase awareness of the overall project and for each tool where it is used. Information and achievements can be posted on lunch room and work station bulletin boards.

To suit organizational needs, facilities may modify certain INTERACT tools while preserving their integrity. As an example, at least one organization printed the Stop and Watch tool on a badge to go with every staff member’s ID. See additional examples under specific tool sections starting on page 14.

It may be effective to provide a “reward” to participating departments or units, especially rewards that reduce work burden. One organization recommended that for every one INTERACT tool or form implemented, the reward can be eliminating or streamlining at least one other form and/or process.

**INTERACT TOOLS**

The INTERACT toolkit consists of:

1. The SBAR (Situation, Background, Assessment or Appearance, Request) tool, designed to promote effective nurse-physician communication.
2. The Early Warning tool, also known as the Stop and Watch tool, designed to promote early recognition and communication of a significant change in a resident’s status.
A hospital transfer review tool, known as the Quality Improvement tool, to guide retrospective review of cases of hospitalization and avoided hospitalization to identify potentially preventable causes.

A standardized resident transfer form and checklist to facilitate the receiving organization’s access to critical patient information.

Care paths to guide evaluation and treatment of common conditions that precipitate hospital transfer (e.g., mental status change).

Advance care planning tools designed to help providers have successful conversations about this topic.

INTERACT tools are available at no charge at [http://interact2.net](http://interact2.net).

**TIPS FOR IMPLEMENTING SPECIFIC INTERACT TOOLS**

During INTERACT NY, 16 nursing homes implemented at least one INTERACT tool. The average number of tools implemented among these facilities was 5.8. The most commonly implemented tools were the Early Warning tool (Stop and Watch) in 13 nursing homes, the SBAR in 12, the hospital transfer review tool in nine, the acute care transfer log in seven, care paths in four, and advance directive planning tools in three. What follows are tips for implementing specific INTERACT tools from the INTERACT NY experience.

**STOP AND WATCH TOOL**

The Stop and Watch tool is designed to promote early recognition and communication of significant change in resident status, based on a successful test with Certified Nursing Assistants (CNAs). The following were suggestions from the INTERACT NY experience with Stop and Watch to improve compliance with the tool:

1. Include a copy of the Stop and Watch tool in the 24-hour nurse report.
2. Have nurse managers report on the Stop and Watch in morning meetings.
3. Use a drop box for duplicate Stop and Watch forms that allows the Administrator to follow up on reported changes in status.
4 Educate and involve families in using Stop and Watch, since they may notice important changes in residents.

5 Consider educating and involving non-clinical staff (e.g., housekeeping and food service staff) in the use of Stop and Watch, since they also can notice important changes in residents.

During INTERACT NY, a few organizations customized the Stop and Watch tool. Examples are: adding “no bowel movement” to the letter “N” in STOP AND WATCH, adding “missing equipment,” and adding “comments” to the bottom of the tool. As noted previously, at least one organization printed the Stop and Watch tool on a badge to go with every staff member’s ID.

The Stop and Watch tool has also been used in home care settings with home care workers, and has been adapted for electronic health records.

TRANSFER FORM AND CHECKLIST

Many nursing facilities participating in INTERACT NY already had transfer forms and checklists they used with hospitals that contained similar, or sometimes identical information as the INTERACT transfer form. Using a transfer form consistent with the INTERACT NY transfer form demonstrated the importance of cross-setting partnerships in reducing preventable hospitalizations and improving care transitions for certain unavoidable acute care transfers. Based on the INTERACT NY experience, the following are recommendations for building and establishing partnerships:

1 Identify key contacts at each care setting responsible for facilitating communication of pertinent resident/patient information during transfers.

2 Assess current status and identify gaps in the partnership.

3 Collaborate with key staff at the partner hospital(s) to develop specific protocols for acute care transfer for certain conditions (e.g., congestive heart failure).
“Early detection and clear and concise plans with the families are keys to team success.”
Review the INTERACT Care Paths with key staff at the partner hospital and agree on specific clinical parameters for acute care transfer for certain conditions.

Raise awareness of partner hospitals regarding nursing home capabilities to manage certain acute conditions.

Plan and conduct ongoing cross-setting education that promotes peer-to-peer learning on INTERACT and related care transitions activities.

If feasible, explore and adopt technological innovations that enhance cross-setting sharing of essential resident/patient information during transfers. CCITI NY (www.ccitiny.org) is an example of providers adopting such a solution.

During INTERACT NY, at least two partnerships organized a Care Coordination Committee, which facilitated planning, implementation, and retrospective review of acute cases admitted to the hospital and those managed in the nursing home. This Committee comprised key staff from the nursing home and the hospital, including an administrator, a nurse leader, a medical director, a hospitalist, and a case manager, social worker, or discharge planner. Additionally, at least one partnership established educational rotations between the nursing home and the hospital for medical students.

Additional resources are available from the Joint Commission. The Joint Commission SHARE mnemonic (Standardize, Hardwire, Allow, Reinforce, Education) outlines its recommended components of improving handoff communication:

1. standardize critical transfer information content,
2. implement systems that make information transfer automatic,
3. allow receiving providers the opportunity to ask questions,
4. reinforce quality of transfer care by measurement and feedback,
5. provide education and coaching.
**CARE PATHS**

INTERACT care paths are designed to guide evaluation and treatment of common conditions that precipitate hospital transfer (e.g., mental status change). To optimize the care paths’ effect, the following INTERACT NY suggestions were made:

1. Raise awareness and agreement among facility clinical staff about the specific parameters necessary to manage conditions in the long term care setting when safe and appropriate, as opposed to habitually transferring to the hospital.

