Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

The INTERACT Program

June 14, 2012
Objectives

• Describe the INTERACT Program
• Understand how to put the INTERACT tools to work in everyday practice
• Explore strategies to increase communication with referral hospitals
The INTERACT Program: What is It and Why Does It Matter?

(“Interventions to Reduce Acute Care Transfers”)

Is a quality improvement program designed to improve the care of nursing home residents with acute changes in condition.
The INTERACT Program: What is It and Why Does It Matter?

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources
- The basic program is located on the internet:

  http://interact2.net
The INTERACT Program: What is It and Why Does It Matter?

INTERACT is One of Several Evidence-Based Care Transitions Interventions

“BOOST” (Better Outcomes for Older Adults Through Safe Transitions)
http://www.hospitalmedicine.org

“Project RED” (Re-Engineered Discharge)
https://www.bu.edu/fammed/projectred
• Enhanced hospital discharge planning

“Care Transition Program”
http://www.caretransitions.org
• Transition coach
• Trained volunteers
• Empowered patients and caregivers

“POLST” (or “MOLST”)
(Physician (or Medical) Orders For life Sustaining Treatment)
http://www.ohsu.edu/polst
• Advance care planning

High Quality Care Transitions for
Older Adults & Caregivers

“Bridge Model”
http://www.transitionalcare.org/the-bridge-model
• Social Worker coordinating Aging Resource Center Services at hospital discharge

“Transitional Care Model”
http://www.transitionalcare.info/index.html
• APN coordinates care during and after discharge
• Home, SNF, and clinic visits

“INTERACT” (Interventions to Reduce Acute Care Transfers)
http://interact2.net
• Communication Tools, Care Paths, Advance Care Planning Tools, and QI tools for nursing homes and SNFs

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The INTERACT Program: What is It and Why Does It Matter?

Why Does This Matter?

- At the beauty salon
- At risk for complications
  - Delirium
  - Polypharmacy
  - Falls
  - Incontinence and catheter use
  - Hospital acquired infections
  - Immobility, de-conditioning, pressure ulcers

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The INTERACT Program: 
What is It and Why Does It Matter?

Why Does This Matter?

1. Hospital transfers are common and often result in complications in older NH residents
2. Some hospital transfers are preventable
3. Care can be improved, resulting in fewer complications and reduced cost
4. Cost savings to Medicare can be shared with NHs to further improve care
5. Financial and regulatory incentives are changing
Can help your facility safely reduce hospital transfers by:

1. **Preventing conditions from becoming severe** enough to require hospitalization through early identification and assessment of changes in resident condition

2. **Managing some conditions in the NH** without transfer when this is feasible and safe

3. **Improving advance care planning** and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents
The goal of INTERACT is to improve care, not to prevent all hospital transfers.

- In fact, INTERACT can help with more rapid transfer of residents who need hospital care.
The INTERACT Program: What is It and Why Does It Matter?

Communication Tools
Decision Support Tools
Advance Care Planning Tools
Quality Improvement Tools
The INTERACT II tools are meant to be used together in your daily work in the nursing home.

http://interact2.net
1 in 4 patients admitted to a SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion.

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006

The INTERACT Program: What is It and Why Does It Matter?

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

- 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
1. **Accelerate Reduction in Harm to Patients in Hospitals**
   - Achieve a 40% reduction in preventable harm by 2013
   - ~ 1.8 million fewer injuries to patients; ~ 60,000 lives saved;
   - ~ $20 billion in health care costs avoided

2. **Decrease Preventable Hospital Readmissions Within 30 Days of Discharge**
   - Reduce readmissions by 20% by 2013
   - ~1.6 million hospital readmissions prevented and ~ $15 billion in health care costs avoided

http://www.healthcare.gov/center/programs/partnership
Why Start By Tracking Transfers?

- Tracking hospital transfers allows you to:
  - Determine your baseline, set goals for improvement, and follow your progress
  - Identify situations that commonly result in transfers of your residents to the hospital
## Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool

### ACUTE CARE TRANSFER LOG

<table>
<thead>
<tr>
<th>Resident Room Number</th>
<th>Date of most recent admission to the facility</th>
<th>Admitted to the facility from* (circle)</th>
<th>Status at time of Transfer* (circle)</th>
<th>Date of Transfer</th>
<th>Time of Transfer (circle a.m. or p.m.)</th>
<th>Outcome of Transfer (check which applies)</th>
<th>Hospital Diagnosis for ED visit or admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/1</td>
<td>Hosp H O</td>
<td>S LT O</td>
<td>/ / /</td>
<td></td>
<td>a.m. p.m.</td>
<td>ED visit only (returned to facility)</td>
<td></td>
</tr>
<tr>
<td>2/2/2</td>
<td>Hosp H O</td>
<td>S LT O</td>
<td>/ / /</td>
<td></td>
<td>a.m. p.m.</td>
<td>Admitted to the hospital</td>
<td></td>
</tr>
</tbody>
</table>

*Hosp = Hospital
H = Home
O = Other
S = Skilled (Medicare Part A)
LT = Long-term (Medicaid, private pay)
O = Other (e.g. managed care)
What are the Incentives to Hospitalize?

