

INTERACT

**Implementation
Guide
Version 4.0 Tools**

Implementation Guide

Program Overview



Purpose of the Guide

This Guide is intended primarily for INTERACT ‘champions’ and trained ‘educators’ who are responsible for implementing and sustaining the program in one or more nursing homes. It provides an overview of the INTERACT program and tools, as well as strategies for implementing and sustaining the program over time. These strategies have been identified by thoughtful and dedicated long-term care professionals who have shared them over the last several years.

The Guide is not meant to stand alone, but to supplement the information and resources that can be found on the INTERACT website <http://interact.fau.edu>.

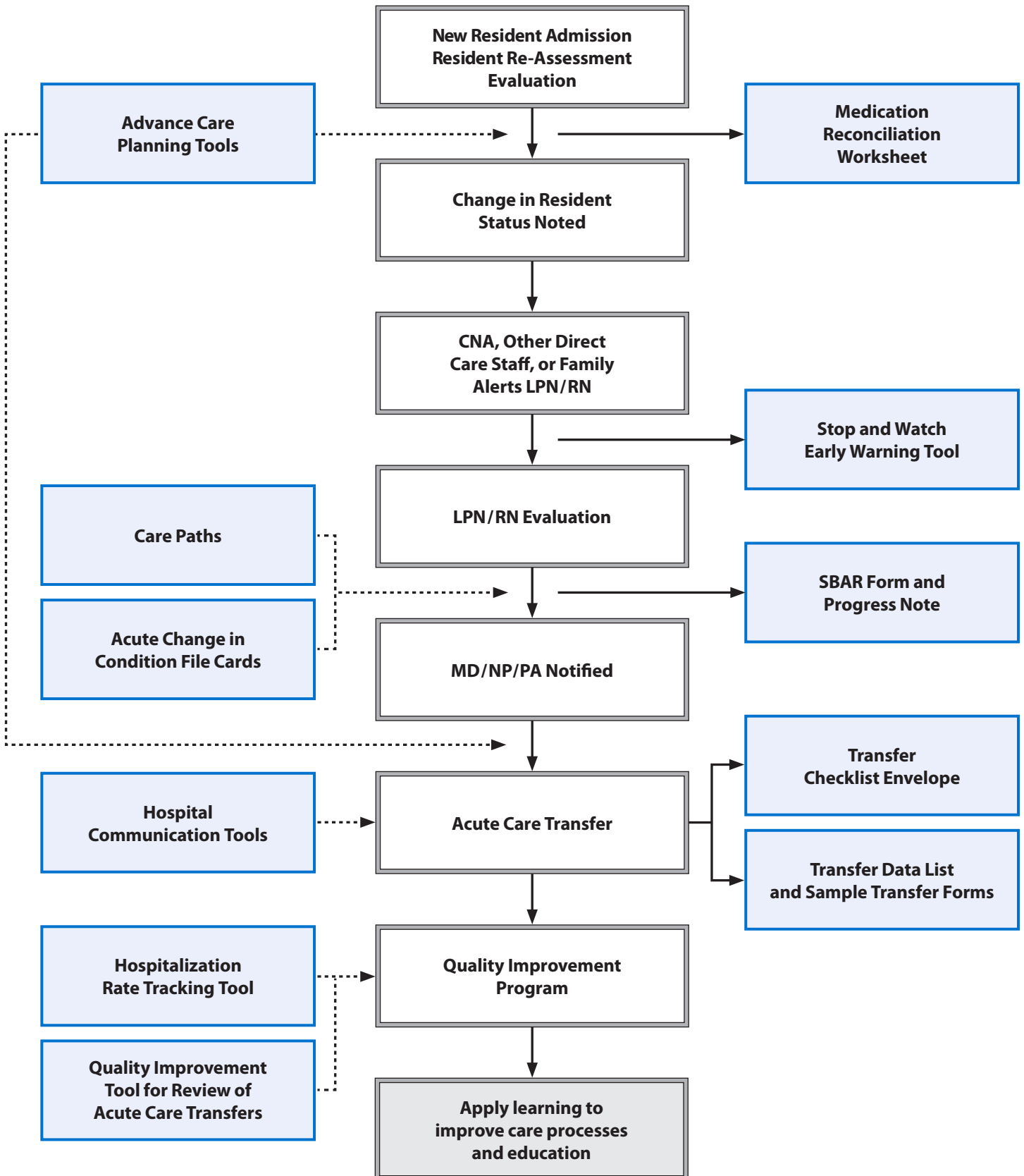
Overview of INTERACT as a Quality Improvement Program

