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Improving Nursing Home Care and Reducing Unnecessary Hospital Transfers, Admissions, and Readmissions

Presented by Laurie Herndon, MSN, GNP-BC, Massachusetts Senior Care Foundation, and Joseph G. Ouslander, MD, Florida Atlantic University. 80-minute webinar, November 8, 2012

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Please stand by for real time captions.

Thank you for waiting. Your conference will begin in a few minutes. Thank you for your patience.

Welcome to the interventions to reduce acute care transfers INTERACT conference call. My name is Olivia and I will be your operator for today's call. At this time all participants are in a listen only mode. Later, we will conduct an audio question-and-answer session. I will now turn the call over to Sue Johansen.

Good afternoon and welcome to the WebEx entitled Interventions to Reduce Acute Care Transfers INTERACT. Let me briefly introduce a staff that we have here, Brian -- our partners include Alaska, Colorado, Hawaii, Kansas, Minnesota, Montana, Nebraska, New Mexico, Utah and Wyoming. I am pleased to present Joseph Ouslander and Laurie Herndon to present the intervention discussion. Joseph Ouslander is currently professor at Charles E. Schmidt College of Medicine and professor of Atlantic University.

He has served as a Director of geriatric medicine and is past president and co-chair of the American Geriatrics Society. Laurie Herndon is a nurse practitioner. She is currently the director for quality at Massachusetts Senior Care Foundation and in this role works with nursing homes, and colleagues from all sectors of health care to improve quality, innovation, and research at this Massachusetts senior care facility.

The information today on this WebEx including the slide and audio transcript will be provided on our website within the next seven days for review. They will remain for review for a short period of time. The opportunity for questions will be provided at the conclusion of this WebEx. Without further delay, we will introduce Joseph Ouslander and Laurie Herndon. Thank you very much. I will be presenting an overview of the INTERACT program. Then Laurie will present the

second half and then we will have an opportunity for interactions.

We have an interdisciplinary team that has been working on various aspects of the INTERACT program over the last five or six years. Most of them are listed here, we actually have a couple of new team members who are not. You can see that this really involves a team of different professionals. I always teach our students that taking care of older people and geriatrics is a team sport. Involvement of the care team and professional care team is very important in the success of any quality improvement program.

The objectives of this presentation are to provide you with a broad overview of the INTERACT quality improvement program and how it fits with the health care reform initiatives. It describes barriers to implementing the INTERACT program that are based on our experience with lots of facilities and the strategies to overcome them.

We are big believers in improving care, improving health and making care more affordable. I think in the population that we deal with, a complex older population, the second goal, improving health, has to be qualified often by maintaining or enhancing function and quality of life and preventing complications. I really believe that this presents major opportunities for providers of geriatric care and long-term care particularly because there is just so much unnecessary and potentially harmful care that is driven by the current Medicare fee-for-service system. It really is, in my view, a no-brainer to be able to not only improve care but reduce unnecessary health expenditures.

I am going to go through some points about why all this matters. I will reinforce these points with just a few slides. The first thing is that hospital transfers are very common from the nursing home population, 60 percent of nursing home residents are transferred to a hospital emergency room each year. And I will show you some other data as well. We know now from considerable that some of these hospital transfers are in fact preventable. Not all of them, but a large portion of them.

We can improve care with fewer hospital complications and reduce costs. Those cost savings to Medicare can be shared with the provider community to further improve care. There are initiatives underway that are already starting to do that.

There are other financial and regulatory incentives that are changing and will really incentivize providers to work closer together on quality initiatives that relate to reducing unnecessary hospital transfers.

We know from data such as those shown on this slide that one in four patients admitted to a skilled nursing facility from a hospital are readmitted to the hospital within 30 days.

We also know that hospitalization has a number of risks for vulnerable older people. Those of you who are listening who have had any experience in receiving patients from hospitals, know that there is a high incidence of acute confusion and delirium by being put in the hospital. People are put on very complicated, expensive drug regimens that increase falls and injuries. Hospital

acquired infections occur. Even staying in bed in a hospital for two or three days can create immobility and make people prone to pressure ulcers.

In addition to the benefits of being in a hospital when someone is acutely ill, there are these risks that need to be considered. A good way to reduce the risk is to avoid unnecessary hospital transfers.

As I mentioned, several studies suggest that a substantial percentage of hospital transfers, hospital admissions, and readmissions are unnecessary and can be prevented. I will not spend a lot of time going into the data on these, but I will spend a moment talking about how critical the individual decision is to hospitalize an older person.

I think you can see my cursor here. People ask a lot what does it mean when a hospitalization is preventable. What does unnecessary mean?