- Physician reimbursement
- Hospital reimbursement
- NH Capabilities
- Qualification for skilled nursing facility stay
- Patient and family preferences
- Liability

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The **INTERACT Quality Improvement Tool** is meant to identify opportunities to improve management of changes in condition through a **root cause analysis** process.
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.
The QI Review Tool: 5 Sections

1. Background Information
2. Change in Condition
3. Evaluation and Management
4. Transfer Information
5. Opportunities for Improvement
The Transfer Log and QI Tool Will Help Your Facility:

- Look for patterns in transfers and the clinical situations that result in them
- Identify situations you believe can be managed safely and effectively without transfer
- Work together to develop strategies to manage these situations
- Develop education on specific topics
Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool

Common Reasons for Transfers Identified in QI Tools

- Acute change in condition with unstable vital signs
- Family expectations
- Lack of availability or communication problems with primary care physicians
- Services required are unavailable in the facility
- Lack of advance care planning and advance directives

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Putting the Tools to Work in Everyday Practice

Do any of you use the Stop and Watch Tool? What is your experience?

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)
A ND drank 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 ____________

Putting the Tools to Work in Everyday Practice

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

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)
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 ________________________________
## Background

Primary diagnosis and/or reason resident is at the nursing home ________________________________
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) ____________________

<table>
<thead>
<tr>
<th>Vital signs</th>
<th>BP</th>
<th>HR</th>
<th>RR</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse Oximetry</td>
<td>% On RA</td>
<td>on O2 at</td>
<td>L/min via</td>
<td>(NC, mask)</td>
</tr>
<tr>
<td>Change in function or mobility</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication changes or new orders in the last two weeks</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental status changes (e.g. confusion/agitation/lethargy)</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain level/location</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in intake/hydration</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in skin or wound status</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labs</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)</td>
<td>________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>________________________________</td>
<td>Any other data</td>
<td>________________________________</td>
<td></td>
</tr>
</tbody>
</table>
Putting the Tools to Work in Everyday Practice

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) ____________________________
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)
Making the Case for SBAR

- Assists nurses in organizing their evaluation
- Improves communication with MDs/NPs/PAs
- Improves shift to shift communication
- Alerts all providers about a change in condition
- Enhances documentation
- Can be copied and sent to ER with resident
Putting the Tools to Work in Everyday Practice

INTERACT Decision Support Tools: Care Paths and Change in Condition File Cards

Change in Condition: When to report to the MD/NP/PA

Immediate Notification:
Any symptom, sign or apparent discomfort that is:
1. Sudden in onset
2. A marked change (i.e., more severe) in relation to usual symptoms and signs
3. Unrelieved by measures already prescribed

Sources:
AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003.

CARE PATH: Symptoms of Lower Respiratory Infection

Symptoms of Lower Respiratory Infection Noted
• Labored breathing / shortness of breath
• New or worsened cough
• New or increased sputum production
• New or increased findings on lung exam (rales, wheezes)
• Chest pain with inspiration or coughing

Take Vital Signs
• Temperature
• BP, Pulse
• Respirations
• Oxygen saturation
• Finger stick glucose (diabetics)
Putting the Tools to Work in Everyday Practice

- The Care Paths and Change in Condition File Cards are meant to be used with other tools.
- The change in condition or new symptom or sign may have been noted using the Stop and Watch Tool.
- Nurses should consider completing an SBAR Form and Progress Note using guidance from these tools.
The INTERACT Change in Condition File Cards:

- The case of Mrs. S: a classic case that illustrates their purpose

Immediate Notification:
Any symptom, sign or apparent discomfort that is:
1. **Sudden** in onset
2. **A marked change** (i.e. more severe) in relation to usual symptoms and signs
3. **Unrelieved** by measures already prescribed

Sources:
- AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003
### Putting the Tools to Work in Everyday Practice