The INTERACT quality improvement program is designed to improve the early identification, evaluation, management, documentation, and communication about acute changes in condition of residents in nursing homes, assisted living facilities and home health care. The fundamental goal of INTERACT is to improve care; its strategies and tools will help reduce the frequency of potentially preventable transfers to the acute hospital and related complications that lead to increased health care costs.

The program includes evidence-based and expert-recommended tools, strategies to implement them, and related educational resources. The INTERACT tools are meant to be integrated into every day care and be incorporated into your facility’s quality improvement program and processes as illustrated by the figure on the next page.

Implementation Guide

Figure Overview



- As illustrated in the diagram, advance care planning should begin at the time of, or shortly after admission, and should be continued throughout the resident's stay, including when an acute change in condition occurs. The **INTERACT Advance Care Planning Tools** can be helpful in developing a person-centered care plan and discussing options for palliative and end-of-life care if appropriate.
- For patients discharged from acute hospitals for post-acute care, medication reconciliation is a critical task. The **INTERACT Medication Reconciliation Worksheet** is designed to help nurses, primary care clinicians, and pharmacists develop accurate and safe medication orders at the time of admission.
- When an acute change in condition occurs, the **Stop and Watch Tool** can be used by CNAs to identify changes in residents and clearly communicate those changes to the licensed nursing staff. This tool can also be used by staff who have direct contact with residents and are in a position to observe changes, including rehabilitation therapists, environmental services, and dietary staff. It can also be used to educate families so that they can report changes in condition they notice while visiting. The tool is a clinical alert, and licensed nurses who receive one of these tools should acknowledge its receipt in writing.
- Once the licensed nurse is alerted to the change in condition, **INTERACT Care Paths and Change in Condition File Cards** can be used as decision support tools to help with the recognition, evaluation, management, and reporting of specific symptoms and signs. These tools include explicit criteria for notifying primary care clinicians. Engagement and buy-in of the medical director and primary care clinicians is critical to their success.
- The **SBAR Form/Acute Change in Condition Progress Note** is designed to enhance the nursing evaluation of and documentation on residents who have an acute change in condition, and to structure and improve communication with primary care clinicians. It is intended to be used as a change in condition progress note, and should replace, rather than be added to, other documentation.
- For those residents who do need to be sent to the hospital, the **Transfer Checklist** and **Transfer Form** can help clearly and succinctly communicate the information that is critical for the emergency room and other hospital staff to care for the resident. In many areas of the country, this is done using other forms or electronically. In these areas, the INTERACT tools can help identify the key elements that should be included. INTERACT also has tools for better proactive communication with hospitals, including a **Nursing Home Capabilities List**, which can be useful for emergency room staff, discharge planners, and hospital physicians in understanding the specific capabilities of each facility when making hospital discharge decisions.
- The **Quality Improvement Tools** are fundamental to the INTERACT program. The **Hospitalization Rate Tracking Tool** and the **Quality Improvement Tool** are designed to assist in two of the basic components of a quality improvement program:
 1. Tracking, trending, and benchmarking clear and consistently defined measures; and
 2. Conducting root cause analyses that identify areas for improvement. Summarizing the findings from **Quality Improvement Tools** over time should help focus educational and care improvement activities.