Defining that is challenging because there are so many factors that contribute to a decision to hospitalize older people. They include financial incentives that are in the system that you all know about. There are patient and family preferences that come into play. There is person centered care, advanced care plans, advanced directives, and palliative and hospice care. To keep someone out of the hospital safely, there needs to be trained physicians, nurse practitioners, physician assistants, and other staff to care for them safely.

Diagnostic and pharmacy services have to be available. Once a person actually gets transferred, there is enormous time pressure and older patients often get a lot of tests and procedures quickly and then are admitted to the hospital. There are concerns about legal liability and regulatory sanctions when there is an adverse outcome. My view is that like any geriatric condition, this is a multifactorial condition.

Another thing that is happening is that the affordable care act mandated that each nursing home have a quality assurance and performance improvement program. Regulation and related surveyor guidance are being written now and the intent is to spread them in 2013. Improving the management of changes in condition and reducing unnecessary hospital transfers is one potential focus of a QAPI quality improvement project that will help meet that new requirement.

Let me summarize what I have been saying in this diagram. Our goal and a new goal for the campaign and nursing homes is to safely reduce unnecessary acute care transfers. This will improve quality care, and result in decreased morbidity and decreased costs. What is needed to do that?

Well I mentioned that in order to manage complex older people outside a hospital safely, there needs to be an infrastructure. Trained staff, lab services, pharmacy services and financial incentives have to be aligned properly.

And there needs to be quality improvement programs and tools for practitioners to use. Whenever one tries to make a health policy change or health reversal change, you have to be conscious of potential for unintended consequences. In this situation, financially incentivizing

providers to manage sick people outside of the hospital when they are not prepared to do that could result in a deterioration of quality and care, and an increase in harm to patients.

That is why it is important to combine changes in financial incentives with quality improvement programs and education and tools that people can use and practice.

That is what we think that the INTERACT program does.

INTERACT stands for interventions to reduce acute care transfers. While it started off as a toolkit and many people still call it a tool or a toolkit, we have evolved it into a full quality improvement program and the quality improvement program is designed to improve the care of nursing home residents with acute changes in condition.

The program does include evidence and expert recommended clinical practice tools, strategies to implement them, and related educational resources. The basic program is available on the Internet at the web address on the slide.

There is an acknowledgment for the use of the INTERACT program but the current program is available for free. We just request that it be appropriately acknowledged.

This is a picture of Laurie who was on the cover of provider magazine who will be speaking in a couple of minutes. The slide is intended to emphasize the point that the goal of INTERACT is to improve care and not to prevent all hospital transfers. I do not believe that you can safely prevent all hospital transfers. We might be able to safely prevent a relatively small proportion of them. Just like you cannot safely prevent all falls or all pressure ulcers.

In fact, if you look in detail at some of the tools that Laurie would show you, using these tools properly could result in more rapid transfer of residence who need hospital care and not simply keeping them from going to the hospital.

So INTERACT has three strategies. I will describe those strategies and then I will illustrate them by real case examples in just a moment.

The first strategy is to prevent conditions from becoming severe enough to require hospitalization through early identification and evaluation of changes in resident condition. So that is proactive prevention once a change has been identified.

The second strategy is we know that conditions are going to occur in this population, but not all of them require transfer to the hospital and they can be managed outside the hospital when it is feasible and safe and consistent with the person's preferences.

The third is to improve advanced care planning and the use of palliative care, or hospice, as an alternative hospitalization for residents who are in the end stages of life where hospital care may be harmful and, in fact, futile.

I use a tale of three siblings to illustrate these three strategies. Sadie, Sarah, and Sam.

Sadie is a 96-year-old long stay nursing resident. All the siblings are based on patients. She was put in a hospital for urinary tract infection and dehydration, and discharged back to the nursing home after four days in the hospital. Within a week she was rehospitalized for dehydration and a recurrent urinary tract infection. Without going into the particulars of the case, this woman over the course of the week, became dehydrated in front of her family, the staff and the nursing home.

The question is was it appropriate? The answer is, yes. But it requires observation, medication and it requires documentation through early detection and evaluation.

The second example is Sadie's younger sister, Sarah,. She was a 92-year-old long stay nursing home resident who was hospitalized for a lower respiratory infection, but she was sent to the emergency room because of her cough. At the time she had normal vital signs and oxygen saturation but because of the way that the emergency room did the evaluation, questions about her chest x-ray and a falsely elevated enzyme test, she was admitted to the hospital. In the hospital she developed delirium, fell and fractured her pubic bone and then developed an early pressure ulcer. Was is appropriate? Yes, perhaps. Not everyone with early symptoms of a lower respiratory infection needs to go to the hospital. At least initial management with careful monitoring and observation can be done outside the hospital.