**Vital Signs**
*(Report Why Vital Signs Were Taken)*

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Report Immediately</th>
<th>Report on Next Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>• Systolic BP &gt; 210 mmHg, &lt; 90 mmHg</td>
<td>• Diastolic BP routinely &gt; 90 mmHg</td>
</tr>
<tr>
<td>Pulse</td>
<td>• Diastolic BP &gt; 115 mmHg</td>
<td>• Resting pulse &gt; 120 bpm on repeat exam</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>• Resting pulse &gt; 130 bpm, &lt; 55 bpm, or &gt; 110 bpm and patient has dyspnea or palpitations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Respirations &gt; 28, &lt; 10/minute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oral (electric thermometer) temperature &gt; 101°F</td>
<td></td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
<td>• New Onset of anorexia with or without weight loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5% or more within 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 10% or more within 6 months</td>
</tr>
</tbody>
</table>

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### Laboratory Tests/Diagnostic Procedures

*Report Why the Test or Procedure was Done*

<table>
<thead>
<tr>
<th>Test/Procedure</th>
<th>Report Immediately</th>
<th>Report on Next Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count</td>
<td>- WBC &gt;12,000&quot;</td>
<td>WBC &gt;10,000 without symptoms of fever</td>
</tr>
<tr>
<td></td>
<td>- Hemoglobin (Hb) &lt;8&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hematocrit &lt;24&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Platelets &lt;50,000&quot;</td>
<td></td>
</tr>
<tr>
<td>Chemistry</td>
<td>- Blood urea nitrogen (BUN) &gt;80 mg/dl</td>
<td>- Glucose consistently &gt;200 mg/dl</td>
</tr>
<tr>
<td></td>
<td>- Calcium (Ca) &gt;12.5 mg/dl</td>
<td>- Hb A1c (any value)</td>
</tr>
<tr>
<td></td>
<td>- Potassium (K) &lt;3.0; &gt;6.0 mg/dl</td>
<td>- Albumin (any value)</td>
</tr>
<tr>
<td></td>
<td>- Sodium (Na) &lt;125; &gt;155 mg/dl</td>
<td>- Bilirubin (any value)</td>
</tr>
<tr>
<td></td>
<td>- Blood glucose</td>
<td>- Cholesterol (any value)</td>
</tr>
<tr>
<td></td>
<td>- &gt;300 mg/dL in diabetic patient not using sliding-scale insulin</td>
<td>- Triglycerides (any value)</td>
</tr>
<tr>
<td></td>
<td>- &gt;430 mg/dL. (or machine registers high) in diabetic patients using sliding scale insulin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- &lt;70 mg/dL in diabetic patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- &lt;50 mg/dL in nondiabetic patient</td>
<td></td>
</tr>
</tbody>
</table>
## Putting the Tools to Work in Everyday Practice

### Signs & Symptoms A’s

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>Abrupt onset severe pain or distention, OR with fever, vomiting</td>
<td>Moderate diffuse or localized pain, unrelieved by antacids or laxatives</td>
<td>Persistent mild to moderate discomfort, without associated symptoms</td>
</tr>
<tr>
<td></td>
<td>(Notify the attending or on-call MD, NP, or PA on call as soon as possible)</td>
<td>(Notify the attending or on-call MD, NP, or PA no later than the next work day)</td>
<td>(Notify the attending or on-call MD, NP, or PA no later than the next regular visit or phone or fax communication)</td>
</tr>
</tbody>
</table>

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Putting the Tools to Work in Everyday Practice

Using the Change in Condition File Cards

- Staff education to develop critical thinking skills
  - Nurse educators and managers use *Change of Condition File Cards* when teaching staff nurses who are assessing a resident’s change in condition

- Strategies
  - 5-minute huddle on the unit
  - Morning stand-up meeting
  - Report between shifts
The **INTERACT** Care Paths focus on 6 conditions that are:

- Common reasons for hospital transfer
- Often manageable in the nursing home
- Frequent causes of potentially avoidable and preventable transfers or hospitalizations

The **INTERACT** Care Paths:

- Acute mental status change
- Fever
- Dehydration
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI
Putting the Tools to Work in Everyday Practice

**INTERACT Care Paths**

- All structured the same way
- Provide guidance on when to notify the MD/NP/PA consistent with File Cards
- Suggest evaluation strategies
- Provide recommendations for management and monitoring in the facility
Interacting with Your Hospitals

RESIDENT TRANSFER FORM

RECIPIENT: (Name of Hospital)

DATE: / / Unit:

CONTACT PERSON: (Name of Nursing Home)

CODE STATUS:

MUNDERA IN NURSING HOME:

WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT:

REASON FOR TRANSFER:

DEVICE/SPECIAL TREATMENTS: AT RISK ALERTS:

CAPABILITIES OF THE NURSING HOME TO CARE FOR THIS RESIDENT:

COPY SERVICES SENT WITH RESIDENT (Check all that apply):

Those 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
- Blood bank 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 Appliances
- Other (specify)

Signature of ambulance staff accepting envelope: ____________________________

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

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Purpose of the Transfer Checklist and Resident Transfer Form

- Provide essential information to emergency department staff that will lead to the most appropriate evaluation of your resident
- Insure that the safe handoff of your resident to the emergency department
Implementation Strategies

- Remove old forms from the units
- Consider contacting printer to have forms printed on NCR paper
- If not on NCR paper, forms need to be copied and one copy needs to stay in the facility
This **Transfer Checklist** can be printed or taped onto an envelope, and is meant to compliment the Transfer Form by indicating which documents are included with the Form.
Interacting with Your Hospitals

Implementation Strategies

- Notify your local Emergency Departments
- Notify your EMS/Ambulance Services
- Consider alternative format for checklist
Interacting with Your Local Hospitals

- Schedule in-person meetings
  - Offer a tour of your facility
  - Create an agenda
- Start with who staff you already interact with on a regular basis
  - ED staff
  - Case Managers
- Emphasize 2-way communication
- Set mutual expectations
Interacting with Your Hospitals

Make Sure the Hospital Knows Your Facility’s Capabilities

- This tool can be posted in the ER and in Case Managers’ offices

<table>
<thead>
<tr>
<th>Available on Site*</th>
<th>Yes/No</th>
<th>Interventions</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency interventions</td>
<td></td>
<td>CPR – basic only</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drains and catheters</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td></td>
<td>Epidural catheters</td>
<td></td>
</tr>
<tr>
<td>Stat EKG (within 4-6 hrs)</td>
<td></td>
<td>Suprapubic catheters</td>
<td></td>
</tr>
<tr>
<td>Stat Xray (within 4-6 hrs)</td>
<td></td>
<td>Urostomy</td>
<td></td>
</tr>
<tr>
<td>Stat lab work (within 4-6 hrs)</td>
<td></td>
<td>Surgical drains</td>
<td></td>
</tr>
<tr>
<td>Bladder ultrasound</td>
<td></td>
<td>Pulmonary</td>
<td></td>
</tr>
<tr>
<td>Cardiac Echo</td>
<td></td>
<td>Q2 management</td>
<td></td>
</tr>
<tr>
<td>Venous duplex</td>
<td></td>
<td>Suction q/hr</td>
<td></td>
</tr>
<tr>
<td>Physicians/NP Services</td>
<td></td>
<td>Suction q/hr</td>
<td></td>
</tr>
<tr>
<td>7 day/wk visits</td>
<td></td>
<td>Tracheostomy management</td>
<td></td>
</tr>
<tr>
<td>5 day/wk visits</td>
<td></td>
<td>Nebulizer treatments</td>
<td></td>
</tr>
<tr>
<td>1-2x/wk visits</td>
<td></td>
<td>CPAP</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td></td>
<td>Wound care program</td>
<td></td>
</tr>
<tr>
<td>One on one</td>
<td></td>
<td>VAC dressings</td>
<td></td>
</tr>
<tr>
<td>Therapies</td>
<td></td>
<td>Debridement</td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td></td>
<td>IV capabilities</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
<td>PICC Insertion</td>
<td></td>
</tr>
<tr>
<td>Speech therapy</td>
<td></td>
<td>PICC management</td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td></td>
<td>IV fluids</td>
<td></td>
</tr>
<tr>
<td>UTI, MRSA, c. diff</td>
<td></td>
<td>IV antibiotics</td>
<td></td>
</tr>
<tr>
<td>Typical turnaround time when new Meds are ordered:</td>
<td></td>
<td>Q4 hrs</td>
<td></td>
</tr>
<tr>
<td>Nursing Services</td>
<td></td>
<td>Q12 hrs</td>
<td></td>
</tr>
<tr>
<td>IV meds – other (e.g., furosemide)</td>
<td></td>
<td>CAD pumps</td>
<td></td>
</tr>
<tr>
<td>Vital sign monitoring (0.2 hrs)</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Vital sign monitoring (0.4 hrs)</td>
<td></td>
<td>G/F tube feeding</td>
<td></td>
</tr>
<tr>
<td>O2 saturation monitoring (0.4 hrs)</td>
<td></td>
<td>NG tube feeding</td>
<td></td>
</tr>
<tr>
<td>Peak flow</td>
<td></td>
<td>TPN</td>
<td></td>
</tr>
<tr>
<td>Glucose monitoring (at least 0.6 hrs)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Effective implementation is critical to long-term sustainability of the program. The program cannot be effectively implemented or sustained without strong support from facility leadership.
1. Select Your Team

