INTERACT II: Increasing residents’ experiences and quality of life while reducing hospital transfers

External Leadership Project By Kellie Ahrens

Introduction:
Marshfield Care Center needed a system to track hospital transfers and discourage the transfer of residents to the hospital. This project aimed to proactively implement a system to track hospital transfers while putting systems in place to reduce the amount of hospital transfers; there in, improving resident quality of life.

Desired outcomes: Maintenance of a log tracking all hospital transfers, detection of hospital transfer trends within the facility, increased awareness in nursing staff of the importance of reducing hospital transfers, and the actual reduction of hospital transfers due to targeted symptoms & diagnoses (CHF, UTI, & Pneumonia)

**Desired Care Process Outcome**

- Resident’s condition deteriorates/resident becomes symptomatic
- Floor Nurse references Care Path tools for assistance/direction in treating resident
- Floor Nurse contacts MD/NP/PA to update on condition or request orders as suggested by Care Path
- Implement treatment as able & as suggested by Care Path
- Manage Condition in-house as possible utilizing Care Path Tools for reference

Current knowledge of task:
INTERACT II (Interventions to Reduce Acute Care Transfers) is an evidence-based quality improvement program created through a contract with CMS. Tools from this program are proven to reduce acute care transfers 17–24%.

Care Path Tools created by INTERACT II were implemented at the facility to help guide evaluation of specific symptoms which were shown to precipitate frequent hospital transfers as well as provide options on how to manage conditions in-house.

Hypothesis:
Reduction of hospital transfers in the Marshfield Care Center would lead to:
- Improved resident experience at the facility & increased quality of life and care
- Decreased staff work load related to hospital transfers and readmissions
- Increased revenue and a reduction in lost patient days due to hospital stays

Results:
• Trends were identified in diagnosis and symptoms of hospital transfers to enhance quality of care.
• Tools were implemented to assist staff in better management of CHF, UTI, and Pneumonia to reduce the risk of need for hospital transfer.
• The Nursing Department’s goal is to decrease hospital transfers related to targeted diagnoses by 8-10%. In 1 yr

In a survey of a random sample of professional nursing staff working the floor & nurse administration after one month of implementation the following was reported:

**Methodology:**

1. Researched best practices in reducing re-hospitalizations from a SNF & selected evidence-based quality improvement program INTERACT II
2. Recorded hospital transfers for April ’13 to January ’14 using INTERACT II Hospital Rate Tracking Tool. Found need to improve discharge summary documentation.
3. Evaluated & analyzed current hospital transfer process. Discussed current discharge process with: DON, Nurse Managers, Floor Nurses, and Medical Records Director.
4. Analyzed data collected from the Hospital Rate Tracking Tool to find trends in hospital transfers to find the largest amount were: CHF, UTI, and Pneumonia
5. Discussed hospital transfer trends with DON & NHA as well as tools to implement which included the Stop & Watch Tool or Care Paths. After discussion, research, and root causal analysis Care Paths were chosen.
6. Updated Discharge Checklist (a “cheat sheet” for nurses to follow for hospital transfers) included on all discharge packets.
7. Introduced INTERACT II Leadership project at CQI Meeting which included entire management team as well as the Medical Director & Consultant Pharmacist
8. Presented INTERACT II & Care Path tools at a nurses’ meeting.
9. Placed laminated, Care Path tools on each unit & updated all discharge packets to include new Discharge Checklist.
10. Continued to update the INTERACT Hospital Rate Tracking Tool

**Recommendations:**
1. The INTERACT Hospital Rate Tracking Tool be updated in a timely basis.
2. Results of trends be shared at CQI meetings.
3. Results of trends be shared with nursing staff on a quarterly basis.

Implementation of this project in other facilities would be extremely beneficial for reimbursement, resident care, and staff satisfaction.

Care Path tools are readily available, easy to understand, great for resident care, and if presented as a supplement to current knowledge professional nursing staff are very open to the Care Paths.

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