Key Strategies for Implementation

Effective implementation of the INTERACT program is critical to its long-term sustainability. ***The program cannot be effectively implemented or sustained without strong support from leadership of the facility (and corporation, if applicable).***

In addition, there are four general concepts and strategies that are essential for success:

1. Make the INTERACT program an integral component of the facility's quality improvement activities and QAPI program
2. Integrate the INTERACT program and tools into everyday care, and ensure that primary care clinicians (MDs, NPs, PAs) are aware of and support the program and tools
3. Make the INTERACT tools visible and accessible for everyday care; they are not intended to be in a notebook gathering dust on a shelf
4. Recognize that organizational change takes time – programs such as INTERACT can take several months to fully implement

The sections that follow outline key strategies for successful implementation of the INTERACT program and sustaining it over time.

Selecting a Team and Champions

- **Selection of the Champion for the program is one of the most important decisions for success.** An individual should be selected who is enthusiastic about the program and its potential, respected and can motivate the staff, and has the experience and skills to coordinate the program.
- **Appointment of a Co-Champion is highly recommended.** If for some reason the champion becomes unable to fulfill the role and there is no trained co-champion, the program is unlikely to be effectively sustained.
- **Implementing the INTERACT program requires involvement of an interdisciplinary team.** The team should hold regular meetings to review goals and progress as the program gets started and continue these meetings as the program becomes integrated into everyday care.

Determining Baseline Measures and Conducting Root Cause Analyses

- In order to effectively implement any quality improvement program you must involve all levels of staff and carry out two activities:
 - a. Track, trend, and benchmark well-defined measures, and;
 - b. Learn from root cause analyses of events (in this case hospital transfers)
- **INTERACT Quality Improvement Tools** are designed to assist with these activities (*see description in the table below*)
- To get started, baseline measures can be determined by:
 - a. Looking back at acute care transfers for the last 3-6 months using the **Acute Transfer Log** or the **Hospitalization Rate Tracking Tool**.
 - b. Reviewing records of several transfers using the **INTERACT Quality Improvement Tool** in order to understand factors that contribute to transfers and help identify opportunities for initial areas to focus improvement and educational activities. You may also want to enter the data into Excel or another database so that you can analyze the trends over time.

Quality Improvement Tools	Use	Suggested Formats
Hospitalization Rate Tracking Tool	<ul style="list-style-type: none"> • This tool calculates hospital transfer outcomes (<i>unplanned admissions, 30-day readmissions, emergency room visits without admission</i>) using standard definitions 	<ul style="list-style-type: none"> • Excel template with embedded formulae to calculate and trend rates • Advancing Excellence also has an Excel-based tracker, located at www.nhqualitycampaign.org
Acute Care Transfer Log	This tool is a paper and pencil worksheet that can be used to calculate hospital transfer measures to enter into an Excel or other data base	<ul style="list-style-type: none"> • 8.5" x 11" pads
Quality Improvement Tool for Review of Acute Care Transfers	INTERACT champion, other facility leadership, and members of the facility quality committee <ul style="list-style-type: none"> • Root cause analysis of individual transfers 	<ul style="list-style-type: none"> • 8.5" x 11" pads
Quality Improvement Summary Worksheet	INTERACT champion, other facility leadership, and members of the facility quality committee <ul style="list-style-type: none"> • Root cause analysis summarizing findings and trends from individual QI reviews • Trends should guide educational and care improvement efforts 	<ul style="list-style-type: none"> • Paper and pencil worksheet (<i>8.5" x 11" pads</i>)

Getting Ready for Process Improvement

Several steps are important in getting ready for process improvement:

- Review current processes and tools and compare them to tools in the INTERACT program
- Identify and prioritize processes to change in order to improve care
- Select one area to improve and implement changes one at a time
- Involve staff at all levels in the change process
- Trial the change on one unit or area to identify and address issues created during the change process
- Be transparent: share goals, timeline, and all data and results (good and bad) with the staff frequently as the change is implemented across the facility
- Ask for and listen to staff input throughout the implementation process
- Use the INTERACT tools to fill the gaps in your processes
- As you implement new tools, replace current forms and tools to avoid redundancy and streamline work processes
- Make the INTERACT tools visible and readily accessible to staff