The third patient is Sam. He is Sarah's older brother. He is a 101-year-old long stay nursing home resident. He was hospitalized for the fourth time in two months for aspiration pneumonia related to end stage Alzheimer's. On the first day of the fourth hospitalization, he was transferred to hospice. Is was finally agreed to send him to hospice. While I understand that these decisions are difficult, you ask the question was is appropriate? Yes, with improved advance care planning and communication with the person and their proxies.

It should not take hospitalizations for a condition that we know will occur over and over again. To recognize that hospital care is futile and unnecessarily uncomfortable for someone like Sam and that the vast majority of nursing homes can do good comfort palliative and hospice care without sending people to the hospital.

So let me just briefly review some of the evidence behind the effectiveness of INTERACT. INTERACT was initially developed through a CMS contract with the Georgia quality improvement organization.

A lot of this was dependent on Mary Perla actually physically going to the nursing homes every couple of weeks and developing good relationships with the staff and interacting with them on a regular basis. We found that the tools were acceptable to staff, they had lots of comments on them. There was a highly significant reduction in hospitalization and a significant reduction in hospital transfers that were made affordable by this expert panel.

So we revised the tools in a grant supported by the Commonwealth Fund. We revised these tools based on this CMS pilot study and got a lot of input from experts along with front-line staff. We created the second version of the interact program. What we did was on-site training for part of

the day. Members of our team, went to the participating nursing homes which were tenancy homes in Florida, 10 in New York, and 10 in Massachusetts.

We physically brought them all of the tools. We focused on the training for facility-based champions, as well as raising awareness of the program among any staff we could get to attend. That was followed by implementation of the program over six months with twice monthly telephone calls facilitated by Laurie. We then asked the participating facilities to complete and send us quality improvement reviews which are root cause analyses of transfers.

In this collaborative improvement program, what happened? 25 facilities completed the entire six-month intervention period and provided us pre-intervention hospital position data and post hospitalized dimension position data.

And those facilities, the baseline hospitalization made was about four per thousand residents. I will not go into detail, but a lot of health care facilities are doing that now but many of them are not. It is sometimes difficult to compare apples to oranges.

This hospitalization rate is adjusted for the census, so it is adjusted like epidemiological studies infections and nursing homes per thousand residents per day. What does that mean? That means for a 100 bed facility that would be 10 days. So these are 100 bed facilities we are having for hospital admissions every 10 days.

During the six months of the intervention compared to the same six months in the previous year, there was a relative reduction in all cost hospitalizations of 70 percent. We then rated the nursing without knowing the hospitalization rate and how engaging they were with the program. We rated 17 of them as engaged. Of those 17, there was a dramatic regressive reduction in all cost hospitalization of 24 percent. They only had a 6 percent reduction.

So this is not an experiment, it is not strong evidence, we had volunteer facilities with high hospitalization rates but this data is pretty compelling that something happened during that six months that we were working with them. It caused dramatic reduction in hospitalization and it was associated with how strongly we felt they were implementing the program.

What are the implications in these findings? If facilities could reduce their hospitalization rates modestly, the reduction we got in a 100 bed nursing home would amount to 25 fewer hospitalizations in the year or about two per month. So we are not talking about a lot and if you put a \$5000 Medicare DRG payment tied to those hospitalizations, that is a projected savings in Medicare part A that would be recurrent of \$125,000.

We did some accrued calculation with how much we thought the project cost to implement and we estimated \$8000. So there was over \$100,000 per year left on the table.

One of the key health policy issues in my mind is how can Medicare share the savings to support further care improvements with providers? Again, I think some of that is going on. We can talk about that during the discussion period.

I actually switched some slides, but I will let Laurie go over the overview of the tools and how they work in practice and then some of the measurement slides if you want me to take back over, I will do that. I think I said that in a different file.

I am glad to. The tools are organized in these four different categories. They are organized based on what we know drives hospital transfers from facilities. The communication tools are probably the tools that we talked most about.

These are communications both within the facility and across the continuum. There are decision-support tools that are meant to help nursing staff in the facilities critically think about what to do with the changing conditions.

The advance care planning tools and quality improvement tools that are critically important and some of the first tools that we're going to talk about.

The purpose for this diagram is to highlight the idea that the INTERACT tools are meant to complement the process that is already in place in your nursing facility. The boxes in the middle are meant to describe your usual care practices. The resident comes in, we suggest right after the resident can talk about advance care planning using the advanced care planning tools.

Using the early warning tool, the nurse then takes the progress note to mediation form together with care path any Q changing condition file cards. If there is a need for an acute care transfer, use the transfer checklist form.

