



# **INTERACT Implementation Learning in Action Collaborative Webinar 3: Transfer Forms**

**November 19, 2015  
11:30 a.m. – 12:30 p.m. EST**



# AQIN – SC QIO Team:

Sarah Stein Banyai, MPH  
Quality Specialist  
[SStein@thecarolinascenter.org](mailto:SStein@thecarolinascenter.org)  
803.212.7521

Heather Jones, MHA, PTA, CPHQ  
Manager Care Coordination  
[HJones@thecarolinascenter.org](mailto:HJones@thecarolinascenter.org)  
803.212.7584

Marilee Mohr, RN  
Quality Specialist  
[MMohr@thecarolinascenter.org](mailto:MMohr@thecarolinascenter.org)  
803.212.7517

Karen Southard MHA, RN  
State Program Director, SC-AQIN/QIO  
[KSouthard@thecarolinascenter.org](mailto:KSouthard@thecarolinascenter.org)  
803.212.7518



# Learning In Action Collaborative

During this 6 month, action oriented, virtual collaborative participants will:

- Receive education, coaching, and resources from experts in the field
- Develop strategies to reduce avoidable hospital readmissions
- Learn about evidence-based INTERACT tools and have the opportunity to implement interventions to reduce hospital readmissions: QI tools, capabilities list, transfer forms, SBAR, and STOP and WATCH
- Build a community of practice with their peers and share successes and challenges
- Learn to use data in a meaningful way to improve care

# Welcome

- All webinars will be recorded and can be accessed at <http://atlanticquality.org/initiatives/care-coordination/care-coordination-sc/>
- Meeting norms:
  - We will be flexible and understanding with technology
  - We will be attentive and not multitask during the webinar
  - We will be engaged and participate in discussions and peer-to-peer sharing

# Collaborative Timeline

(All webinars are scheduled on Thursdays from 11:30 am -12:30 pm EST)

## **October 8, 2015 – Kickoff Webinar #1: Readmission Tracker**

October 19-23, 2015 Check in/Coaching call (15-30 min)

## **November 5, 2015 – Webinar #2: Capabilities List**

November 9-13, 2015 Check in/coaching call (15-30 min)

## **November 19, 2015 – Webinar #3: Transfer Forms**

December 7-16, 2015 Check in/coaching call (15-30 min)

## **January 7, 2016 – Webinar #4: SBAR**

January 25-29, 2015 Check in/coaching call (15-30 min)

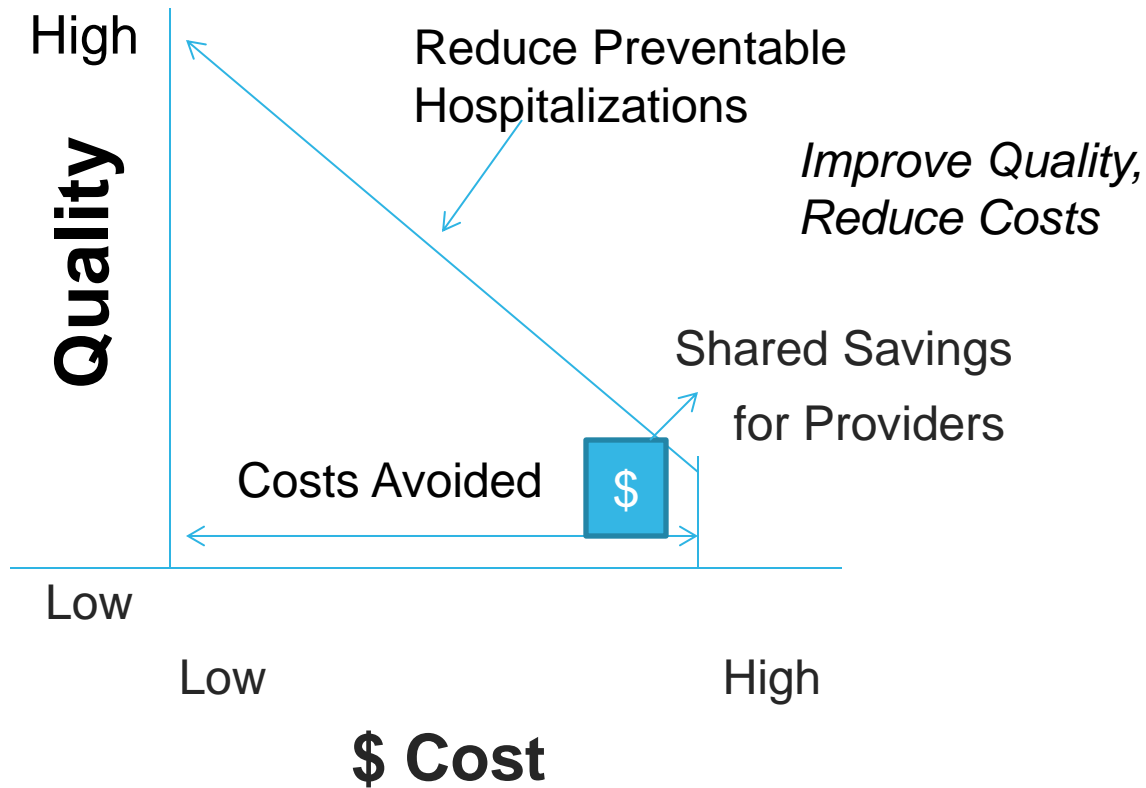
## **February 18, 2016 – Webinar #5: Stop and Watch**

