INTERACT NY
Interventions to Reduce Preventable Acute Care Transfers

GREATER NEW YORK HOSPITAL ASSOCIATION
CONTINUING CARE LEADERSHIP COALITION
Introduction to INTERACT Tools and Resources
Overview of the INTERACT NY Implementation
CNR and NYM Experience with INTERACT
Lessons Learned from the Multi-provider Experience
Conclusion and Additional Resources
INTERACT Tools and Resources

Communication Tools

Care Paths

Advance Care Planning Tools
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
D rank less than usual

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

Staff _______________________________________

Reported to ___________________________________

Date _____ / _____ / _______ Time ____________
**SBAR**

**Physician/NP/PA Communication and Progress Note**

Before Calling MD/NP/PA:
- Evaluate the resident, 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 (most recent progress notes and nurse’s notes from previous shift, any recent labs)
- Review an INTERACT II Care Path or Acute Change in Status File Card if indicated
- 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**

This is _______________ (nurse) I am calling about _______________ (Resident’s name)
The problem/symptom I am calling about is ____________________
The problem/symptom started ________________
The problem/symptom has gotten (circle one) worse/better/stayed the same since it started
Things that make the problem/symptom worse are ____________________
Things that make the problem/symptom better are ____________________
Other things that have occurred with this problem/symptom are ____________________

**BACKGROUND**

Primary diagnosis and/or reason resident is at the nursing home ________________
Pertinent medical history/include recent falls, fever, decreased intake/fluids, CP, SOB, other

Mental Status or Neuro changes: (Y/N: confusion/agitation/lithargy) Temp ______________ BP ______________
Pulse rate/rhythm Resp rate Lung Sounds ______________
Pulse Oximetry % on RA ______________ on O2 ______________ L/min via: ______________ (NC, mask)
GI/GU changes nauces/vomiting/diarrhea/impaction/constipation/decreased urinary output ______________
Pain level/lociation/status changes ______________
Change in function/intake/hydration ______________
Change in Skin Color ______________________________ Wound Status (if applicable) Labs ______________
Medication changes or new orders in the last two weeks __________________
Advance Directives (Full code, DNR, DNI, DNH, other, not documented) Allergies ______________
Any other data ______________

**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 patient appears ____________________ (e.g. SOB, in pain, more confused)

**REQUEST**

I suggest or request:
- Provider visit (MD/NP/PA)
- Monitor vital signs (Frequency ______________) and observe
- Lab work, x-rays, EKG, other tests ______________
- Medication changes ______________
- New orders ______________
- IV or SC fluids ______________

Staff name ________________ RN/LPN

Reported to: Name ________________ (MD/NP/PA) Date ________________ Time ________________ am/pm
If to MD/NP/PA, communicated by: □ Phone □ Fax (attach confirmation) □ In person

(Please see Progress Note on back of this Form)
Quality Improvement Tool

- Value of tracking residents at risk for transfers who stay in addition to those who go out to the hospital
- INTERACT tools often assisted in keeping residents in nursing homes
  - Facilitation of advance care planning discussion
  - Better communication among the care team and between partners
  - Identification of opportunities to prevent unnecessary transfers
- INTERACT tools facilitated certain transfers
ACUTE CARE TRANSFER DOCUMENT CHECKLIST

RESIDENT NAME

COPIES SENT WITH RESIDENT (Check all that apply):

These documents should ALWAYS accompany patient:

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

Send these documents IF INDICATED:

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

Signature of ambulance staff accepting envelope: __________________________

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

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# RESIDENT TRANSFER FORM

**SENT TO:** (Name of Hospital)  
**SENT FROM:** (Name of Nursing Home)  
**Date:** / /  
**Unit:**

**RESIDENT:**  
**Last Name:**  
**First Name:**  
**MI:**  
**DOB:** / /  
**Language:** English  
**Other:**  
**Resident is:** SNF/rehab  
**Long-term**

**CONTACT PERSON:**  
**(Relative, guardian or DPOA/Relationship):** name  
**Is this the health care proxy?** Yes  
**No**  
**Telephone:**  
**Notified of transfer:** Yes  
**No**  
**Aware of diagnosis:** Yes  
**No**

**WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?**  
<table>
<thead>
<tr>
<th>name</th>
<th>title</th>
<th>Telephone</th>
</tr>
</thead>
</table>

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

**List of Diagnoses:**

<table>
<thead>
<tr>
<th>VS: BP</th>
<th>HR</th>
<th>RR</th>
<th>T</th>
<th>pOx</th>
<th>FS glucose</th>
<th>Time Taken:</th>
<th>AM/PM</th>
</tr>
</thead>
</table>