And then there is a quality improvement tool that is used as a root cause analysis to help determine what the cause was for the transfer.

Actually you will see that we revised all of these tools and we have actually revised this table to make it look more circular. After you look at your review and you look at what happens after you transfer, it will circle back from the beginning.

This is actually what I just said. Note that as we speak we are updating the program in the tools. The newest version will be INTERACT three tools. The INTERACT program will still be called INTERACT. Baseline will be available soon. We are very excited, they look great.

We learned through all of our work with the project and we have worked with a lot of QIOs and organizations across the country that this make sense to anybody who has done QI. You really need to start a quality improvement project with data.

You have to know your baseline to be able to track and trend and benchmark your metrics. The other piece of that is to not only look at what your raw numbers are, how many transfers you have going out, but to actually know what is going on in your own building. You do that by doing a root cause analysis.

To be efficient with people's time and to really engage people and to keep them interested it needs to matter what is going on in your facility. You can only find that out if you do the QI review. We will talk about that in a minute.

I will let you take this and another slide. I am getting a call and my phone is beeping I think I'm going to lose it. So you go ahead.

We talked about how important it is to track measures. One of the things that I realized and talking to a lot of people is that people are not calculating the same measures and, even if they say they're calculating them, they may be calculating very differently.

So one of the things that I have worked on is a white paper that is referred to on this slide. Katie Massillon co-authored this. It is really a compendium of how people have to find preventable hospitalizations.

Definitions have been all over the place and I have been working with the Advancing Excellence campaign. They just put up a new goal on November 1 for reducing unnecessary hospitalizations safely. You can go to the website and look at the goal and some of the tools.

The definitions I will talk about now are based on what we have done with the Advancing Excellence campaign. So think about hospital admissions and this can be for a nursing home, assisted living, large group homes regarding all unplanned admissions. What is a planned admission?

CMS is developing definitions for planned admissions that would be excluded. There are things like reversions of surgical procedures or planned chemotherapy. So the rest are all unplanned admissions. As a subgroup of all unplanned admissions are 30 day readmissions, which everyone is focusing on because the hospital penalties went into place a month ago.

Then there are other admissions that are not readmissions within those two categories, a subgroup of those readmissions and admissions that are for preventable diagnoses. Diagnoses in the literature frequently cites ambulatory care. Outside of a hospital.

That is not the whole picture because there are emergency department evaluations that have costs to Medicare and costs to facilities and human costs to patients that are often not being tracked, such as when someone goes to the emergency room and comes back to the facility.

Then there are admissions that are not full inpatient admissions, when a patient stays after for observation. These have financial consequences for patients and their families, for nursing facilities, as well as hospitals.

Several people including myself have recommended that eventually CMS track these as a quality measure as well.

Currently INTERACT has an acute care paper transfer log. You can use this log as a worksheet to populate their transfer rates.

I have been working very hard with the Advancing Excellence campaign and in particular the Colorado Foundation for Medical Care, the QIO in Colorado, to develop a spread sheet that looks like this. You can actually enter data into a transfer log. In the kit that I'm showing you, the data entry process is quite simple. A lot of different components of the calculations can be made.

Then rates and care process measures can be trended over time and benchmarked automatically. So the rates and trends can be calculated any consistent way. This is being updated and it will be available through the Advancing Excellence campaign. There will be a version of this on the INTERACT website as well.

Is Laurie back on the phone?

I am here.

Why don't you pick up and go over the quality improvement tool and the rest of the other tools.

Just let me know if I fade out. I am on my cell phone, I apologize to everybody for the technical difficulties.

So the quality improvement tool is a tool that we talked about using to actually engage the line staff. When we are talking to facilities, there are two messages. The message that Joe talked about. We can expand a little bit more on the reason in terms of health policy reform and partnering with acute care hospital. You need to know what your numbers are in order to be participating in this conversation.

That is important. That raw data. The information and the data that will engage your front lines comes from the QI tool. This is a cost analysis. We talk about using this right up front and engaging the front line. Rather than talking about big picture of readmissions to the front line, the message that needs to be that you want to improve care. To improve care you want to talk about cases. So you look at a couple of recent cases with your front line and help them get engage in thinking about what happened.

You might even start with the case that did not go well. Those are the cases to start with. This is a retrospective review, it is meant to be done as soon as somebody goes out the door to the hospital. It is meant to be done by the entire staff.

The interdisciplinary team.

Before -- CXR Laurie, I think some slides got left out.

Joan I have done this so much that we don't need a visual and we could talk you through what these tools look like without any visuals at all. So that is no problem.