Planning Education

While education alone is insufficient to change behavior and improve outcomes, planning training carefully is essential to successful implementation of any quality improvement program. Here are some tips learned from implementing the INTERACT program:

- Consider what else is going on in the facility, what resources are available to devote to the training, and what traditionally works best for the facility.
- Smaller facilities may want to train all staff and implement the program throughout the entire facility, whereas larger facilities with several nursing units may want to implement the program on one unit at a time.
- Depending on how education is generally conducted in the facility, and the strengths of the educators, it may be best to focus on large group training, one-on-one teaching, small group sessions, or a combination.
- Another factor is the timeline to implement the program
 - a. With a short timeline for program implementation all of the training may have to be done up front
 - b. With a longer timeline, the training can be spread out over several weeks, using time for implementation exercises and review of program implementation

Tools for Improving Resident Admission and Return to Community

- At the time of or shortly after admission, the INTERACT **Advance Care Planning Tools** can be helpful in discussing options person-centered goals for care, and for palliative and end-of-life care if appropriate (*see table below*)
 - a. Advance Care Planning should not only be done soon after admission, but should be regularly updated as the resident’s condition changes, especially when acute changes in condition occur
- For patients admitted for post-acute care, medication reconciliation is a critical task. The INTERACT **Medication Reconciliation Worksheet** is designed to help nurses, primary care providers, and pharmacists develop accurate and safe medication orders on admission

Advance Care Planning Tools	Use	Suggested Formats
Advance Care Planning Communication Guide	Social workers, licensed nurses, primary care clinicians, clergy, direct care staff • Educational tool on how to communicate with residents and family members for those appropriate for palliative or comfort care, or hospice care	• Half-page laminated cards in a plastic ring binder or • Half-page laminated cards in a flip-chart format
Advance Care Planning Tracking Tool	Social workers, licensed nurses, primary care clinicians, clergy • Documents and tracks advance care planning discussions and refers to more detailed notes about the discussions	• 8.5" x 11" pads (<i>each page can document multiple discussions</i>) with hole punches for insertion into medical record
Comfort Order Set	Licensed nurses, primary care clinicians • Guidance on examples of orders that may be appropriate for residents on palliative or comfort care plans who decline hospice	• 8.5" x 11" laminated cards for nurses' stations • 4" x 6" laminated cards for primary care clinicians
Educational Information • Risks and Benefits of Hospitalization • Decision Making Vignettes on CPR and Enteral Feeding	Directed at residents and families • Educational information designed to supplement what is available on various websites that have links on the INTERACT website, and POLST, MOLST, and POST forms • Illustrated vignettes discussing DNR and No Enteral Feeding decisions	• 8.5" x 11" pads (<i>glossy preferred</i>) for Benefits page • 8.5" x 11" laminated flip chart for vignettes
Medication Recommendation	Use	Suggested Formats
Medication Reconciliation Worksheet	All nursing home licensed nursing staff and/or primary care clinicians, pharmacists • Structured medication reconciliation for new admissions or residents returning from the hospital to identify discrepancies and other issues related to safe and appropriate medication orders that need clarification	• 8.5" x 11" pads (<i>one page, front and back</i>)

Tools for Improving Acute Change in Resident Condition Care Processes

Two INTERACT communication tools and two INTERACT decision support tools are designed to improve the identification, evaluation, management, communication, and documentation about acute changes in resident condition:

Communication Tools

- The **Stop and Watch or Early Warning Tool** is useful for CNAs and others in regular contact with residents to identify changes in residents and communicate them clearly to the licensed nursing staff. This tool can also be used by other front-line staff, including rehabilitation therapists, environmental services, and dietary staff, and may be used by families to help educate them to report changes in condition they notice while visiting
- The version of 4.0 Stop and Watch tool includes a checkbox for “Click here if no change while monitoring high risk patient”. This was added so that the tool can be used to monitor residents/patients who are at high risk for hospital transfer for specific periods of time (e.g. once per shift for the first 3 days after admission from the hospital; or daily for one week after a change in condition that did require transfer).
- The **SBAR Form/Acute Change in Condition Progress Note** is designed to enhance the nursing evaluation of and documentation on residents who have a change in condition and improve communication with primary care providers. It is intended to be used as a change in condition progress note and should replace, rather than add to, other documentation

Communication Tools	Use	Suggested Formats
Stop and Watch Early Warning Tool	<p>Certified Nursing Assistants, other direct care staff (rehabilitation, environmental services, dietary, others); consider providing to families</p> <ul style="list-style-type: none"> • Regular evaluation of and recognition of changes in residents’ condition • Monitoring residents at high risk for hospital transfer on a specific schedule for a defined period of time (e.g. every shift for the first 3 days after admission from the hospital) • Reporting changes to licensed nurses • Documentation in medical record (<i>or other location</i>) 	<ul style="list-style-type: none"> • 4" x 6" laminated cards • 4" x 6" pads with NCR copies
SBAR Communication Tool/Change In Condition Progress Note	<p>All nursing home licensed nursing staff</p> <ul style="list-style-type: none"> • Evaluation and communication of acute changes in condition to MD, NP, and/or PA • Documentation of evaluation and communications 	<ul style="list-style-type: none"> • 8.5" x 11" pads with hole punches for insertion into medical record

Implementation Guide

Decision Support Tools

Decision Support Tools

- The **Change in Condition File Cards** are decision support tools for the nursing staff to help with determining whether to report specific symptoms, signs, and lab results immediately, vs. non-immediately (*e.g. the next day*)
- The **Care Paths** are educational decision support tools that provide guidance on the recognition, evaluation, and management of 10 conditions that commonly cause hospital transfers, and provide guidance on when to notify the primary care clinician that is consistent with the **Change in Condition File Cards**
- Support of the medical director and primary care clinicians is essential to the successful implementation of these tools

Decision Tools	Use	Suggested Formats
Change in Condition File Cards	All nursing home licensed nursing staff and primary care clinicians <ul style="list-style-type: none"> • Provide guidance on when to communicate acute changes in status to MD, NP, and/or PA • Recommend placement at nurse's station or on med carts for quick reference 	<ul style="list-style-type: none"> • 4" x 6" laminated cards that can be kept in a rolodex format near the phone at the nurses station, or • 4" x 6" laminated cards with hole punched in upper left corner and hooked onto the med carts, or • 4" x 6" laminated cards put in a flip-chart format, or • 4" x 6" laminated cards in a plastic ring binder
Care Paths <ul style="list-style-type: none"> • Acute Mental Status Change • Change in Behavior – New or Worsening Symptoms • Dehydration • Fever • GI Symptoms: Nausea, vomiting, diarrhea • Shortness of Breath • Symptoms of lower respiratory illness • Symptoms of CHF • Symptoms of UTI • Fall 	All nursing home licensed nursing staff and primary care clinicians <ul style="list-style-type: none"> • Educational tool and reference for guiding evaluation of specific symptoms that commonly cause acute care transfers 	<ul style="list-style-type: none"> • 11" x 14" glossy prints for posters • 8.5" x 11" laminated, 3-hole punched cards for inclusion in a ring binder

Tools to Improve Communication and Care with Local Hospitals

INTERACT includes several tools to improve communication and collaboration with hospitals. These include tips on ‘**Engaging Your Hospitals**’, and a **Nursing Home Capabilities List**, which can be useful for emergency room staff, hospital discharge planners, and hospital physicians in understanding the capabilities of each facility when making hospitalization and discharge decisions. The **Capabilities List** may also be useful in educating new staff, family members and on-call primary care clinicians about the facility’s capabilities.