**Allergies:**  
**Tetanus Booster:** (date) / /  
**Usual Mental Status:**  
**Alert, oriented, follows instructions**  
**Alert, disoriented, but can follow simple instructions**  
**Alert, disoriented, but cannot follow simple instructions**  
**Not alert**

**Usual Functional Status:**  
**Ambulates independently**  
**Ambulates with assistance**  
**Ambulates with assistive device**  
**Not ambulatory**

**Devices/Special Treatments:**  
**IV/PICC line**  
**Pacemaker**  
**Foley Catheter**  
**Internal Defibrillator**  
**TPN**  
**Other:**

**At Risk Alerts:**  
**None**  
**Seizure**  
**Falls**  
**Harm to:**  
**Self**  
**Others**

**Isolation/Precaution:**  
**MRAE**  
**VRE**  
**C-Diff**  
**Other:**

**Capabilities of the Nursing Home to Care for this Resident:**

<table>
<thead>
<tr>
<th>IVF therapy</th>
<th>IV antibiotics</th>
<th>MD/NP/PA follow up visit within 24 hours</th>
<th>Other:</th>
</tr>
</thead>
</table>

**Nursing Home Would be able to Accept Resident back under the following conditions:**

<table>
<thead>
<tr>
<th>ED determines diagnosis, and treatment can be done in NH</th>
<th>VS stabilized and follow up plan can be done in NH</th>
</tr>
</thead>
</table>

**Form Completed By:**  
**Report Called in By:**  
**Report Called to:**

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INTERACT NY
Interventions to Reduce Preventable Acute Care Transfers
CCITI NY Transfer Form
Executive Briefing: Oct 6 2010

SBAR & Stop and Watch Tool: Feb 16 2011

Standardized Transfer Form: Apr 13 2011

Support Tools: Care Paths, Change in Condition File Cards: Jun 8 2011

Advance Care Planning-Cases From the Field: Aug 3 2011

Lessons Learned & Next Steps: Oct 24 2011


QI Review Tool & Avoidability: Mar 16 2011

Care Transitions-Partnering With Acute Care Hospitals: May 16 2011

Sharpening Clinical Skills: Jul 6 2011

Engagement of the Frontline Staff: Sep 7 2011
INTERACT NY
Design & Opportunities

- Acute care hospital involvement
  - Cross-setting programs
- Interdisciplinary staff involvement
  - Frontline staff
  - Clinical staff
- Emphasis on skill-building of staff
  - Teaching methods: Simulation & Debrief
  - Integration with quality improvement
- Electronic transfer assessment
The Participants

- Amsterdam Nursing Home
- Beth Abraham Health Services
- Buena Vida Continuing Care and Rehabilitation Center
- Center for Nursing and Rehabilitation
- Dr. Susan Smith McKinney Nursing and Rehabilitation Center
- Eger Health Care & Rehabilitation Center
- Elizabeth Seton Pediatric Center
- Good Samaritan Nursing Home
- Hebrew Home at Riverdale
- Helen and Michael Schaffer Extended Care Center
- Isabella Geriatric Center
- Jewish Home Lifecare-Bronx
- Jewish Home Lifecare-Manhattan
- Lutheran Augustana Center
- Margaret Tietz Nursing and Rehabilitation
- Menorah Center
- Morningside House
- Orzac Center for Extended Care and Rehabilitation
- Our Lady of Consolation
- Parker Jewish Institute
- Rivington House
- Ruby Weston Manor
- Rutland Nursing Home
- Sarah Neuman Center
- Schnurmacher Center for Rehabilitation and Nursing
- Sea View Hospital Rehabilitation Center and Home
- St. Catherine of Sienna Nursing Home
- St. Mary's Hospital for Children
- Stern Center for Extended Care and Rehabilitation
- Village Center for Rehabilitation and Nursing

INTERACT NY
Interventions to Reduce Preventable Acute Care Transfers
### Partner Participants

