INTERACT for Assisted Living

Part 1

NYSHFA/NYSCAL 2014 Fall Conference & Trade Show

LuAnne Leistner MS, RN, BC, NE, BC, CALN
Director Clinical Services- Assisted Living/Brookdale
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Bio/Disclosures

LuAnne Leistner  MS,RN,BC,NE,BC,CALN

is the Director of Clinical Services for Assisted Living with Brookdale. She is a graduate of Wright State University, Bluffton University, Sinclair Community College with 38 years of varied nursing experience. She completed course work toward a post graduate certificate with the University of Toledo-Center for Successful Aging and is a member of the National Gerontological Academic Honor and Professional Society of Sigma Phi Omega. She currently holds 2 national certifications from the American Nurses Credentialing Center (ANCC) in gerontological nursing and nursing administration as a nurse executive. She is also a Certified Assisted Living Nurse (CALN) with NADONA/NALNA and has been an Ohio Assisted Living Association (OALA) Board member since 2006 and just completed the Chairperson position from 2011-2013. She is a member of the Quality Committee with the National Center for Assisted Living-NCAL and a recently elected Board member to the American Assisted Living Nurse Association (AALNA). She has been with Brookdale since 2005.
Acknowledgements of Contributions to this Presentation

Kevin O’Neil, M.D. Chief Medical Officer Brookdale Senior Living
Practiced and taught geriatric medicine for over 30 years.
Clinical Professor in the Department of Aging Studies at the University of South Florida.
Certified by the American Board of Internal Medicine in both Internal Medicine and Geriatric Medicine.
Co-Director for the Center for Medicare Services (CMS) Health Innovations Challenge Grant for application of INTERACT in IL, AL, and HH settings.

Joseph G. Ouslander, M.D. Professor /Senior Associate Dean for Geriatric Programs
Interim Chair, Department of Integrated Medical Sciences
Charles E. Schmidt College of Medicine
Professor (Courtesy), Christine E. Lynn College of Nursing
Florida Atlantic University
Executive Editor, Journal of the American Geriatrics Society
OBJECTIVES

Describe the development of the INTERACT QI program for Assisted Living as it relates to the CMS Innovations Challenge grant

Identify the goals of the INTERACT Quality Improvement program and the 4 categories of INTERACT tools (http://Interact.fau.edu)

Identify strategies to prevent avoidable hospitalizations & improve the quality of resident care

Describe the role of direct care staff in identifying/reporting acute changes in resident condition

Describe how this program could be beneficial in the care of your AL residents & community

Apply select INTERACT tools using clinical case scenarios
The Changing Landscape……..HELP!

ACA……Higher Acuity…..ACO…….Bundled Payments…
Pay for Performance…….Hospital Readmission Penalties…..
Employer Mandates…O’Bama Care…..Satisfaction….
Medicare Shared Savings Plan…New Medicare Tax…Outcomes
The Triple Aim…Transition of Care…BOOST……Project Red..
INTERACT…CMS…Shared Responsibility…Quality….
Care Transition Partners..National Transitions of Care Coalition
Reducing Hospital Admissions….Advanced Care Planning….Accountability…EMR…Avoidable Re-hospitalizations
Post Hospital Syndrome…Acute COC….Performance Metrics…
Medical versus Social Model…Safety….State Surveys…CNL’s
“The Silver Tsunami”….Growing Cost of Dementia Care..
Assisted Living Landscape

- Fastest growing segment of elder care
  - Over 31,000 ALFs
  - 971,900 beds

- Acuity level has increased*
  - 86% need assistance with taking meds
  - 72% with bathing
  - 57% with dressing
  - 41% with toileting
  - 36% with transferring
  - 23% with eating

*Source: National Center for Health Statistics, 2010
Triple Aim of CMS

• Better health of populations
• Better care for individuals while lowering the per-capita costs of care over time
• Improve the care experience
Costs of Care are Unsustainable

Total Medicare Expenditures

1997–2017


Courtesy: Advisory Board Company

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients with 4+ Chronic Conditions</th>
<th>Patients with &lt;4 Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>$225 B</td>
<td>79%</td>
</tr>
<tr>
<td>2007</td>
<td>$431 B</td>
<td>91%</td>
</tr>
<tr>
<td>2017</td>
<td>$857 B</td>
<td>96%</td>
</tr>
</tbody>
</table>
Functional Limitations Exacerbate the Challenge