For those residents who do need to be transferred to the hospital, the INTERACT **Acute Care Transfer Checklist** and **Nursing Home to Hospital Transfer Form** help clearly and succinctly communicate the information that is critical for the emergency room and other hospital staff to care for the resident. Since several states and local coalitions have developed their own forms and procedures, and in many areas of the country this is done electronically, the **Transfer Form** and the **Nursing Home to Hospital Transfer Data List** can help identify the key data elements that should be included in the electronic transfer of information. INTERACT also has similar tools for recommended data when a hospital transfers a patient to the nursing home (see table below).

Hospital Communication Tools	Use	Suggested Formats
Engaging Your Hospitals	Nursing home champions and leadership • Tip sheets for better communication and collaboration with local hospitals	• 8.5" x 11" laminated cards
Nursing Home Capabilities List	All nursing home licensed nursing staff and ER staff • Standardized pre-populated checklist explaining nursing home	• 8.5" x 11" laminated card
Acute Care Transfer Checklist	All nursing home staff at time of transferring residents to acute care • Recommended list of documents to send to the ER (or hospital for direct admits) at time of transfer from nursing home to the hospital	• Printed on oversize heavy stock envelopes (in which documents are placed), or • 8.5" x 11" pads with NCR copies
Nursing Home to Hospital Transfer Form	All nursing home licensed nursing staff and ER staff • Recommended data elements to be included in paper or electronic forms at time of acute care transfer from nursing home to hospital	• 8.5" x 11" laminated cards • 8.5" x 11" pads with NCR copies
Nursing Home to Hospital Transfer Data List	All nursing home licensed nursing staff and ER staff • Recommended data elements to be included in paper or electronic forms at time of acute care transfer from nursing home to hospital	• 8.5" x 11" laminated cards
Hospital to Nursing Home Transfer Form	All nursing home licensed nursing staff and ER staff • Recommended data elements to be included in paper or electronic forms at time of acute care transfer from nursing home to hospital	• 8.5" x 11" laminated cards • 8.5" x 11" pads with NCR copies
Hospital to Nursing Home Transfer Data List	All nursing home licensed nursing staff and primary care clinicians; hospital discharge planners, nurses, and discharging physicians • Recommended data elements to be included in paper or electronic forms at time of transfer from hospital to nursing home or SNF	• 8.5" x 11" laminated cards

Implementation Guide

Removing Barriers

Continue Collecting and Reviewing Data to Further Improve

The INTERACT quality improvement program **can take several months to fully implement**. This time is necessary to complete the training, get the tools on the units, and integrate the tools into everyday use. As front line staff learn about and implement the tools in their everyday practice, the INTERACT champion and team should continue the quality improvement cycle by:

- Consistently tracking and trending key hospitalization measures
- Continuously reviewing the **Quality Improvement Tools**, and summarizing and analyzing this information to guide further education and care process improvements

Removing Barriers to INTERACT Implementation

Experience implementing the INTERACT quality improvement program in several hundred facilities has helped to identify numerous perceived and real barriers to effective program implementation. These barriers, and strategies to help overcome them, are outlined in the table below.