<table>
<thead>
<tr>
<th>Hospital/Network</th>
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<tbody>
<tr>
<td>Bronx Lebanon Hospital</td>
</tr>
<tr>
<td>Brookdale University Hospital</td>
</tr>
<tr>
<td>Catholic Health Services of Long Island</td>
</tr>
<tr>
<td>Continuum Health Partners, Inc</td>
</tr>
<tr>
<td>Flushing Hospital</td>
</tr>
<tr>
<td>Forest Hills Hospital</td>
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<tr>
<td>Greenwich Hospital</td>
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<tr>
<td>Jacobi Medical Center</td>
</tr>
<tr>
<td>Jamaica Hospital</td>
</tr>
<tr>
<td>Kingsbrook Jewish Medical Center</td>
</tr>
<tr>
<td>Lutheran Medical Center</td>
</tr>
<tr>
<td>Maimonides Medical Center</td>
</tr>
<tr>
<td>MediSys Health Network</td>
</tr>
<tr>
<td>Montefiore Medical Center</td>
</tr>
<tr>
<td>Mount Sinai Medical Center</td>
</tr>
<tr>
<td>Mount Sinai Queens</td>
</tr>
<tr>
<td>Nassau University Medical Center</td>
</tr>
<tr>
<td>New York City Health and Hospitals Corporation</td>
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<tr>
<td>New York Downtown Hospital</td>
</tr>
<tr>
<td>New York Presbyterian Hospital</td>
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<tr>
<td>New York University Langone Medical Center</td>
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<tr>
<td>North Shore-Long Island Jewish System</td>
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<tr>
<td>SUNY Downstate Medical Center</td>
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<tr>
<td>Trinitas Regional Medical Center</td>
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<tr>
<td>Wyckoff Heights Medical Center</td>
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<tr>
<td>Sound Shore Medical Center</td>
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<tr>
<td>Staten Island University Hospital</td>
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<tr>
<td>Stony Brook University Medical Center</td>
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**INTERACT NY**

Interventions to Reduce Preventable Acute Care Transfers
Member Participation

- 156 interdisciplinary staff from participant organizations attended learning sessions
- Additional staff trained at the local level
Implementation of Evidence-based Tools

<table>
<thead>
<tr>
<th>Tools</th>
<th>% Use</th>
</tr>
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<tbody>
<tr>
<td>Stop and Watch</td>
<td>83%</td>
</tr>
<tr>
<td>SBAR</td>
<td>75%</td>
</tr>
<tr>
<td>QI Tool for Review of ACTs</td>
<td>67%</td>
</tr>
<tr>
<td>Acute Care Transfer Log</td>
<td>50%</td>
</tr>
<tr>
<td>Care Paths</td>
<td>35%</td>
</tr>
<tr>
<td>Resident Transfer Form</td>
<td>25%</td>
</tr>
<tr>
<td>Transfer Envelope and Checklist</td>
<td>25%</td>
</tr>
<tr>
<td>Change in Condition File Cards</td>
<td>8%</td>
</tr>
<tr>
<td>Advance Care Planning Tools</td>
<td>8%</td>
</tr>
</tbody>
</table>
Recognizing the Value of the Interdisciplinary Team

Exemplary Frontline Staff---

V. Black, CNA
Jewish Home Lifecare-Manhattan

L. Davis, LPN
Jewish Home Lifecare-Manhattan

K. Marte, CNA
Isabella Geriatric Center

B. Miller, CNA
Center for Nursing and Rehabilitation

N. Moreira, RN
Sea View Hospital Rehabilitation Center and Home

C. Taylor, CNA
Isabella Geriatric Center

L. Torres, PCT
Sea View Hospital Rehabilitation Center and Home
Support for Skill-Building
Integration of INTERACT into Health Information Technology
CNR and NYM Experience
With INTERACT NY
Lessons Learned

- Value of tracking residents at risk for transfers who stay in addition to those who go out to the hospital
- INTERACT tools often assisted in keeping residents in nursing homes
  - Facilitation of advance care planning discussion
  - Better communication among the care team and between partners
  - Identification of opportunities to prevent unnecessary transfers
Lessons Learned Continued...

- INTERACT tools helped facilitate certain unavoidable transfers through early identification, communication, and assessment of significant change in a resident’s status.

- Effective implementation of INTERACT is critical to long-term sustainability of the program.

- The program cannot be effectively implemented or sustained without strong support from facility leadership.
Implementation

- Most organizations implemented in pilot units; Few organizations implemented facility-wide.
- Many organizations took a staggered approach to implementing tools. At least one organization implemented all tools at the same time.
- Organizations typically did not implement all tools.
- Stop and Watch, QI Tool & SBAR are the most commonly adopted tools.
Mean per 1000 Resident-Days

<table>
<thead>
<tr>
<th></th>
<th>Pre-INTERACT NY</th>
<th>Post-INTERACT NY</th>
</tr>
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<tbody>
<tr>
<td>Hospital Admissions</td>
<td>4.53</td>
<td>3.73</td>
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</table>
Internet Resources

INTERACT Web site:
http://www.interact2.net/

Journal of American Geriatric Society Article:

New England Journal of Medicine Article:
Questions

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