SUCCESS STORY

# Regina Health Center reduces unnecessary hospital admissions using eINTERACT™ tool in PointClickCare

INTERACT™ is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in care facilities.



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## Organization Description

Regina Health Center (RHC) is a not-for-profit Medicare/Medicaid certified nursing facility with 101-licensed nursing beds, a special dementia care unit, 54 assisted living units, respite care services, and short-term inpatient and outpatient rehabilitation. Regina Health Center is regularly recognized for its superior quality of care. In 2014, U.S. News and World Report again named Regina Health Center among the best nursing homes in the country.

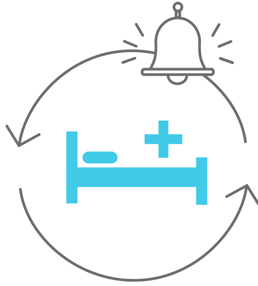
Located in Richfield, Ohio, Regina Health Center is part of Mt. Augustine, which is the motherhouse for the Sisters of Charity of St. Augustine. Over 50% of Regina's residents are retired and aging members of the Catholic clergy – every other resident you meet is a Sister, Brother or Father. Located on an expansive 230 acres of land that offers a peaceful environment with lovely grounds and outdoor gardens, Regina Health Center is located about 30 minutes from both Akron and Cleveland.

### Organization Type

- Skilled Nursing Facility
- Assisted Living
- Respite Care Services and Short-Term Inpatient and Outpatient Rehabilitation

### Category

**Clinical Decision Support Systems,** including those aimed at reducing inappropriate hospital admission and acute care transfers.



## Project Description

At Regina Health Center, there is a constant focus on quality, and they are always looking for ways to improve the resident experience and provide ongoing education to their staff.

In 2012, Regina Health Center's leadership recognized that their all-cause annual re-hospitalization rate was at a historical high of approximately 18%, and the threat of penalties was looming. Thus, they decided that it was an important strategic priority to focus on reducing unnecessary returns to hospitals and volunteered to participate in a study of Interventions to Reduce Acute Care Transfers (INTERACT) with a team from Florida Atlantic University, which afforded them the opportunity to support their mission of improving quality outcomes and the resident's everyday experience.

INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in care facilities. INTERACT uses a standardized, evidence-based set of tools to promote timely assessments, appropriate and timely communication to practitioners and the communication tools to make sure the right information is conveyed to practitioners to prevent transfer and, in the event a transfer becomes necessary, that the right information is delivered to hospitals. The intent of the INTERACT study was to measure the effect of implementing the standardized tools within a quality improvement framework in order to prevent unnecessary returns to hospital.

## Implementation Approach

This national INTERACT research study involved two phases. During the first phase, as part of a control group, the home continued with the status quo, tracking returns to hospital but not changing their current practice or approach. In the second phase, completed in March 2015, INTERACT was implemented in its paper format for the project.

Using funds donated for the purpose of education and staff retention, Regina Health Center paid for all staff to complete the Medline University INTERACT courses. Staff were paid at the regular rate for attending the classes on their own time and received CEU credits upon completion. The nurses diligently attended the required courses. Some of the State-Tested Nursing Aides (STNAs), however, struggled with self-paced learning and so a few small group sessions were established. To ensure an optimal educational experience for all, special attention was paid to the design of the physical learning environment, which included a dedicated training room with a large projection screen and comfortable seating in classroom style. This training room set-up improved attendance and helped to ensure all staff received the same information.

Introduction of the INTERACT program using paper forms had a profound effect on readmissions – not only did rates drop, but staff and physician communications drastically improved – residents and families were included in decision making and advanced directives became a more important part of resident care. Truly understanding and implementing a resident's wishes became part of the process with any transfer. Collaboration among physicians, clinical staff and the resident and their family lead to more informed decisions; including families and residents choosing to

stay at Regina Health Center to receive the necessary treatments and services. For example, if a resident understood that his/her lung infection could be treated with trained IV nurses at the Health Center, he/she was more likely to stay in place, avoiding a transfer and potential admission entirely.

And when a situation occurred where the resident did have to go to a hospital, consistent and comprehensive health information accompanied them, improving communications during the transition of care. The guidance provided through the INTERACT forms meant that it didn't matter what nurse completed the transfer documentation, the same information was compiled in the same way each time – facilitating a smoother transition for the resident, better informed ER staff and less aggravated nurses as the follow-up phone calls decreased with the improved tool set.