2. Encourage staff vigilance for symptom recognition and management, before the condition becomes severe enough to require hospital transfer.

3. If feasible, increase medical services available in the facility, such as lab turnaround during off hours and IV antibiotics.

4. Consider using outpatient transfusion centers, rather than transferring residents to the hospital for clinically indicated transfusions.

**WHAT TRAINING ACTIVITIES ARE NEEDED TO IMPLEMENT INTERACT?**

In INTERACT NY there were a total of 333 attendees across the program’s 13 sessions (mean 25.6 per session; mean 11.1 per facility; range 1–44 per facility). The most common staff attendees, in order of frequency, were nurse administrators, unit-based nurses, medical directors and attending physicians, nursing home administrators, certified nursing assistants, and case managers and social workers.

The following are some observations and suggestions from the INTERACT NY training experience:

1. It is important to carefully plan the initial training curriculum, since it will take multiple sessions in multiple venues.

2. Post-exercise role playing and debriefing is an effective teaching method for using INTERACT tools, while refining clinical skills and improving outcomes.
Case simulation holds the interest of training participants more than didactic teaching.

It is important to ensure that training and feedback are provided on all three shifts and for all disciplines that might use INTERACT tools.

It is helpful to utilize the INTERACT tools themselves, especially the care paths, to support team education on all clinical topics.

After the initial training curriculum, it is vital to provide ongoing education to train new employees and reinforce knowledge of already trained employees.

It is useful to “close the loop” and provide regular updates on resident or patient outcomes to staff members who used INTERACT tools.

Because staff may naturally have an aversion to process changes, it is important to work with them and discuss their “fears” or concerns about change.
“The evaluation of the INTERACT tools helped to determine learning and training opportunities.”
WHAT ARE POTENTIAL BARRIERS TO IMPLEMENTING INTERACT AND EFFECTIVE STRATEGIES TO OVERCOMING THEM?

INTERACT NY identified the following barriers and strategies to overcoming them:

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<td>Lack of support from senior leadership.</td>
<td>Champions may engage senior leadership by sharing INTERACT publications and other materials, under-scoring opportunities under INTERACT for quality improvement and cost savings.</td>
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<td>Lack of staff buy-in and compliance with using the INTERACT tools; resistance to cultural change.</td>
<td>Streamline forms and quality improvement activities. To reduce work burden for every INTERACT tool implemented, eliminate or streamline one or more other forms and/or processes. Make the tools useful and visible in everyday practice in the facility.</td>
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<td>Different resident/patient and family cultural and faith-based preferences.</td>
<td>Engage pastoral care or families, together with a clinical team, in facilitating advance care planning discussions.</td>
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<td>Lack of compliance with follow-up assessment resulting from reported status change using the Stop and Watch tool.</td>
<td>Use a drop box for Stop and Watch duplicate forms, which allows a clinician to follow up on reported changes in status.</td>
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<td>Need for partnership with local hospital to promote bi-directional use of the Transfer Form.</td>
<td>Collaborate with key staff at a local hospital in developing specific protocols for acute care transfer for certain conditions.</td>
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<td>Limited engagement of key interdisciplinary staff in project planning and implementation.</td>
<td>Informal lunches provide a relaxed environment conducive to brainstorming and soliciting feedback on implementation issues.</td>
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NEXT STEPS
HOW CAN INTERACT BE SUSTAINED OVER TIME?

Sustaining a complex program such as INTERACT over time is a big challenge. It is important to first make INTERACT one of the facility’s key quality improvement activities, and to incorporate INTERACT activities into the facility’s policies and procedures. It is also important to get regular feedback on implementation issues through informal discussions or lunches with floor staff and regularly scheduled meetings with managers. Finally, measurement and evaluation are keys to understanding the organization’s successes and opportunities for improvement in implementing INTERACT. Some tips for measurement and evaluation are:

1. Track compliance and outcomes data (e.g., hospitalization rate) and look for ways to improve your performance. Utilize the INTERACT hospitalization QI Review Tool to compare outcomes of care with and without INTERACT tools in place. At least one organization in INTERACT NY created a database to track changes in resident conditions and staff response.

2. Analyze variations in care delivery (e.g., discharges on a weekday versus a weekend, discharges during day shift versus evening shift, hospital readmissions by hospitalists versus non-hospitalists).

3. A commonly held tenet is that one cannot improve what one does not measure. It may also be useful to learn the “Plan, Do, Study, Act” (PDSA) quality improvement cycle.

The INTERACT program can be an important framework for improving care coordination for the individuals who are at the highest risk of avoidable hospitalizations or readmissions. The fact that this program provides opportunities for long term care organizations to use evidence-based tools to improve care and assist hospitals and systems facing penalties from hospital readmissions, and support larger health policy imperatives, will support the business case for sustaining INTERACT over time.
REFERENCES & ACKNOWLEDGEMENT
REFERENCES


ACKNOWLEDGEMENT

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