Average Annual Medicare Spending per person in 2006

- **Chronic Disease & Functional Limitations**: $15,833
- **3 or More Chronic Conditions Only**: $7,926
- **1-2 Chronic Conditions Only**: $3,559
- **No Chronic Conditions**: $2,245

Source: Avalere Health, LLC analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use File
Why it matters - Going to the Hospital …

• Disrupts our resident’s/patient’s life
• May cause health complications
• Is difficult for families and friends
• Costs billions of dollars to Medicare and Medicaid each year
Benefits for Associates

• Knowledge to identify and manage acute changes in the community when it is safe and practical
• Identify residents/patients who require acute care transfers more rapidly
• Maintain connections and provide support to residents and families
• Improve resident/patient care using clinical practice tools
Benefits to the Community

• Better outcomes for our residents/patients
• Improved resident/patient and family satisfaction
• Increased reputation for quality care
• Reduced time associated with transfers
• Complying with...
Impact on Hospitals

• More than 2000 hospitals have received readmission penalties
• Penalties:  >$280 million
• Impact on reputation:  Hospital Compare website
• Revisions to CMS Guidelines for Discharge Planning
• 40% of Medicare beneficiaries admitted to PAC settings
• Skilled nursing, assisted living, and home care become critical to reducing readmissions
Definition

**Transition of Care** refers to the movement of patients/residents between healthcare locations, providers or different levels of care within the same location as their conditions and care needs change.

A transition of care can occur
- **within** settings (hospital ICU to medical unit)
- **between** settings (clinic to senior day care center)
- **across** health states (personal residence to Assisted Living)
- **Inbetween** providers (generalist to specialist)

**Taken from AMDA TOC LTC Practice Guideline**
Why Focus on Care Transitions?

• 20% of Medicare beneficiaries readmitted within 30 days
• 25% admitted to SNF readmitted within 30 days
• Negative physical, emotional, psychological impact
• Costs Medicare billions of dollars\(^1\)
  – $26 billion annually
  – $17.5 billion on in-patient spending
• Avoidable hospitalizations/readmissions a key strategy
  – 25-42% of readmissions are avoidable\(^2\)

2. Long-Term Quality Alliance. Improving Care Transitions: how quality improvement organizations and innovative communities can work together to reduce hospitalizations among at-risk populations. June 2012.
Ineffective Transitions Lead to Poor Outcomes

- Wrong treatment
- Delay in diagnosis
- Severe adverse events
- Resident complaints
- Litigation
- Increased healthcare costs
- Increased length of stay

“Post-Hospital Syndrome”

An Acquired transient period of vulnerability

30 day post hospital risk period
(stress/sleep/nutrition/inactivity/
deconditioning/weight loss/pain/medications

20% of Medicare patients discharged
experience acute medical problem within 30 days

Focus on Stressors that Contribute to Vulnerability

– Reduce disruption of sleep
– Minimize pain and stress
– Promote good nutrition
– Optimize use of sedatives (reduce risk of delirium and confusion)
– Emphasize physical activity and strength
– Enhance cognitive function
“Post-Hospital Syndrome”
Harlan M Krumholz, M.D. & 30-day period following transition

Proportions of Rehospitalizations for Causes Other Than the Condition at Initial Discharge.
Data are from Jencks et al.¹
Overview of QI Programs

High Quality Care Transitions for Older Adults & Caregivers

“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

“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

Courtesy: Joseph Ouslander, MD

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Geriatrics is a TEAM Sport!

It’s a lot easier if we all pull together!
The Solution

• Acknowledge and empower direct care staff as an integral part of the team.
• Educate and help direct care staff to recognize and report the “not-normal.”
• Learning how to give information can be taught.
• Provide tools, guidelines and protocols.
• Improve team communication
CMS Health Innovation Challenge Grant

• 3-Year $7.3 million Grant - Awarded July 1, 2012 to University of North Texas Health Science Center in partnership with Brookdale Senior Living

• Goal is to revise and implement the INTERACT Program in skilled nursing, assisted living, and home care settings to reduce avoidable readmissions and emergency room transfers

• Quality Nurse Leaders will evaluate data and guide quality improvement programs

• Implementing electronic health record to share data between healthcare providers

• Implementing in 67 Brookdale Communities (Florida/Texas/KS/Denver) during grant period and share lessons learned with acute and post-acute care partners

• Expected savings of more than $9 million
PROCESS

Organization of the CMS Grant Team Summer 2012

October to December 2012: Began a Review of the INTERACT version 2 tools & made recommendations for changes for AL and HH.