February 29-March 4, 2015 Check in/coaching call (15-30 min)

## **March 10, 2016 – Webinar #6: Lessons Learned and Next Steps**

# The INTERACT Program

Opportunities for You and Your Facility



# Process Improvement Principles

Resident Focus

Leadership Involvement

Team-Based

Data and QI Tools

Just Culture

Prevent Overcorrection

Staff Empowerment

Continuous Improvement



INTERACT tools are meant to be used together in your daily work in the nursing home or home health agency.

INTERACT tools will help identify common causes of readmission.

INTERACT aligns with QAPI initiatives.



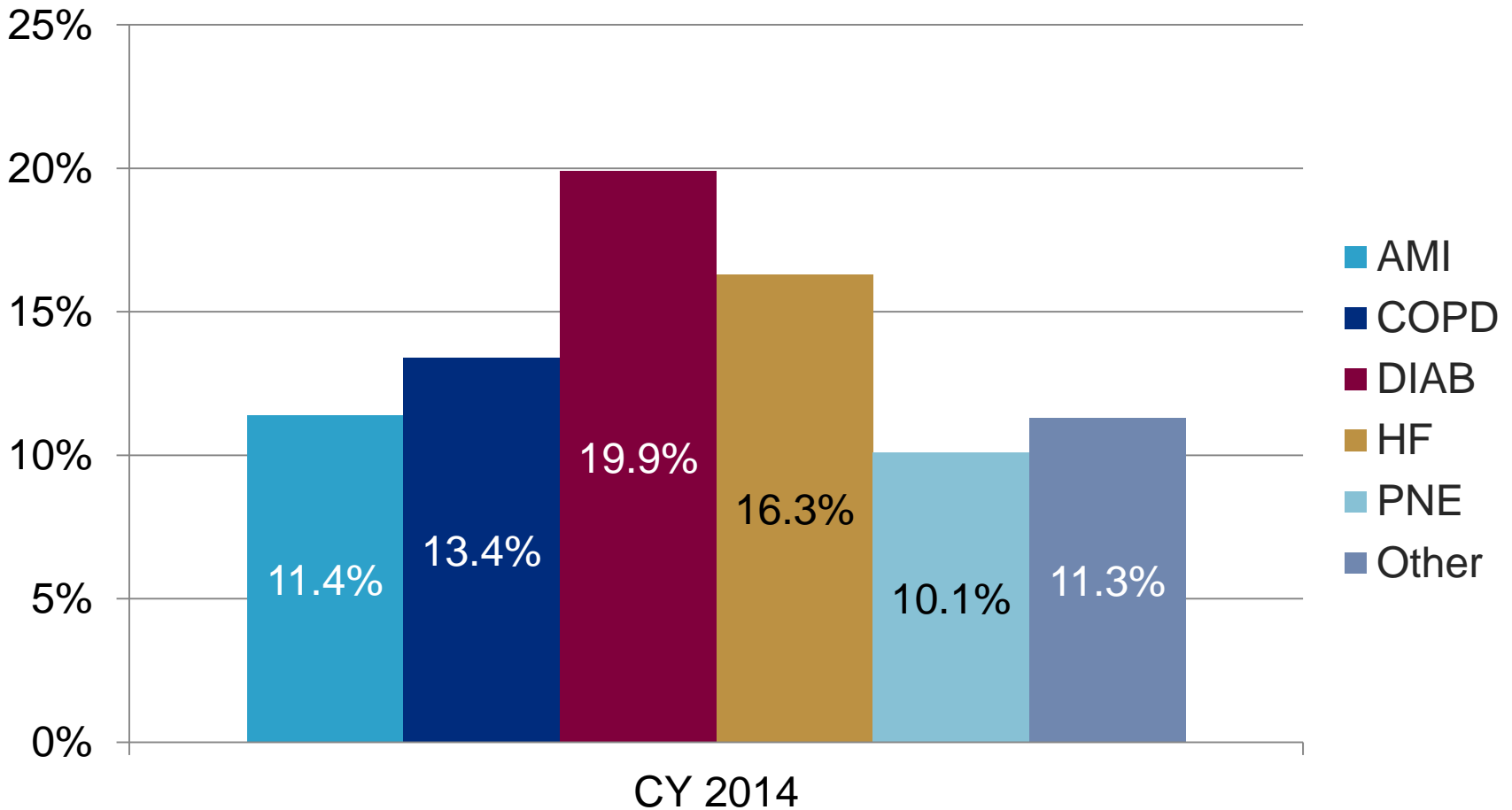
<https://interact2.net/>