The QI has several different sections. And asks for demographic information, what time they went out, who the physician or petitioner is, the time, who was covering, all that basic

information. But you may have some suspicions about whether it was the evening nurse or supervisor, etc. You need to get that right up front.

It also gives you information about what the chief complaint was. It starts people thinking right away when did it start. It asks you when the symptoms started. The only way you're going to get that information is to go back and talk to staff. Find out what they noticed about a change in condition.

They are also encouraged to find out what happened. What did you do to manage this condition? That is important information. You had the opportunity to document that. You got a chest x-ray, you started IV fluids, you've given some IV antibiotics and they got worse. The physician came in and talked to the family, all these things were done. That is fairly simple. There is no need to go back and improve your system.

You may also find that something was messed by your front-line nurses and they went out with congestive heart failure. So it is meant to give you a bigger picture of what happened clinically. It also describes the other factors that contributed to the transfer.

For instance, the family insisted. You could've done all of those things right and the family insisted that they go somewhere else. If the resident went out and you did not feel that they needed to go out and you did all the right things, and the family insisted, your feedback back to your system for improving quality and reducing the chance of something happening again is to work with the family.

It also allows you the opportunity to say that the physician insisted. When the physician assisted that's where you need to start going forward.

You can get your lab people in there or you could get the x-ray in. It shows a much better picture of what happened, what you did to manage this person in the facility, and what the other contributing factors were. It asks was it supportable or not and suggests what your opportunity for improvement is—what should be happening. I just talked to a facility that adjusted how they are working since 2009 and they are still doing 100 percent review on the transfers out. With each transfer they learn something.

So these are two examples of our communication tools. When we hear about people using the INTERACT tool, I suspect that these are the tools they're talking about. To Joe's point we are trying to be consistent and I get a little bit nervous to hear that somebody is using the INTERACT tool because we want you to.

These are very popular tools and they're used by the front-line and they are very well-received. The Tran 18 is the nursing progress note or the change in condition. I will start with a stopwatch.

The stopwatch is our early warning tool that is meant to capture that early changing condition that we have been talking about. It is the foundation of the entire program. It is a recognition of the early changing condition. The change--that the patient was right, they did go to bingo, for example. This is the information that our CNAs get 24 to 48 hours ahead of us. We really want

to capture that information right away. The CNA is advised to circle whatever is not right and hand it to a nurse.

As soon as we started talking about this and people started getting it in their buildings, we heard that it was integrated. You can imagine how effective the communication is. Residents are off unit, rehab goes wrong, we have Bruce back, the nurse's biggest opportunity when sending to rehab is to pass something to the nurses you can follow up on.

They are being used everywhere--in the kitchen, dining room, housekeeping--that should be the philosophy. All hands on deck are interested in recognizing an early change if something is not right and beginning that process.

This is also been used as ways to engage family and the initiatives. It can be hard to have a conversation about why you're trying to reduce readmissions and big picture things. This is being used as a very effective tool upon admission. You say you really don't want to send your patient back to the hospital so we're going to do everything we can. Can you partner with us so if you see something that is not right, please fill this out so we can address it.

The facilities can use a standard protocol that any nurse can work with the family, then there is an automatic assessment call within 24 hours. So it can be an effective way to engage family as well.

The Tran 18—the SBAR—is also like the stopwatch meant to guide the nurse to a comprehensive assessment and documentation about the change in condition. The purpose is to standardize the approach of communication and documentation. It is like a recipe and how to go through her assessment. At the beginning she is reminded of what you need to do before she picks up the phone. You make sure you completed the SBAR, you have gotten all of your information and when you pick up the phone to call the physician, you then go through the entire form. It gives you a brief analysis of what the symptoms are that you're calling for, the background, it gives pertinent past medical history, other relevant information. One section is the assessment on what they think is going on. It is meant to begin the conversation with the nurse and the provider about what they think is going on.

Then the recommendation. The SBAR is one my favorites and we could talk about it for a long time. It is meant to give nurses some language to capitalize on the information that they know. They may know if the same situation happened last week and it was managed with a certain strategy or certain intervention and things went well. We really want to have nurses be able to utilize and communicate the information that they know about the resident.

That is the SBAR. Next slide. So we have some physician support of the tools in the program that are meant to help nurses.

To critically think through the change in condition, there are two sets of tools and a change in condition file card. The changing condition file card divides information on lab values, normal and abnormal, vital signs and symptoms. So literally from A to Z. They are meant to be kept at the nursing stations for the nurse to quickly look through when there is a symptom that she is not

sure whether or not they can wait till tomorrow or if it needs to be called in tonight. Same thing with labs and vital signs.