External survey of tools conducted with NCAL/AALNA/ through December 2012
  ▪ Stop & Watch tool
  ▪ SBAR for AL Nurses
  ▪ SBAR for Caregivers-AL

December 2012: External survey conducted to gather additional feedback on tools
  Goal of 30-40 survey participants for AL

  Internal experts: Brookdale Senior Living

Pilot tools finalized Spring 2013 & training initiated August 2013

Training of approx. 71 communities (Skilled/AL) completed in June 2014.

May 2014: Initiated use of “select” Interact tools for Independent Living
All of us have a role in resident care & service. Working as one team to manage subtle changes in condition effectively and safely preventing unnecessary resident transfers.
3 key strategies to help 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 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

http://www.interact.fau.edu
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
What is INTERACT?

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

What is the purpose of INTERACT?

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

Announcements

- INTERACT Program Tools for Assisted Living Now Available 7/25/2014
- New published review of the INTERACT Program available - see Publications below 5/15/2014
- INTERACT Hospitalization Rate Tracking Tool for 2014 now available 1/9/2014
- INTERACT eCurriculum on Medline University 6/13/2013
- Information about the eINTERACT Certification Panel and Process is available at http://www.interact.info/vendors.html 6/31/2013
- Licenses for INTERACT v3.0 for Nursing Homes for EMRs and HIT are now available 9/24/2013

Publications Related to INTERACT

- Overview of INTERACT JAMDA 2014
- INTERACT Evaluation - J Amer Geriatr Soc 2011
- INTERACT and the EMR Ann LTC 2011
- Avoidable Hospitalizations - J Amer Geriatr Soc 2010
Interact Tools

• Communication Tools
• Decision Support Tools
• Quality Improvement Tools
• Advanced Care Planning Tools
Communication Tools

• Stop and Watch Early Warning Tool

• SBAR Communication Form and Progress Note for RN/LPN/LVN

• SBAR Communication Form and Progress Note for Caregiver
What is STOP and WATCH?

- Each letter in STOP and WATCH stands for a symptom
- 12 early warning signs
Stop and Watch
Early Warning Tool

If you have identified an important change while caring for or visiting a resident, please circle the change and notify a nurse or supervisor.

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening: Moans or grimaces (for residents with severe dementia), participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Observation Reported to: Date and Time (am/pm)

Nurse/Supervisor Response Date and Time (am/pm)

Nurse/Supervisor Name

This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living (www.ahcancal.org/ncal/).
2  SBAR Types for AL

Nurse: Situation/Background/Assessment/Request
Caregiver or Supervisor: Situation/Background/Appearance/Ready to Call

• **Situation**: What is going on with the resident?
• **Background**: What is the clinical background or context?
• **Assessment/Appearance**: What do I think the problem is?
• **Request/Ready to Call**: What do I think needs to be done for the resident?
SBAR Communication Form
and Progress Note for RN/LPN/LVNs in Assisted Living

Before Calling the Physician/NP/PA/other Healthcare Professional:
☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, and finger stick glucose for diabetes
☐ Review Record: Recent progress notes, labs, orders
☐ Review an INTERACT Care Path or Acute Change in Condition File Card. If indicated (nurses only)
☐ Have Relevant Information Available when Reporting
   (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is (are) __________________________________________

This started on _________/_______/_______ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom worse are ______________________________________________________

Things that make the condition or symptom better are ______________________________________________________

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode (if applicable) _________________________________________________________________

Other relevant information ________________________________________________________________

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Respite ☐ Other: __________________________________________

Primary diagnoses ____________________________________________________________

Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) ________________________________

Medication Alerts
☐ Changes in the last week (describe): ☐ Resident is on blood thinners warfarin/coumadin: Result of last INR ______ Date ______/_____/______

Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Diuretic

Allergies

Pharmacy name __________________________________________________________ Phone (__________) ______________________

Vital Signs

BP _________ Pulse _________ (or Apical HR _________ ) RR _________ Temp _________ Weight _________ lbs (date _______/_____/______)

For CHF, edema, or weight loss: last weight before the current one was ______________________ on _________/_____/______

Blood Sugar (Diabetic) _____________________________________________________________

Pulse Oximetry (if indicated) __________% on ☐ Room Air ☐ O₂ (__________) ______________________

Resident Name ________________________________________________________________ (continued)
SBAR Communication Form

and Progress Note for Caregivers in Assisted Living

This form is for caregivers who are not licensed nurses (RN/LPN/LVN). There is another INTERACT tool for licensed nurses.

Before Calling the Nurse/Supervisor:

☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, and finger stick glucose for diabetes
☐ Have Relevant Information Available when Reporting
  (i.e., resident record, vital signs, advance directives such as DNR / POLST and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are ________________________________________________________________

This started on __________ / __________ / __________ Since this started has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom worse are ________________________________________________________________

Things that make the condition or symptom better are ________________________________________________________________

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Other relevant Information ________________________________________________________________

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-term Care ☐ Respite ☐ other: __________________________

Medication Alerts
☐ Changes in the last week (describe) ☐ Resident is on blood thinners warfarin/aboutin: Result of last INR _______ Date _______ / _______ / _______
Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies ________________________________________________________________

Pharmacy name __________________________________________________________ Phone (___________) ______________________

Vital Signs

BP ___________ Pulse ___________ RR ___________ Temp ___________

Pain: ☐ No ☐ Yes (describe location, intensity) ____________________________

Pulse Oximetry (If indicated) ___________ % on ☐ Room Air ☐ O₂ (___________)

Resident Evaluation

1. Mental Status Changes (compared to baseline; check all that you observe)
  ☐ Decreased consciousness (sleepy, lethargic) ☐ Unresponsiveness
  ☐ Increased confusion (disoriented) ☐ Other symptoms or signs of delirium
  ☐ New or worsening behavioral symptoms (e.g., inability to pay attention, disorganized thinking)

Describe symptoms or signs________________________________________________________________________________________

Resident Name __________________________________________________________

(continued)
Decision Support Tools

Change of Condition File Cards

Care Paths: Version 4 for NH to be released soon
(AL and HH to follow)

9 Care Paths: Lower Respiratory Illness, Acute MS Change, Change in Behavior, Dehydration, Fever, GI Symptoms(N-V-D), SOB, Symptoms of CHF, UTI
## Decision Support Tools

<table>
<thead>
<tr>
<th>Tools</th>
<th>Use</th>
<th>Suggested Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Change in Condition File Cards</strong></td>
<td>All assisted living licensed nursing staff and primary care clinicians</td>
<td>• 4” x 6” laminated cards put in a flip-chart or rolodex format for placement by nursing station phones, or</td>
</tr>
<tr>
<td></td>
<td>• Provide guidance on when to communicate acute changes in status to MD, NP, and/or PA</td>
<td>• 4” x 6” laminated cards that can be kept in a file box near the phone at the nurses’ station, or</td>
</tr>
<tr>
<td></td>
<td>• Recommend placement at nurse’s station or on med carts for quick reference</td>
<td>• 4” x 6” laminated cards with hole punched in upper left corner and hooked onto the med carts</td>
</tr>
<tr>
<td><strong>Care Paths</strong></td>
<td>All assisted living licensed nursing staff and primary care clinicians</td>
<td>• 8.5” x 14” glossy prints for posters</td>
</tr>
<tr>
<td>- Acute Mental Status Change</td>
<td>• Educational tool and reference for guiding evaluation of specific symptoms that commonly cause acute care transfers</td>
<td>• 8.5” x 11” laminated, 3-hole punched for education for inclusion in a ring binder</td>
</tr>
<tr>
<td>- Change in Behavior: New or Worsening Behavioral Symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dehydration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GI Symptoms – nausea, vomiting, diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shortness of Breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Symptoms of CHF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Symptoms of Lower Respiratory Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Symptoms of UTI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Change in Condition: *When to report to the MD/NP/PA*