# Alignment of QAPI and INTERACT

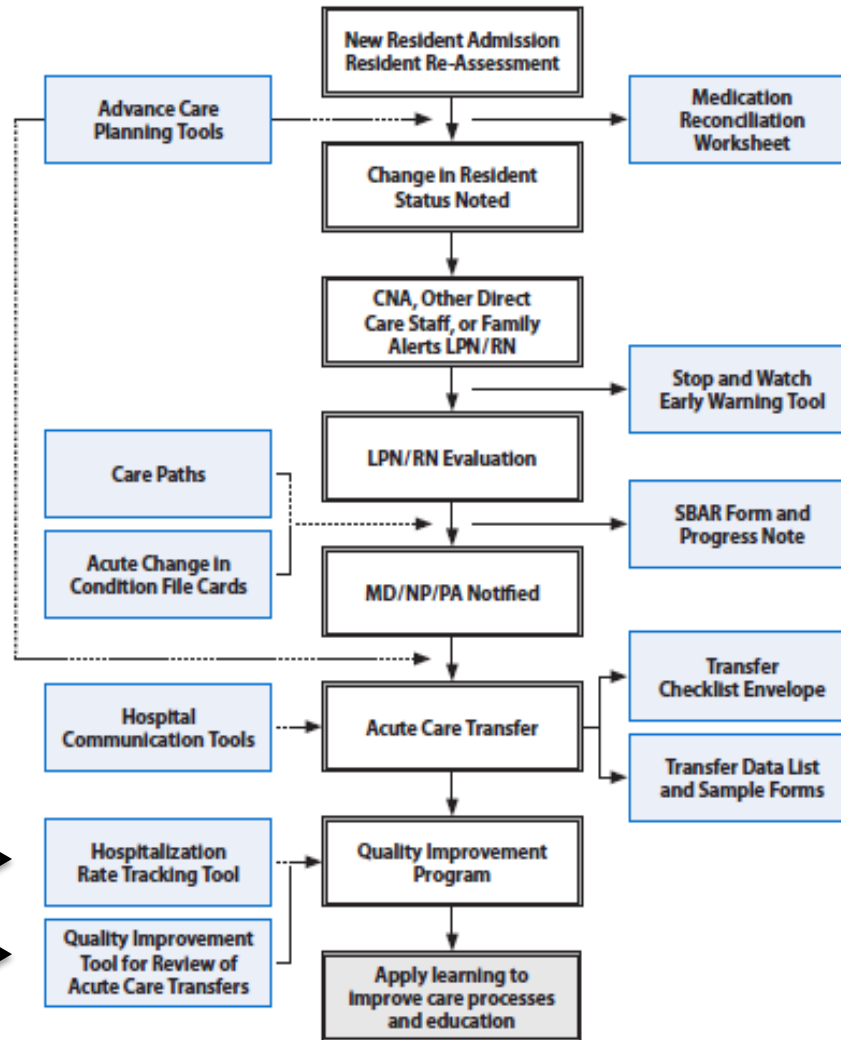
QAPI	INTERACT
Improves communication	Provides communication tools
Driven by leadership and empowers staff to be part of the decision making	Leadership sets the charter and works with staff to implement
Standardize practice	Evidence-based tools
Data drives the change	Data helps identifies the opportunity to improve
Provides a system to monitor effectiveness of care	Provides tools to analyze process, provides care paths to deliver care in a consistent manner
Systemwide improvement	Utilize PDSA cycles and spreads success across the organization
Organizes the change plan into a performance improvement project	INTERACT is a performance improvement project

