Engaging Hospitals in Your Program

INTERACT®
Version 4.0 Tool

Keys to Engaging Your Local Hospitals

1. **Transitions in care require two partners.** Although there are numerous process improvements that INTERACT facilities can implement to improve care and reduce acute care transfers, safely and effectively sending patients to the hospital and receiving patients from the hospital are fundamental to improving transitional care. Hospital discharges to post-acute care (PAC) are very important and high-risk transitions in care setting. By definition, an effective transition requires the active participation of both a sending provider and a receiving provider.

2. **The best 'sending' to the acute care setting is only meaningful if the receiver uses the information.** The INTERACT III Tools include a sample **NH-Hospital Transform Form**, and a **Transfer Document Checklist** that can be printed on or taped to an envelope to help guide best-practice with complete NH-hospital transitional care information. INTERACT facilities should invest effort in ensuring that high quality information is transferred to the hospital. You will want to establish a partnership with hospital leadership to ensure that information you send is used to inform and improve care.

3. **INTERACT facilities should stand ready to accept the patient back to the facility and avoid a hospitalization, if safe and appropriate.** On occasion, a NH clinician will transfer a resident for tests and evaluation, but the clinician and the NH would be willing to accept the patient back following the evaluation when safe and appropriate. This represents a practice change for many hospitals and Emergency Rooms (ERs). Specific dialog about your NH capabilities will benefit your INTERACT goals. In addition, ERs should be encouraged to keep the INTERACT III **NH Capabilities List** readily available to consult in these situations.

4. **INTERACT facilities can influence improved methods of communication and transitioning patients from hospital to NH.** INTERACT facilities may note when using the INTERACT III **Quality Improvement Tool** for review of acute care transfers that early returns to acute care are often a result of poor hand-offs or missing information regarding the hospital clinical course. Hospital-NH partnerships to improve information and hand-off practices will benefit patients, hospitals, and post-acute care facilities. INTERACT III tools include a **Hospital to Post-Acute Care Data List** and **Sample Form** to help achieve this goal.

5. **INTERACT facilities will demonstrate their value-added in an increasingly competitive post-acute care business environment.** Improving care and reducing readmissions and other preventable hospital transfers will not only benefit your patients and your facility's 30-day readmission rates, but will also provide valuable quality information to your referral base. Partnerships with hospitals around preventable hospital utilization and other principles of safe, high quality care embedded in the INTERACT program will be increasingly relevant in a value-based purchasing environment. The INTERACT III **Hospital Transfer Tracking Tool**, as well as other similar tools, can provide clearly-defined and easy-to-read trends in various measures that will help in these partnerships.

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Engaging Hospitals Checklist

1. **Create** a list of all hospitals your facility sends patients to or receives patients from.

2. **Identify** the 'readmissions champion' for each hospital. You can most easily discover who is leading the readmissions effort at local hospitals by reaching out to one of the leaders listed below. They will know who is the organizational lead for readmissions for example, the:
   - **a.** Chief Quality Officer
   - **b.** Chief Medical Officer
   - **c.** Chief Nursing Officer
   - **d.** Director of Case Management
   - **e.** Director of Quality

3. **Host** or join a 'cross-continuum' or Community Care Transitions Working Group or Coalition. Start by inviting the hospitals in your area to your facility to see your capabilities first hand. Also, attend cross-continuum team meetings hosted by your local hospitals. It is optimal to meet in person to form and strengthen relationships, but start with one person and one phone call if needed.

4. **State** your facility's goals to reduce avoidable hospital transfers, admissions, and readmissions, and link that to the hospitals' goals in readmission reduction. Lead with a brief set of numbers:
   - **a.** The average number of patients you receive from the hospital each month
   - **b.** The current 30-day readmission rate among those patients
   - **c.** Your facility's goal to reduce preventable and unnecessary hospital transfers

5. **Describe** the set of quality improvements underway in your facility through INTERACT and other initiatives.

6. **Ask** the hospital to be an active partner in your INTERACT improvements.
   - **a.** Post the INTERACT III **NH Capabilities List** in the ER and at floor case manager workstations
   - **b.** Educate ER staff and inpatient teams about relevant INTERACT forms and tools
   - **c.** Encourage ER physicians to review your transfer forms and consider returning the resident to NH if safe and appropriate based on the **NH Capabilities Checklist**
   - **d.** Develop a process to ensure INTERACT forms are sent from the ER to the patient care units
   - **e.** Improve hand-off communication between hospital and NH using 'Warm Hand-Offs' (in-person communication)
   - **f.** Engage in regular readmission reviews to identify improvement opportunities

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How INTERACT Can Help Your Hospital

As a leader of quality and safety at your hospital, you may be responsible for ensuring that your staff executes safe transitions in care and that your hospital's readmission rates are not higher than expected. As you know, CMS now penalizes hospitals for higher than expected all-cause 30-day readmission rates for three conditions. Within 24 months, the list of conditions is projected to expand to eight conditions, and perhaps to 11 or more after 2015. Many of these conditions are associated with transfers to and from local post-acute care (PAC) facilities.

Your hospital may have a broad portfolio of efforts aimed at improving care transitions and reducing readmissions. National data demonstrate that Medicare patients discharged to PAC skilled nursing facilities commonly experience high 30-day readmission rates. Partnering with the facilities that are implementing the INTERACT quality improvement program will contribute to reducing preventable admission and readmission rates among this very high-risk population.

What INTERACT Facilities Offer to Hospitals

INTERACT facilities are committed to implementing a set of strategies, tools, care process improvements, and related staff education aimed at identifying acute changes in resident condition early, effectively initiating evaluation and management of these clinical conditions within the facility, and preventing hospital transfers when safe and feasible. INTERACT facilities will:

- Send an organized and comprehensive set of transitional care information to your ER
- Provide a list of the INTERACT facility's capabilities to support providers in their decisions whether or not to admit or return the patient to the nursing facility.
- Engage in improving hand-offs from hospital to nursing facility – through accepting 'Warm Hand-Offs', participating in post-transition follow up phone calls, regular process improvement meetings, etc…
- Pro-actively engage in advance care planning with facility residents and their families to clarify goals of care

What INTERACT Facilities Request of Hospitals

- Include INTERACT as part of your hospital's strategy for reducing readmissions
- Provide your ER and inpatient staff information about INTERACT
- Encourage your ER staff to look for and use the INTERACT tools and forms
- When appropriate, consider whether the patient can return to the NH after ER evaluation
- Develop a reliable process to ensure the INTERACT forms reach the inpatient teams
- Encourage your inpatient teams to provide 'Warm Hand-Offs' prior to transfer, with nurse-to-nurse, and doctor-to-doctor communication via phone or secure email
- Work with INTERACT facilities to implement other safe transfer practices
- Meet with INTERACT facilities to review readmissions and data, identify areas for improvement, and work together toward your shared goals