**Immediate Notification**

- Any symptom, sign or apparent discomfort that is:
  - Acute or Sudden in onset, and:
  - A Marked Change *(i.e. more severe)* in relation to usual symptoms and signs, or
  - Unrelieved by measures already prescribed

**Non-Immediate Notification**

- New or worsening symptoms that do not meet above criteria

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This guidance is adapted from: AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003; and Ouslander, J, Osterweil, D, Morley, J. *Medical Care in the Nursing Home*. McGraw-Hill, 1996
## Vital Signs *(report why vital signs were taken)*

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Report Immediately*</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>• Systolic BP &gt; 200 mmHg or &lt; 90 mmHg</td>
<td>• Diastolic BP &gt; 90 mmHg</td>
</tr>
<tr>
<td>Pulse</td>
<td>• Diastolic BP &gt; 115 mmHg</td>
<td>• New irregular pulse</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>• Resting pulse &gt; 100, &lt; 50</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td>• Respirations &gt; 28, &lt; 10/minute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oral temp &gt; 100.5 F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oxygen saturation &lt; 90%</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>
<tr>
<td>Weight Gain</td>
<td></td>
<td>• &gt; 5 lbs in one week in resident with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- CHF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- chronic renal failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- other volume overload state</td>
</tr>
</tbody>
</table>

*Unless these values are stable and known by the primary care clinician*
## Laboratory Tests / Diagnostic Procedures

(report why the test or procedure was done)

<table>
<thead>
<tr>
<th>Test/Procedure</th>
<th>Report Immediately*</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count</td>
<td>• WBC &gt; 14,000&lt;br&gt;• Hemoglobin (Hb) &lt; 8&lt;br&gt;• Platelets &lt; 50,000</td>
<td>WBC &gt; 10,000 without symptoms or fever</td>
</tr>
<tr>
<td>Chemistry</td>
<td>• Blood/urea/nitrogen (BUN) &gt; 60 mg/dl&lt;br&gt;• Calcium (Ca) &gt; 12.5 mg/dl&lt;br&gt;• Potassium (K) &lt; 3.0, &gt; 6.0 mg/dl&lt;br&gt;• Sodium (Na) &lt; 125, &gt; 155 mg/dl&lt;br&gt;• Blood glucose &gt; 300 mg/dl or &lt; 70 mg/dl (diabetic)</td>
<td>• Glucose consistently &gt; 200 mg/dl&lt;br&gt;• Hb A1c (any value)&lt;br&gt;• Albumin (any value)&lt;br&gt;• Bilirubin (any value)</td>
</tr>
<tr>
<td></td>
<td>Consult Reports&lt;br&gt;Consultant report recommending immediate action or changes in management</td>
<td>Routine consultant report recommending routine action or changes in resident’s management</td>
</tr>
<tr>
<td>Drug Levels</td>
<td>Levels above therapeutic range of any drug <em>(hold next dose)</em></td>
<td>Any therapeutic or low level</td>
</tr>
<tr>
<td>INR <em>(International Normalized Ratio)</em></td>
<td>• INR &gt; 6 IUs <em>(hold warfarin)</em></td>
<td>• INR 3-6 IUs <em>(hold warfarin)</em>&lt;br&gt;• PT *(in seconds) 2x control <em>(hold warfarin)</em></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Abnormal result in resident with signs and symptoms possibly related to urinary tract infection or urosepsis <em>(e.g. fever, burning sensation, pain in suprapubic or flank area)</em></td>
<td>Abnormal result in resident with no signs or symptoms</td>
</tr>
<tr>
<td>Urine Culture</td>
<td>&gt;100,000 colony count with a urinary pathogen with symptoms</td>
<td>Any growth with no symptoms</td>
</tr>
<tr>
<td>X-ray</td>
<td>New or unsuspected finding <em>(e.g. fracture, pneumonia, CHF)</em></td>
<td>Old or long-standing finding, no change</td>
</tr>
</tbody>
</table>

*Unless these values are stable and known by the primary care clinician
# Signs and Symptoms A’s