# SC Diagnosis-Specific Readmissions



SC overall readmission rate is 11.7%

# Using the INTERACT Tools In Every Day Care



**Quality  
Improvement Tools**



# Tracking in Real Time – Review

- Track and trend transfer measures using QI Tool
- Conduct root cause analysis using QI Tool
  - Analyze transfers
  - Look for common patterns
- Choose interventions based on your findings

## Acute Care Transfer Log



You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. This tool is not necessary if you use the INTERACT Hospitalization Rate Tracking Tool, which allows you to enter the data directly into an Excel spreadsheet, and calculates rates and generates reports. A similar tracking tool is available through the Advancing Excellence Campaign in America's Nursing Homes at [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)

Facility Name \_\_\_\_\_ Month/Year \_\_\_\_\_ / \_\_\_\_\_

Resident ID	Date of Most Recent Admission to Facility	Admitted to Facility from <sup>1</sup> (circle)	Status on Admission <sup>2</sup> (circle)	Date of Acute Care Transfer	Time of Transfer (circle AM or PM)	Outcome of Transfer <sup>3</sup> (circle)	Reason for Transfer <sup>4</sup>
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	



## INTERACT Hospital Rate Tracking Tool

January 1, 2015

**Confidentiality is important.** Please do not transmit this form with resident-identifying information. Instructions for de-identifying this tool are provided in the Common Qs & As tab.

<http://www.interact2.net>

# Communication Tools – Review

## Capabilities List

- Standardized, pre-populated checklist of nursing home/home health capabilities for decisions about transfers back into facility
- Distribute to EDs and hospital discharge planners
- Marketing and education tool

[https://interact2.net/tools\\_v4.html](https://interact2.net/tools_v4.html)



# Building Partnerships



Readmission  
Champion

NH/HHA  
Capability List



Share your  
QI Goals

Host or join a  
community care  
transitions meeting



**Engaging Your Hospitals – Communication Tool**

## Using the Tool in Different Ways

- Combines the QI Review for readmission and compare to your capabilities list – gaps?
- Allows you to build a business case for service line expansion within the facility
- Establishes a quality scorecard using the most frequent admission DRG/readmission QI review tool and facility capabilities list
- Targets both internal and external education to staff and other providers

# Quality Improvement Tool

## For Review of Acute Care Transfers



The INTERACT QI Tool is designed to help your team analyze hospital transfers (*including ER visits, observation stay and admissions*) and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

Patient/Resident \_\_\_\_\_ Age \_\_\_\_\_

Date of most recent admission to the facility \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary goal of admission:  Post-acute care  Long-stay  Others: \_\_\_\_\_

