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Use of INTERACT Tools: Reducing Readmissions and Increasing Patient Satisfaction in Long Term Care

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INTRODUCTION:

The Centers for Medicare & Medicaid Services (CMS) contracted Joseph G. Ouslander, MD and Mary Perloe, MS, GNP to develop the INTERACT (2016) Program and Tools to address the growing problem of acute care readmissions from the long term care setting. INTERACT (2016) is evidence based and has been shown to greatly reduce avoidable readmissions when the tools are implemented as a bundle. The INTERACT program takes advantage of advance care planning and the use of palliative care medicine as ways to increase continuity of care and honor resident/patient choice.

OBJECTIVES:

- To identify resident wishes for advance care planning and honor those wishes
- To improve overall resident / customer satisfaction
- To reduce unnecessary admissions, readmissions and inpatient hospital mortality.
- To improve the quality of clinical care delivered to residents being discharged from the hospital to long term care facilities.
- To optimize the transition and continuity of care process from inpatient hospital to skilled nursing facility or long-term care
- To optimize the quality of life of our residents and families and empower them with choices. Outcomes are best when residents are identified proactively, early and have appropriate and consistent care.

METHODS:

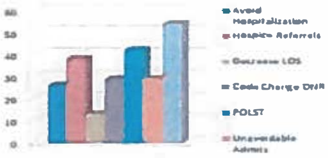
Sentara Life Care Corporation in collaboration with EVMS Glennan Center for Geriatrics implemented a palliative care program at the SLCC Norfolk Nursing Center in 2012. As part of this program an education program for nursing and social services was developed including the use of INTERACT Tools to reduce avoidable readmissions. At this time the palliative care team was comprised of nursing, social services and EVMS Palliative Care Medicine.

In 2013 SLCC added chaplaincy to round out the palliative care team to fully address the body, mind, and spirit in our palliative care services.

In 2014 Sentara Medical Group Palliative Care Medicine (PCM) proposed collaboration between PCM, an urban acute care hospital, skilled nursing and long term care with the potential to increase the continuity of patient care and impact readmission rates. An Advanced Practice Nurse was hired in October and by early 2015 a pilot program was launched between SVBH PCM and SLCC – Windermere Nursing Center. Within six months the program moved out of the pilot phase and a second program was launched at SLCC – Virginia Beach.

Following a readmissions summit in June of 2015, education on the use of INTERACT was expanded to all SLCC nursing centers and embedded in the electronic medical record.

OUTCOMES



RESULTS:

The SMG palliative care program noted the following results during the 2015 implementation:

- 193 consults facilitated between the start of the program in February and September 2015.
- Increase communication of the PCM teams
- 56 transfers / readmissions avoided
- 22 Hospice referrals
- PCM followed 15 patients whose deaths were not followed by Hospice in the nursing care centers
- Avoidance of 9+ readmissions and 13 admissions
- 33 family meetings for goal clarification
- 18 POLST completed
- 15 DNR Code Status Change

Readmission Rate %	2015	2016
January	26	18
February	21	15
March	23	17
April	24	13
May	16	14
June	22	16
Goal	15	17.2

Satisfaction Scores	Rank
2014	37
2015	76
2016	77
Goal	50

CONCLUSIONS:

- Increased education of healthcare providers, long-term care staff, residents, and families on the benefits of early intervention can reduce readmissions to acute care facilities.
- Readmission rates continue to trend downward from a rate of 22 in June of 2015 to 16 in June of 2016.
- Patient satisfaction scores dramatically increased from the 37 percentile in 2014 to the 76 percentile in 2015. As of July 2016 the scores have remained high at 77.
- Implementation of INTERACT increased the use of Palliative Care consults and reduced the transfers to different levels of care.

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