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain ¹</td>
<td>Abrupt onset severe pain or distention, OR with fever, vomiting</td>
<td>Mild diffuse or localized pain, unrelieved by antacids or laxatives</td>
</tr>
<tr>
<td>Abdominal Distention ¹</td>
<td>Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding</td>
<td>Progressive or persistent distension not associated with symptoms</td>
</tr>
<tr>
<td>Abdominal Tenderness ¹ (e.g., bloating, cramps, etc…)</td>
<td>Associated with fever, continuous GI bleeding, or other acute symptoms</td>
<td>Persistent discomfort not associated with other acute symptoms</td>
</tr>
<tr>
<td>Abrasion</td>
<td>Accompanied by significant pain or bleeding</td>
<td>If bleeding continues or if associated with evidence of local infection</td>
</tr>
<tr>
<td>Agitation ²</td>
<td>Abrupt onset of significant change from usual, OR associated with fever or new onset abnormal neurological signs</td>
<td>Continued progression or persistence of symptoms</td>
</tr>
<tr>
<td>Altered Mental Status</td>
<td>Abrupt significant change in cognitive function from usual with or without altered level of consciousness</td>
<td>Persistent change from usual cognitive function with no other criteria met for immediate notification</td>
</tr>
<tr>
<td>Appetite, Diminished</td>
<td>No oral intake 2 consecutive meals</td>
<td>Significant decline in food and fluid intake in resident with marginal hydration and nutritional status</td>
</tr>
<tr>
<td>Asthma</td>
<td>Acute episode with wheezing, dyspnea, or respiratory distress</td>
<td>Self-limited episode that was more extensive or less responsive to treatment than the usual</td>
</tr>
</tbody>
</table>

¹ See INTERACT GI Symptoms Care Path   ² See INTERACT Change in Behavior Care Path

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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
- Educational tools
  - Recommended as posters
  - Use for case-based learning
CARE PATH
Acute Mental Status Change

New Mental Status Change Noted
- New symptoms or signs of increased confusion (e.g., disorientation, change in speech)
- Decreased level of consciousness
- Inability to perform usual activities (due to mental status change)
- New or worsened physical or behavioral agitation
- New or worsened delusions or hallucinations

Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respiration
- Finger stick glucose (diabetics)

Vital Sign Criteria (any met?)
- Temp > 100°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Finger stick glucose < 70 or > 300

NO

Further Nursing Evaluation
- Mental Status
- Respiratory
- Functional Status
- Gastrointestinal
- Cardiovascular
- Abdominal
- Genitourinary
- Skin
- Recent medication change

NO

Evaluate Symptoms and Signs
- Not eating or drinking
- Acute decline in ADL abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Abdominal distention or tenderness
- New or worsened incontinence, pain with urination, blood in urine
- New skin condition (e.g., rash, ulcers suggesting cellulitis, signs of infection around existing wound/pressure ulcer)

YES

Notify MD/NP/PA

Consider Orders for:
- Portable chest X-ray
- Urinalysis and CBC if indicated
- Blood work (Complete Blood Count, Basic Metabolic Panel)

Evaluate Results
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

NO

YES

Manage in Facility
- Monitor vitals, fluids, intake, output
- If on diuresis, consider holding
- Offer frequent small fluids (2-4 oz q2h)
- If on tube feeding, give non-water with flushes
- Update advance care plan and directives if appropriate

Monitor Response
- Vital signs, criteua mat
- Worsening condition

** Refer also to INTERACT Change in Behavior Care Path
** Refer also to the other INTERACT Care Paths as indicated by symptoms and signs
Continuous Improvement

- On-going review of processes and practices
- Evaluating the Process/Outcomes
Quality Improvement Tool
For Review of Acute Care Transfers

The INTERACT QI Tool is designed to help your team analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

Resident ___________________________________________ Age __________
Date resident moved in to the facility __________ / __________ / __________
Major reason for move in __________________________________________

SECTION 1: Risk Factors for Hospitalization and Readmission

a. Conditions that put the resident at risk for hospital admission or readmission:
   - Cancer, on active chemo or radiation therapy
   - CHF
   - COPD
   - Dementia
   - Diabetes
   - End-stage renal disease
   - Fracture (Hip)
   - Multiple active diagnoses and/or co-morbidities
     (e.g. CHF, COPD and Diabetes in the same resident)
   - Polypharmacy (e.g. 9 or more medications)
   - Surgical complications

b. Resident hospitalized in the past 30 days? [ ] No [ ] Yes (list dates and reasons)
   (Other than the one being reviewed in this tool)

c. Other hospitalizations or emergency department visits in the past 12 months? [ ] No [ ] Yes (list dates and reasons)
   (Other than the one being reviewed in this tool)