*Pearl of Wisdom:*

- Selection of the Champion and Co-Champion is one of the most important decisions you will make
2. Find the Gaps

*Pearl of Wisdom:*

- Avoid redundancy - the *INTERACT* program should fill in gaps in your care processes and not create more work for your staff.
### 3. Carefully Plan Your Training

**Facility Characteristics** | Start with one unit or one tool and have all of the tools implemented by a set date | Implement the whole toolkit all at once throughout the whole facility
---|---|---
We are a small facility with no other major initiatives underway. |  | X
Our champion does very well teaching one on one. | X |  
Our champion is our in-service director and is experienced conducting large in-services. |  | X
We usually roll out programs for everyone at the same time. |  | X
We are a large facility with several nursing units. | X |  
We have a short time line to carry out the training and implement the program | X |  

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4. Make the Tools Visible in for Easy Use in Everyday Practice

**Pearls of Wisdom:**

- Remove old forms from nursing units to avoid confusion and to encourage standard use of new tools and forms
- Successful INTERACT Champions have found ways to keep the program visible on a daily basis through discussions at stand up meetings, on rounds and other strategies
5. Continue Tracking Your Data and Looking for Ways to Improve Your Care

*Pearls of Wisdom:*

- Complete Quality Improvement tools as soon after acute care transfers as possible so that details are fresh
- Use the data to improve care processes and to focus educational activities
- Set your own benchmarks and work on improving
Tips on Getting Started and Keeping It Going

Overcoming Barriers to Implementation

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Overcoming Barriers to Implementation (1)

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies to Overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We don’t have a problem with hospital transfers”</td>
<td>Regularly track hospital transfers and follow trends; you may have a problem and not know it</td>
</tr>
<tr>
<td>“We don’t have control over who gets admitted”</td>
<td>Using INTERACT tools to improve management of acute changes and communication with physicians and emergency rooms staff will give you more control</td>
</tr>
<tr>
<td>“The doctors won’t cooperate”</td>
<td>The medical director and the primary care providers must buy in to the INTERACT program</td>
</tr>
</tbody>
</table>
## Overcoming Barriers to Implementation (2)

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies to Overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Families want residents hospitalized”</td>
<td>Families need to be educated about the risks as well as benefits of hospitalization</td>
</tr>
<tr>
<td>“We could get sued”</td>
<td>There is no fail-safe way to prevent law suits – but the INTERACT program provides tools for evidence-based and expert recommended care, and improves communication and documentation</td>
</tr>
</tbody>
</table>
### Overcoming Barriers to Implementation (3)

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies to Overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We don’t have the staff or time”</td>
<td>Improving the management of acute changes in condition has to be a priority of the facility and its leadership</td>
</tr>
<tr>
<td>“We have too many other things going on”</td>
<td>INTERACT must be one of the major quality improvement initiatives at the facility</td>
</tr>
<tr>
<td>“We are in our survey window”</td>
<td>INTERACT implementation will result in improved care and adherence to multiple F Tags and other requirements</td>
</tr>
</tbody>
</table>
Overcoming Barriers to Implementation (4)

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies to Overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Things don’t go well when the Champion is not here”</td>
<td>Appointing a co-champion and embedding INTERACT tools into everyday practice will help overcome staff absences and turnover</td>
</tr>
<tr>
<td>“We already have similar forms and processes”</td>
<td>Use your tools, or use or modify the INTERACT tools based on what your facility already has in place</td>
</tr>
</tbody>
</table>
Tips on Getting Started and Keeping It Going

Sustaining the Program

1. Ensure ongoing leadership support

2. Make INTERACT a permanent part of your quality improvement activities and one of your programs for QAPI

3. Appoint and train a Co-Champion

4. Have new staff undergo training
5. Continue to track changes in rates of hospital transfer and how you manage acute changes in condition

6. Learn from you Quality Improvement Review tools

7. Visit the INTERACT website for updates and new resources: http://interact2.net

8. Don’t hesitate to contact us through the website
The INTERACT Program: What is It and Why Does It Matter?

- Questions?
- Comments?
- Suggestions?

mary.perloe@gmcf.org

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