Barriers	Strategies to Address Barriers
Believing you don't have a problem with the way you manage Changes in Condition and Hospital Transfers, without any objective data	<ul style="list-style-type: none"> • Regularly tracking hospital transfer data, trending your data, and comparing your data to benchmarks will provide you with objective data that can identify if you have an area for improvement
Perception you do not have control over resident transfers and hospital admissions	<ul style="list-style-type: none"> • Using the INTERACT program to review systems and processes will provide you and the staff with specific information on areas for improvement • Using INTERACT tools to improve management of acute changes in condition and more effectively communicate with physicians and emergency room staff will give you more control over who gets transferred and admitted
Lack of physician collaboration and cooperation	<ul style="list-style-type: none"> • Getting the buy-in of the medical director and as many primary care clinicians as possible to appreciate the value of the INTERACT program will go a long way towards better interdisciplinary collaboration, as well as more effective implementation and sustainability of the program
Families want residents hospitalized	<ul style="list-style-type: none"> • Begin education with families early regarding why reducing unnecessary transfers is a way to improve care and reduce hospital-related complications • Include a Stop and Watch Tool in the admissions packet and encourage family members to report changes in condition, and have a standard and consistent plan for responding to families • Provide residents and family members information on risks as well as and benefits of hospitalization using the INTERACT Advance Care Planning Tools
'We are in our survey window'	<ul style="list-style-type: none"> • This is a common excuse for not implementing new quality improvement initiatives. The fact of the matter is facilities are technically always in their survey window, and should be continuously prepared • INTERACT implementation will result in improved care and compliance with federal regulations related to resident change in condition • At the national level, the INTERACT team has been and will continue to be involved in surveyor education • INTERACT is one example of a quality improvement program that can help meet the new Quality Assurance and Performance Improvement or 'QAPI' requirement

Implementation Guide

Sustaining Improvements

Barriers	Strategies to Address Barriers
'Things only go well when the Champion is readily available'	<ul style="list-style-type: none"> • Appointing a co-champion who can take over if needed is strongly recommended. Embedding the INTERACT program and tools into everyday practice will also help overcome staff absences and turnover.
'We already have similar forms and processes'	<ul style="list-style-type: none"> • The INTERACT program and specific aspects of the tools are not fixed in stone. • Use your tools if they work for you, or use or modify the INTERACT program and tools based on what your facility already has in place.
Fear of law suits	<ul style="list-style-type: none"> • While there is no fail-safe way to prevent law suits, the INTERACT program provides tools for evidence-based and expert recommended care, and improves communication and documentation. Implementing the program should therefore be of great value in documenting best practices and defending against legal actions related to quality of care.

Key Strategies for Sustaining Improvement

Similar to the barriers and strategies to overcome them outlined above, experience implementing the INTERACT program has resulted in gaining insight into strategies that will help sustain the program and care process improvements over time. These strategies are outlined in the table below.

Strategies	Key Points
Develop a shared vision	<ul style="list-style-type: none"> • Successful leaders are able to: <ul style="list-style-type: none"> - Share their vision within their own institution - Incorporate INTERACT tools and processes into the culture and core function of the institution • Make the connection between INTERACT and improving the quality of care for your residents – this is the message that will resonate with and motivate frontline caregivers • Successful implementation ultimately rests with the buy-in from the frontline staff, so spending time to share your vision and to invite your frontline staff to share the vision is time well-spent • You can demonstrate your belief in the program by 'hardwiring' INTERACT into your institutional culture <ul style="list-style-type: none"> - Include an item about the program on your morning meeting agenda, your quality and other staff meetings, orientation, and annual competency evaluations
Select an Interdisciplinary Quality Improvement Team and a strong Champion	<ul style="list-style-type: none"> • Selection of a core Interdisciplinary Team is essential to set the tone for the work and to keep the program on track • Selection of the Champion is one of the most important decisions you will make. You know best who can motivate your staff and who has the skills to coordinate the program <ul style="list-style-type: none"> - Experience suggests it does not matter what discipline the Champions are from, but rather their leadership abilities • Appointment of a Co-Champion is strongly recommended in case the Champion becomes unavailable to continue their program responsibilities

Implementation Guide

Sustaining Improvements (cont'd)