Typically it is the off shift nurse who is faced with this decision and it is really hard and so many phone calls go out on the off shift for things that can clearly wait for the morning but there is worry and concern on the part of nurses on what to do with this. So the change in condition file card and the care pack are meant to help nurses take that next step in terms of critical thinking.

I think the next slide is the care pack back? Know this is just an example of the vital signs.

Again, very helpful. Does the nurse need to worry about systolic blood pressure up to hundred and 10? The answer is yes. So it gives her the impetus to make a call. It is interesting because I have heard from some of our decisions that would work it with your messages is that they are really interested in these tools. These tools are really good ways to engage physicians because it has everything to do with parameters in your building. There are parameters in blood glucose temperature, and these need to match what is in your policy and procedure. These are not set in stone. If you are looking at them and you're saying these numbers are the same, that is fine, go ahead and change them. Get your doctors involved. Getting your doctors involved in what they do and what they do not want to be called for is a win-win.

I had one doctor who said I love those file cards because I can tell the nurse you do not have to call me for this.

Again, these are lab tests. Many of you on the phone I'm sure have taken calls and have gotten a call on a thyroid function or some other very stable, long-standing lab value that could absolutely wait until the morning. This is really meant to minimize those calls for what can clearly wait for the morning and to be sure that these calls that should be called are called that day.

I actually had a lab value in my own clinical practice with the white count dangerously high. The nursing supervisor and even picked it up into Gujarat: the morning. So you could have extremes in both directions of too high and too low and these are meant to minimize any unnecessary calls and ensure that you're getting calls on the things that you need to.

Again, we can move right to this one. This is signs and symptoms. Helps him know what to call for.

The INTERACT care path--Joe has done a tremendous amount of revisions to these over the last couple of weeks and I cannot wait for you to see them, they look great. Again it is the physician support tool to help nurses. What do you need to think about the diagnostics? Have to make suggestions for what needs a diagnostic workup and it provides.

I would say in my opinion one of the key successful use of these tools is formatting. We put them on a poster. We had six of them, I think we have seven of them coming up, I would suggest if you're interested in these, the nurses do like them. If they are a poster and people are just looking at them and walking back.

I say this cautiously that I was not 100 percent convinced that front-line nurses would find this terribly useful when we started. And I am actually quite converted. If these are put in a place where nurses can see them, they actually do like them a lot. Staff developers use these for a quick 20 minute lunchtime in-service. Cold and flu season is coming up, it is a perfect opportunity over brownbag lunch, to bring out the respiratory care path, heart failure care path, etc.--quick useful and relevant to what people are doing that day.

This is another thing that I'm pretty excited about, we started out knowing that we needed to spend a good deal of time developing relationships with hospitals. The need for cross continuum collaborative work on reducing readmissions is so important right now. Each time I do a training for INTERACT, it becomes increasingly obvious that you cannot talk about INTERACT without talking about what is going on in the hospital because they are so closely connected .

In Massachusetts we have tremendous interest--requests for me to come and talk to their quality groups about what INTERACT. Hospitals are requiring people in their community to use the INTERACT program so this is a really good opportunity for you and your communities and your organizations to become expert and to have that conversation.

They can take a lot of different forms, no pun intended. The transfer form might be the first introduction to the hospital that you are doing something. There are a couple of tools that are coming up that help you figure out how to connect with the hospital. It is really not about the forms necessarily although the forms contain critical data elements that providers need to provide good care, but if you really want to work on improving the quality of transitions and the quality of communications transfer, it is about the relationship. So we have some strategies on how and who to call, to have collaborative meeting, a one-pager and why they should matter. In my experience and across the country, hospitals are dying to know about this.

The resident transfer form is sometimes the first form they see. If you are sending the form to the emergency room, be sure that you get there before the form. These are different for providers in the emergency department. We made an effort to get there face-to-face to show the form and envelope so they're not surprised.

They do not do what some of my facilities in Massachusetts did. We had a couple of envelopes with all of the information, transfer checklist, etc., but they did not open the envelope because they did not know what it was.

The transfer form was developed based on feedback from emergency room physicians and nurses about what information they needed, what order they wanted in and in the format that made the most sense of them.

It is a two-page form. The information on the front of the form is about the critical situation, what is going on, care planning, people to contact in the nursing home, what is bringing them in. The second page is about the functional status, alerts, mobility status, appetite, etc.

We have made significant revisions to the form as well. The idea is that the hospital has the right information available to make the right decision.

