INTERACT: *what medical directors need to know*

What is INTERACT and why is it important?

INTERACT stands for **INTE**rventions to **R**educe **A**cute **C**are **T**ransfers. It is a quality improvement program that has **three key strategies** that reduce potentially avoidable hospitalizations:

1. Improve the identification, evaluation and communication about changes in resident condition before they become severe enough to require a transfer to the hospital
2. Manage select acute conditions in the center. (The Good Samaritan Society refers to nursing homes as "centers.")
3. Improve advance care planning for residents

INTERACT is designed to help center staff manage some conditions without transferring the resident to the hospital, but only when feasible and safe to do so. **It will NOT prevent all hospital transfers.** There will still be times when residents need to go to the hospital. When that happens, the INTERACT tools and process helps the center ensure this transfer happens in a more timely and efficient manner.

INTERACT can empower center staff members to advocate and provide the best care possible for their residents, resulting in improved quality of care and quality of life. It does this by encouraging staff to take the initiative when they see a change in condition of a resident and by promoting better communication and teamwork.

There are financial implications for unnecessary hospitalizations:

- Over $14 billion Medicare dollars a year are spent on 1.3 million hospital stays for skilled nursing facility residents – and a significant percentage of these stays can be avoided.
- Hospitals are financially penalized for high re-admission rates. They will send patients to nursing homes that can manage resident care without unnecessary re-hospitalizations.
- Nursing home regulations and payment models are changing. We need to find a way to provide high quality care at a lower cost.
- ACOs are not partnering with centers that don't use INTERACT to help prevent unnecessary hospitalizations.

INTERACT process flow diagram

The Good Samaritan Society has a process diagram that illustrates how the INTERACT tools can be integrated into the daily workflow of the center. You can request this process diagram from the center's administrator or quality assurance performance improvement (QAPI) coordinator. These individuals can also answer any questions you have about how the center incorporates INTERACT into its every day processes.

Nursing Home Capabilities List

Your center may have a Nursing Home Capabilities List. This list helps guide physicians and discharge planners when making decisions related to hospitalizing residents and admitting new residents to the center. At some point, the center may request your assistance in assessing and improving upon nurses' skills, or ask your advice about adding new capabilities/services.

What communication to expect from a center that uses INTERACT

The center will contact you under the following circumstances:

- Upon admission, the center completes the **medication reconciliation** process. At that time, the center will contact you regarding medication discrepancies or if clarifications are needed.
- Advance care planning (ACP) discussions to discuss end of life wishes take place with the resident and/or family shortly after admission to the center. The center will request physician's orders that align with the resident's wishes. The nurse may also provide information about advance directives when she calls about a change in the resident's condition.
- When a resident change in condition is noted, the nurse will complete an SBAR. The SBAR helps the nurse assess the resident, gather the important information and communicate with the physician in a structured way. The nurse will be able to answer your questions about the reason for the call, provide background information and details of the assessment of the resident and work with you to request appropriate orders/treatment for the resident's condition.

INTERACT also provides decision support tools called **Change in Condition File Cards** and **Care Paths**. If you would like a copy of these tools, please ask the administrator or QAPI coordinator at the center.

The Medical Director's role

Your center needs your assistance in decreasing avoidable hospitalizations and successfully implementing and sustaining the INTERACT program. Please give the center administrator feedback on the quality of the communication and interactions you have with nurses when there is a resident change in condition. If there are issues of concern or you think the INTERACT tools are not being used appropriately, let the administrator know as soon as possible so that he or she can follow up with center staff. We ask that you educate the physicians you work with about the services the center is capable of providing in-house, so that we can avoid transferring residents to the hospital unnecessarily.

The center's QAPI leadership team (Administrator, Director of Nursing and QAPI Coordinator) will be monitoring data to evaluate processes related to hospitalizations and the appropriate use of the INTERACT program and tools. The center's QAPI committee, of which you are a part, will follow up on any concerns noted in the data. As a member of the QAPI committee, we value your input and ideas on actions to take to improve care processes.

Thanks so much for all you do in your role as our medical director and your assistance in making this focus on decreasing avoidable hospitalizations a priority.