Caring Transitions

By James Lett II, MD, CMD

INTERACTing With the Electronic Medical Record

No program or concept has had a deeper, more positive impact on care transitions in skilled nursing facilities than the Intervention to Reduce Acute Care Transfers (INTERACT) initiative. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers result in numerous complications of hospitalization and billions of dollars in unnecessary health care expenditures.

INTERACT was conceived as a quality improvement program, although it is often implemented as a readmission reduction program in the long-term care clinical environment. There are three basic types of INTERACT tools: communication tools, care paths or clinical tools, and advance care planning tools. The first steps in the INTERACT process are designed to improve the early identification of resident problems, promote systematic resident assessment for those changes, and guide efficient documentation of the work of the bedside nursing team. Next, scripted communication about resident status changes in skilled nursing facilities encourages an efficient, accurate, clinical interchange with the attending clinician. These steps allow caregivers to intervene in acute resident change of conditions, resulting in on-site care that reduces the frequency of acute hospital transfer.

Joe Ouslander, MD, PhD, professor of clinical biomedical science and senior associate dean for geriatric programs, and his INTERACT team at Florida Atlantic University, including Jill M. Shutes, GNP-BC, and Janelle Miller, RN, clinical product line manager at PointClickCare have strived to expand the availability and impact of INTERACT. Here, Ms. Shutes and Ms. Miller, the authors of this column, describe a recent innovation to integrate the program into the electronic medical record.

INTERACT is a HIT

A substantial reduction in hospitalization rates has been associated with implementation of the INTERACT quality improvement program using the paper-based clinical practice tools (INTERACT 3.0). There is a compelling opportunity to further increase the impact of INTERACT by embedding INTERACT 3.0 tools into nursing home health information technology (HIT) via standalone or integrated clinical decision support systems. This article highlights the process of embedding INTERACT 3.0 tools from paper to nursing home HIT.

INTERACT is an example of a quality improvement intervention designed to support clinical decision making, as well as to facilitate the identification, evaluation, documentation, and communication about changes in resident status. This is accomplished by collecting information about baseline care plan goals and condition-specific clinical information when a change in status occurs. The INTERACT 3.0 (originally II) care paths and other tools, incorporate information from various sources including best practices, clinical practice guidelines, and input from front line nursing home providers and national experts in long-term care.

Saves Time, Streamlines Processes

Many LTC facilities using electronic health records have already obtained a license agreement with Florida Atlantic University to embed INTERACT within their HIT. Some of the reported challenges associated with using paper-based INTERACT 3.0 tools may be improved when these tools are incorporated into nursing home HIT. Use of an electronic format will enable staff to spend less time updating data, provide greater access to automated information, reduce the time needed to track down information from different sources, minimize the time spent performing manual calculations, and keep tracks on tasks through reminders or prompts noting when specific actions should be taken. Simply put, it will make it easier for front line staff to do the right thing at the right time when a patient’s clinical condition has changed.

Translating INTERACT 3.0 clinical decision support tools from paper to HIT in the nursing home has spotlighted the potential to enhance the detection, management, and communication of acute change in condition among nursing home residents. For example, unlike standalone paper-based tools that rely on employees to follow proper policy when notifying the clinician about a subtle change in condition, INTERACT automatically sends an alert to the nurse when a subtle change has been detected by a nursing assistant, which prompts the nurse to react to that alert within the system.

Developing INTERACT 3.0 clinical decision support tools in an interoperable format that would enable widespread dissemination and integration into various nursing home HIT products, could lead to sustainable improvement in resident and clinician process and outcome measures, including a reduction in unplanned transfers and potentially avoidable hospital admissions.

For information on how to obtain a license for INTERACT please visit the website at http://interact.fau.edu/.

Jill Shutes, GNP, is a research associate at Florida Atlantic University. Janelle Miller, RN, BSN, is clinical product line manager at PointClickCare. Patient Order Sets has provided support through FAU for Dr. Ouslander and Ms. Shutes.

Dr. James Lett II, MD, CMD, chairman of the AMDA Transitions of Care Committee, coordinates this column. You can comment on this and other columns at www.caringfortheages.com, under “Views.”

Tools for Transitions

Improving care transitions has long been a priority for PA/LTC practitioners, as they have sought to enhance communication between care settings and support patients and families as individuals move through the care continuum. AMDA has several tools, developed by interdisciplinary teams and based on clinical evidence, to support care teams and facilities as they improve care transitions.

► Acute Change of Condition Clinical Practice Guideline. This document details a person-centered approach to recognition, assessment, treatment, and monitoring of acute condition changes designed to result in better management of these events and fewer transfers to hospitals and other acute-care settings. For more information, go to www.amda.com/tools/guidelines.cfm#acc.

► Transitions of Care Clinical Practice Guideline. This guideline offers an array of steps, tools, and resources to enable smooth and effective care transitions as patients move from setting to setting. This guideline is available as a free download. For more information, go to www.amda.com/tools/guidelines.cfm#toc.

► The Know-It-All Series includes several tools to encourage communication, documentation, and support that improve transitions and care as patients move between the PA/LTC facility and the hospital, home, or other setting. Included in the series are: Caregiver’s Communication Guide – Caring for the Older Adult in Their Community; Know-It-All Series: Tools to Reduce Transfers to Hospitals; Know-It-All Before You Call Data Collection System; Know-It-All When You’re Called Diagnosing System; and Know-It-All Set (includes both data cards and diagnosing system). For more information, go to www.amda.com/tools/kia.cfm.