I will tell you a quick story about how this started. We had a wonderful relationship with a hospital nurse. They started giving these INTERACT forms and they liked some of it but they did not like all of it. They specifically did not like how the medications were coming in so they asked if the nursing facility within the medications differently. The nursing facility was glad to do that. They also put the transfer form on a three-hole punch piece of paper because one of the biggest complaints on these forms is that they disappear in the emergency room.

With three-hole punch paper, it went right into the chart. They continue to work on the system and make sure they knew what the nursing home was doing, the resident got to hospital and the information is right.

Following that dialogue, we got to the point when they were meeting as a cross continuum team so the hospital wanted to know what they need from us--information you need when the resident goes back to the nursing home. It was such light bulb moment because that is how things work. The hospital called with the next several transfers to make sure that they were getting what they needed. And before long they were looking at cases together. They were doing root cause analysis together.

This is an opportunity in working with the hospital.

If you had any time to consider what was on the transfer form, the first question you would ask would be what about the medications, what about all the other documents? The transfer checklist is meant to be the continuum document to remind staff what to send and what was sent to the hospital. We format it and you will see, you will send the transfer form medications, everything.

We formatted it as an envelope so people could just pop the information right into the envelope. But it does not have to be an envelope. It could be printed and taped onto an envelope.

Getting back to the Massachusetts story, at Cape Cod Hospital they actually printed orange envelopes and distribute them to all other local nurses because they liked it so much. So you can be creative with the formatting and the items on it but it is just meant to be sure that everything gets there, not just the transfer form.

I was just talking about that story about the hospital that finally said what can we do for you. This is one example of a transfer form with importing data elements that would go from the hospital to the nursing home. This is an example from Florida. We have been working with team members to develop a sample of one that could be used going forward.

The idea is the data elements on the transfer form from the hospital have the important information that the SNF needs when they get the resident back. What the date was for the pick and search and having the X-rayed document the pick insertion.

Joe, do you want to say anything else about this piece of it?

No, that is fine.

Again this visual that reminds us where advance care planning should take place. It should be a part of the administration history and the whole of managed admission process. It obviously should be reviewed regularly with routine care, ritual visits in the nursing home. It definitely will be review and acute change in position.

The advanced care planning tools are tips for starting and conducting the conversation. We've had very interesting feedback from focus groups from our work over the last couple years.

Everybody agrees that advance care planning is a demo by everybody, everybody agrees that it should be done better by everybody but is not clear who should do it.

So we really look -- work hard to engage nurses and physicians -- our work on this is painting this as a team effort. Their physicians, practitioner prescribers, they have a role to play. Unless we can get this to the front line, than we are just not doing a good job.

Our front lines and our nursing facility status and physician and practitioners, let us be honest, we have all need help on how to start the conversation.

This just goes through how to start -- set the stage. Get the facts, choosing a private environment, make sure you have time, and that sort of thing.

Many of these conversations, people might get stuck when they start talking about aggressive care when they're back in the hospital versus what? You do not want to feel like you are doing nothing. Truly comfort or palliative care does not mean that you are doing nothing. This gives you the language about the things that you will do. It gives you a full menu of things that you can remind families that patients and residents that you will do. It gives you spots in the language on describing diet. These are the things that we are going to do for your loved ones. Activity, monitoring, oxygen, comfort, turning, repositioning, mouth care.

This slide is about implementation. Good training is dependent on strong facility leadership, executive director, nursing director, etc. That is what strong suit facility leadership looks like.

Here are some general principles. I think we have made this point, it needs to be part of the way you do business. And it needs to be a key aspect of your facility's QAPI program. It needs to be consistent with the way you already provide care and your building. We heard this pretty clearly. It cannot be a parallel path to your process. It must be part of the way you do business.

And we remind people that there is a fair amount of work to get going and organizational change takes time. If you are six months in and you are just seeing real change, be encouraged that that is not uncommon. It may take three months to get the tools onto the units, to get people talking about them and then to really get them in about six months to use the tools. Then you are tweaking and doing innovative things with your hospitals and with their own programs.

We know the barriers. So we will give you a couple of strategies or barriers that we hear.

We have heard this from some of the champions on the calls that we don't have a problem with possible transfers. If you have your data, which is where you start, you will have your evidence and that conversation will quickly be completed with information so that you can actually go forward with the facts.

We hear that we do not have control over who gets admitted. To the hospital and from the hospital. We do want to work on our part and who gets admitted to the hospital from our facilities and if you are looking carefully at the changing condition and you are moving at the comprehensive assessment, you do have control over who gets admitted if you're really working hard up front and assessing them and starting treatment before they're critically ill.

The doctors will cooperate. We do here this a fair amount. Engaging physicians and that QI review in your quality meetings, getting them involved in the cases, making it personal about their particular residence, and why this is a great tool are the strategies that engage doctors.