[https://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%204.0%20NH%20Tools%206\\_17\\_15/148604%20QI\\_Tool%20for%20Review%20Acute%20Care%20Transf\\_AL.pdf](https://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%204.0%20NH%20Tools%206_17_15/148604%20QI_Tool%20for%20Review%20Acute%20Care%20Transf_AL.pdf)



# Acute Care Transfer Log



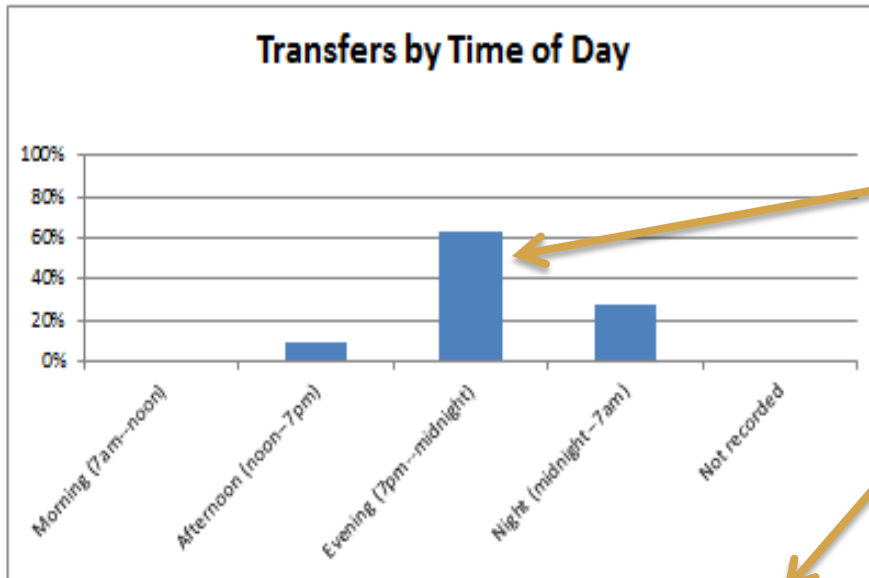
You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. This tool is not necessary if you use the **INTERACT Hospitalization Rate Tracking Tool**, which allows you to enter the data directly into an Excel spreadsheet, and calculates rates and generates reports. A similar tracking tool is available through the Advancing Excellence Campaign in America's Nursing Homes at [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)

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[https://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%20Acute Care Transfer Log%20Dec%2016%202014.pdf](https://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%20Acute%20Care%20Transfer%20Log%20Dec%2016%202014.pdf)

# Plan – Track Data – Analyze



Establish baseline  
 See patterns  
 Pinpoint opportunity  
 Monitor progress

	Status at Time of Admission from Hospital		
	Post-Acute Care	Chronic Long Term Care (non-Medicare)	All Residents
Number of Residents with Date of Discharge from Hospital in This Month	4	2	6
30-Day Readmission Rate percent of those readmitted to hospital within 30 days of the date of discharge from hospital	50.0%	0.0%	33.3%

# PLAN – Quality Improvement Review/RCA

## QI Tool for Review of Acute Care Transfer

- Use Review of Acute Care Transfer or your own form
- Identify common factors
- Isolates details of the surrounding the transfer
- Guide for education

## QI Summary Work Sheet

- Aggregates trends identified for each transfer
- Use to report out at QAPI meeting

# QI Tool for Review of Acute Care Transfers

- Who is high risk?
- What caused the transfer?
- Any attempts to prevent the transfer?
- When are most of the transfers happening?
- Common trends?



# Quality Improvement

## Summary Worksheet



This Worksheet is a guide to learning from individual root cause analyses of hospital transfers. It can be used to summarize findings documented on INTERACT **Quality Improvement (QI) Tools** to determine if there are common factors involved in your hospital transfers. Identifying these common factors will help focus your education and care process changes in order to further improve care and reduce potentially preventable hospital transfers. An Excel template **QI Summary Worksheet** is also available on the INTERACT website. There are several steps involved, which are outlined below.