Strategies	Key Points
<p>Focus on continuous Quality Improvement</p>	<ul style="list-style-type: none"> • INTERACT must be a key aspect of your facility's quality improvement activities in order to be sustained over time • Invite your frontline staff to participate in the Quality Improvement processes to strengthen their buy-in and provide insights to improve processes and systems • Development of baseline data is an essential initial step of the program. Use the Quality Improvement Tools to complete your data analysis and identify areas for improvement and education. Once the areas for improvement are identified, prioritize which areas you will focus on first • Consistent review of Quality Improvement Tools is critical: successful facilities engage the front line staff in this process. You should complete the tool as soon after the acute care transfer as possible so that all of the details are fresh. If the transfer was determined to be preventable, use this information to guide changes in your care processes, as well as to focus educational efforts. • Ongoing tracking and trending of your transfer data is critical to sustain the program and improvements in care quality <ul style="list-style-type: none"> - Make data tracking part of your everyday routine, as well as your overall quality improvement activities so you can determine if you have actually improved care for your residents • You should set your own benchmarks, as well as goals in relation to other facilities in your area or your corporation, as well as national data
<p>Streamline work processes and avoid redundancy</p>	<ul style="list-style-type: none"> • The INTERACT program should fill in gaps in your care processes, not create more work for your staff • Avoid redundancy. Use INTERACT tools to complement or replace what you already have in place • Prior to implementing the INTERACT program, begin to identify areas for improvement and review your current processes <ul style="list-style-type: none"> - You may already have some processes in place that work. Use the INTERACT strategies and tools to improve processes that aren't working as well as you would like
<p>Make the program and tools visible and integrate it into everyday care</p>	<ul style="list-style-type: none"> • Implementing the INTERACT program should be consistent with the way you provide care in your facility <ul style="list-style-type: none"> - You can accomplish this by integrating the INTERACT program and tools into your everyday care practices • INTERACT is not meant to be a program in a notebook gathering dust on a shelf. The tools are meant to be visible and used as part of everyday care in the facility • Examples of formats for the tools that facilities have found useful are illustrated in the Tool Table on the INTERACT website <ul style="list-style-type: none"> - You can be creative and use what you think will work best in your facility • Keep the program visible <ul style="list-style-type: none"> - Incorporate reports on acute change in condition and transfers into daily 'stand up' rounds, morning reports, 'resident at risk' meetings, and/or shift-to-shift reports on each nursing unit
<p>Ongoing education</p>	<ul style="list-style-type: none"> • Provide staff with ongoing education <ul style="list-style-type: none"> - Focus education on areas identified for care process improvement - Review all INTERACT Care Paths and related practice guidelines periodically • Incorporate education on INTERACT into new employee education

Implementation Guide

Sustaining Improvements (cont'd)

Strategies	Key Points
<p>Develop cross-continuum partnerships</p>	<ul style="list-style-type: none"> • Communication across continuum partners, payers, and regulators is essential for the success in an era of policy and payment reform • Answering the following questions provides an opportunity for facility leadership to share their vision as well as their plan with partners, payers, and regulators <ul style="list-style-type: none"> - What are you doing to reduce unnecessary acute care transfers? - How are you doing it? - What are your 30-day readmission rates and how have they been trending over time? • Use the INTERACT Engaging Your Hospitals tips, Nursing Home Capabilities List, and other tools initiate discussions, and joint quality improvement initiatives • Use the INTERACT QI Tool to perform joint root cause analyses
<p>Key focus areas for sustaining the improvements</p>	<ul style="list-style-type: none"> • Make the INTERACT program a permanent part of the facility quality improvement activities • Incorporate INTERACT strategies and tools into everyday care • Ensure ongoing leadership support for the program • Continue to track changes in rates of hospital transfers and how you manage Acute Changes in Condition • Learn by summarizing and analyzing Quality Improvement Tools and continue to try to improve • Develop close relationships and joint quality improvement activities with cross-continuum partners • Recognize that organizational change takes time <ul style="list-style-type: none"> - Major quality improvement programs such as INTERACT can take several months to fully implement, including training, rolling out the tools, and making the program a part of your everyday care
<p>Consider using INTERACT in an Electronic Healthcare Record (EHR)</p>	<ul style="list-style-type: none"> • Several EHR vendors have license agreements that enable them to build components of the INTERACT program in their software • Use the "Contact Us" section of the INTERACT website to find out more about this. (http://interact.fau.edu)