We don't have the staff or time. I hear that and I respect people who say that. We are in a very tight environment in terms of resources. It is a rare nursing unit that I walk on where we have staff just walking around. We have heard and we can say in all honesty that staff are more efficient and more satisfied with their work when they are using this program. The tools and strategies are used to take better care of the residence and to communicate more effectively.

This topic must be a priority in every building, quite honestly these days.

We have too many other things going on. If that is true, then do you wait a couple of months until you do not have too many things going on? Or do you wrap up them up. Implementing this program requires a fair amount of time and focus and you only want to do it once. If you can, make it the priority for your education for a period of time until you're up.

We are in our survey window. That answer also keeps people from starting an initiative, including this one. What we say is that this will result in improved care and enhance multiple F tax and other requirements. I just trained one of our surveyors in Massachusetts. I went through the entire program so they knew what we were doing. We have heard from staff that they are very receptive when you take a moment to tell them what you are doing.

This is true as well. We are dependent on a champion. We talked about training champions and their role in engaging the facility. Engaged facilities have great champions, they've had an impressive reduction in acute care transfers. However, the champion could have an illness or accident and be out; name a co-champion, possibly an evening or weekend staff member. Maybe a supervisor or nurse manager for backup, then you're embedding the tools into everyday practice so you really will not get that far off course.

If you have forms and similar processes already in place that look just like what you're doing with what we are suggesting, then keep what you have. Look at the entire program. Look at what you have in place already and find out where the gaps are. Start with what is missing. If you already have the stopwatch, don't do the stopwatch, start with something else.

Just very quickly, families want the resident hospitalized. You cannot go wrong with spending more time up front talking with families about your overall work on reducing readmissions and the idea. The fact is there is no way to prevent losses. This isn't an evidence-based program with expert recommendations and mentor approved condition.

So, I made it to the timeline for questions and suggestions. I will turn it over to our host for this and see how we might want to go to the questions.

Olivia, do you want to go ahead and open up the questions please?

We will now begin an audio question-and-answer session. If you have a question, please press star then one on your touchtone phone. If you wish to be removed from the queue, please press the #hash key. If using a speakerphone, you may need to pick up the handset before pressing the numbers. Once again if you have a question, please press star then one on your touchtone phone. First question I have is from Christopher.

How is everybody doing? I did have a question about the engagement of EMS and your collaborative learning and action networks. Has anybody engaged emergency medical services as one of the consortium to decrease the appropriate hospitalization for residence 65+?

This is Laurie. Very specifically with the INTERACT program, I'm not sure if you noticed but on the transfer form it asks that the EMS sign it. We did not think that that was a really big deal. We thought it would be clear that they were to sign the form. It turns out that it was a really big deal, they did not know what they were signing and we did not do that here in Massachusetts. So that offered the opportunity to go to the office of EMS in our department of public health and we did have a conversation with them. We found that EMS providers here in Massachusetts are critically involved and we have them very involved in training.

Here in our state we had allowed involvement from EMS, but we have not formally involved them to this point with this work necessarily.

That is understandable. They are the missing link in a lot of ways. Specifically, in the way of logistics and transition. They are the missing piece to the puzzle. We have older residents that go back to the residence or baseline care after admission. It is just one more piece of the puzzle that we can investigate to determine the baseline. It is always good to look at them as a variable. So just food for thought. Thank you.

Thank you for that.

Next question is from Gillian Fryer.

I was wondering where I go to obtain these forms.

You can go right to the website. interact2.net

I just want to say as Laura indicated we will have a new set of INTERACT tools available within probably a month. We not only have a fantastic traffic designer, the content is better, we are also working with a company that is doing the graphic to make them available with printing in various formats. We are working on it. I can tell you and Laurie can tell you that the new INTERACT tools have a much improved look about them.

Again, if you have an audio question, please press star then one on your touchtone phone.

Next question is from Diana.

I missed the location of how to get a copy of the slides. I think you told us in the beginning?

The slides will actually be available at the website. sdfmc Website.

I am showing no further questions at this time. Do you have any closing comments?

I would like to thank everyone for participating. Certainly let us know if you have any issues, problems, or concerns. We will be sending out a brief survey monkey. We would like you to send it back. Otherwise I would like to thank Joseph Ouslander and Laurie Herndon for an excellent presentation. I am looking forward to seeing you in January for training.

Thank you.

Nice to talk with Evelyn.

Thank you ladies and gentlemen, this concludes today's conference. Thank you for participating. You may all now disconnect.

[Event concluded]

If you have any questions, please contact Stratis Health, at info@stratishealth.org.