### **STEP 1: Document the number and timeframe of completed QI Tools included in this summary**

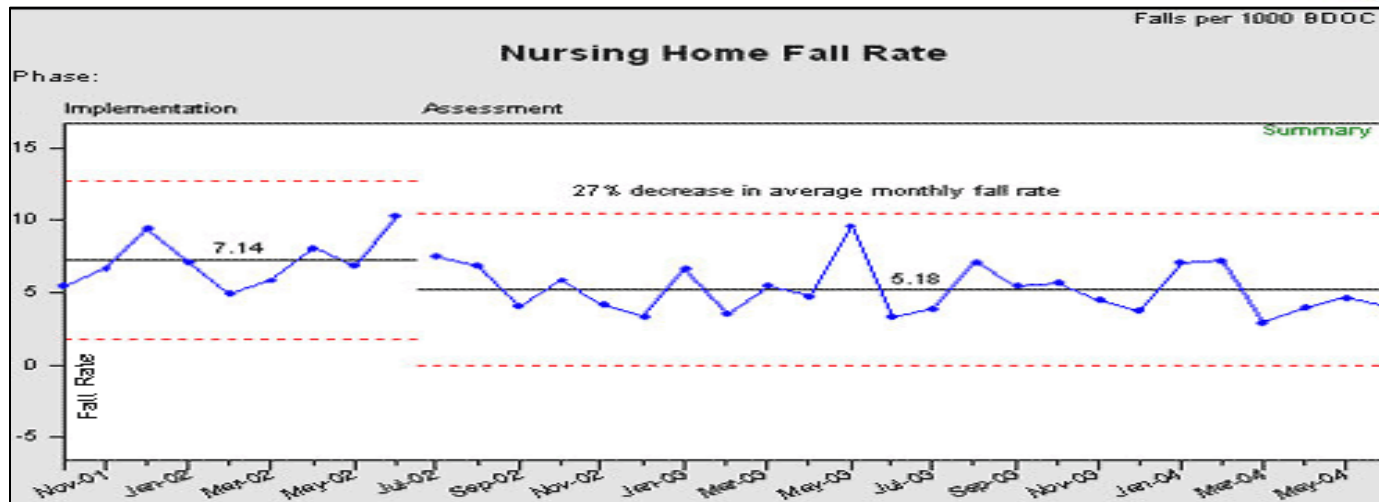
1. Number of completed QI Review Forms included in this summary: \_\_\_\_\_
2. Time frame of completed QI Review Forms: From \_\_\_\_\_ to \_\_\_\_\_

[https://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%204.0%20NH%20Tools%206\\_17\\_15/148604%20QI\\_Summary\\_Worksheet%20v4\\_0.pdf](https://interact2.net/docs/INTERACT%20Version%204.0%20Tools/INTERACT%204.0%20NH%20Tools%206_17_15/148604%20QI_Summary_Worksheet%20v4_0.pdf)

# QI Tool for Review of Acute Care Transfers

## Designed to do three things:

1. Educate team on how to analyze a transfer
2. Highlight common reasons for transfer
  - Section 1: Resident characteristics
  - Section 2: Acute changes and other factors
  - Section 3: Actions prior to transfer
  - Section 4: Characteristics of transfer
3. Focus education and improvement activities



Share

➔
The Data


# Action Items

1. Review the last three months of readmissions using the QI Tool and then complete the summary page?

## Quality Improvement Reviews - Root Cause Analyses



[Quality Improvement Tool for Review of Acute Care Transfers](#)



[Quality Improvement Summary – Worksheet](#)

2. Set up your readmission tracker and begin tracking acute care transfers Nov.1

[https://interact2.net/tools\\_v4.html](https://interact2.net/tools_v4.html)



## Action Items:

3. Schedule a follow-up call with a member of the AQIN-SC team.
4. Share your Capabilities List with your hospitals.
5. Register for INTERACT Implementation Webinar #4

**SBAR – January 7, 2016**

<https://qualitynet.webex.com>

# Thank you!



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