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

a. Date the change in condition first noticed __________ / __________ / __________

b. Briefly describe the change in condition and other factors that led to the transfer and then check each item below that applies

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living (www.ahcancal.org). Check state regulations and professional licensure laws relevant to using this tool.
(continued on reverse side)
Advanced Care Planning

• Advance Care Planning Tracking Form
• Advance Care Planning Communication Guide
• Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders
• Comfort Care Order Set
Advance Care Planning

- ACP should occur at some time shortly after admission
- Decisions should be reviewed regularly and at times of acute changes in condition
Advance Care Planning Tracking Form

Resident Name ____________________________________________

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of a move-in to the assisted living, at times of change in condition, and periodically for routine updating of care plans. The purpose of this form is to provide a tool to document that these discussions are taking place.

At Move-In (within about a week of move-in or return)

Check one of the following:
☐ Resident and/or responsible party did NOT want to have this discussion
☐ Discussion about advance care planning held with (check one or both of the following):
   ___________ Resident
   ___________ Resident’s surrogate, name:

Staff or healthcare provider completing form:

Name ____________________________________________ Title ________________________________
Signature ____________________________________________ Date of discussion ______ / ______ / ______

Location of Advance Care Plan documentation (i.e. advance directive tab, plan of care, progress notes, etc.):

________________________________________________________

________________________________________________________

________________________________________________________

Use Continuation Pages to document additional Advance Care Planning Reviews and Discussions
Advance Care Planning Communication Guide: Overview

The INTERACT Advance Care Planning Communication Guide is designed to assist health professionals who work in assisted living to initiate and carry out conversations with residents and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health status.

The Guide can be useful for education, including role-playing exercises and simulation training.

* This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living (www.ahcancal.org/ncal).

Communicating about advance care planning and end-of-life care involves all assisted living staff

- Physicians must communicate with residents and families about advance directives, but all staff need to be able to communicate about goals of care, preferences, and end-of-life care

This Guide should therefore be useful for:

- Nursing staff
- Primary care physicians, nurse practitioners, and physician assistants
- Social workers and social work designees
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:

- Advance Directives – such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives
- Plans for care when a sudden, life-threatening condition is diagnosed – such as a stroke, heart attack, pneumonia, or cancer
- Plans for care when a resident’s health is gradually deteriorating – such as progression of Alzheimer’s disease or other dementia, weight loss without an obvious medical cause, and worsening of congestive heart failure, kidney failure, or chronic lung disease
- Considering a palliative or comfort care plan or enrolling in a hospice program
AL/MC 30 Day Readmission Trend

30-day Readmission Rates for Residents in Assisted Living Communities (n = 41)

Readmission rate
Median

Calendar Month

Readmission Rate

Aug-13 Sep-13 Oct-13 Nov-13 Dec-13 Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14

0.00 2.00 4.00 6.00 8.00 10.00 12.00 14.00

Readmission rate
Median

Brookdale
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AL/MC Hospitalization Trend

Hospitalization Rate of Residents in Assisted Living Communities (n = 41)
What We Have Learned...

• Importance of Leadership & Communication in quality of care
• Role of Champions/Co-Champions is critical
• Sustaining gains & training new associates
• Integrating QI/tools into the culture
• Challenges with turnover
• Family education on Interact is important
• Advanced Care Planning discussions make a difference
• Involve all associates in quality improvement
• Role of a Transition Team
Transition Team

• Evaluate market dynamics
• Engagement of HCP’s
• Evaluating clinical programs
• Developing effective communication
• Track and Measure results
Additional Resources

• [www.INTERACTteam.org](http://www.INTERACTteam.org) (Training/Education/Management Strategies)
• [www.med-pass.com](http://www.med-pass.com) (printed materials-Stop & Watch & SBARS)
• Advancing Excellence in Long Term Care Collaborative
Interact.fau.edu

View web site