While participating in the INTERACT study, Regina Health Center decided to explore the use of an electronic healthcare record (EHR) system that could support such goals, improve MDS and documentation management, and build efficiencies into care and billing practices. In 2013, Regina Health Center selected PointClickCare as its EHR platform and during the second phase, they introduced electronic tracking of rehospitalizations with eINTERACT™, the industry's first software design effort to embed the INTERACT quality improvement process and tools directly into an EHR framework.

Regular reporting was required throughout both the control and implementation phases of the project. Manual tracking of admissions, discharges and transfers to the hospital on paper forms was tedious and error-prone, requiring long hours to complete and verify. The implementation of the eINTERACT Hospital "portal" in PointClickCare, changed all that.

"PointClickCare has been invaluable in tracking 30-day admissions and readmissions. Graphs were easily accessible to click on and send electronically to the INTERACT research group," explains Janet Cinadr, RN, MSN, and DON of Regina Health Center.

Of course, data collection isn't the only purpose of the INTERACT process. It is, after all, a QAPI (Quality Assurance/Performance Improvement) program. There is the analysis of the data that must occur to positively affect change and achieve outcomes. Quality improvement tools embedded in PointClickCare's eINTERACT program made data analysis and tracking easy.

"Of course, for analysis purposes -- times of day, MDs, days of week for readmissions, hospitals where the resident was sent -- all of this data was right there whenever we needed it," Janet stated. "PointClickCare also has information regarding the symptoms that precipitated readmissions, such as sepsis. And you can work with the team to see if signs and symptoms were there earlier, what chest x-rays or labs were or should have been done and whether the resident could have been treated prior to a temperature of 102 in the middle of night. In short, PointClickCare helps to analyze whether these were preventable or non-preventable readmissions."

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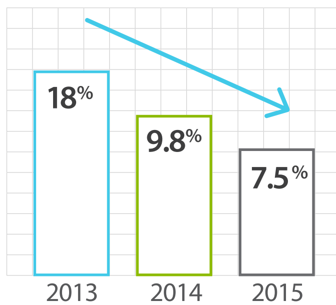
## Outcomes




**Annual readmission rate dropped 6 % with the implementation of INTERACT/eINTERACT.**

Regina Health Center achieved positive outcomes as a result of implementing INTERACT/eINTERACT. Their annual readmission rate dropped – 18% decreased to 12% with the start of the project and in 2014, the annualized rate dropped to 9.8%. Those are big gains for a small home in rural Ohio.

Management also saw an improvement in collaboration and communication and with physicians as well as changes and positive feedback from them regarding transfers. Residents felt like they were involved in the process and decision-making, and not just the subject of it. INTERACT changed the way doctors viewed the nurses and improved trust amongst staff. Knowing that the nurses were using and following the care cards and care paths with information provided in a consistent format, along with remote access to the EHR, helped physicians review notes themselves and make the best decision for a given resident at that time.

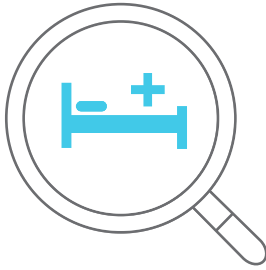
Management strategies were also positively affected by the use of both INTERACT and EHR technology. Managers were able to collaborate using real-time information, from any location, empowering staff to make the right decisions at the right time.

Janet adds "I feel the readmission rate has decreased from the alerts and reading of the nurses' notes on a daily basis. If I see from home a temperature alert and a nurses' note regarding a specific resident on a weekend, I call and make sure labs have been ordered for Monday morning. Reviewing the weights and vital signs alerts, dashboard, and communication takes only 10-15 minutes in our 100 bed facility. This is a good use of my time."

## Challenges and Pitfalls to Avoid

As with any new project, there were challenges the team at Regina Health Center encountered.

Initially, the biggest obstacle was the time it took to implement the INTERACT program. The DON and education nurse spent many hours implementing the program for the team. The training provided by Medline University was 12 hours in total, but Regina was able to pay nurses for their time to complete the online training at home. Nurses also received free contact hours they could use to meet licensure requirements. All full-time nurses completed the program, while 80% of part-time nurses and as needed PRN nurses were able to participate. It proved to be a challenge to get the STNAs to complete the course work at home. Each module was four hours in length. This was difficult for STNAs, in part, because many lacked access to a home computer. Instead, the team formed small group classes, each an hour in length during work hours to get all full time aides trained. Because Regina Health Center was part of the INTERACT research project, the staff were able to complete the training at no cost.



**Another challenge** that ultimately proved to be an extreme benefit in disguise, was the ability to analyze monthly hospital admissions and changes in condition. The INTERACT tool helped guide the team to determine if hospital admission was necessary or avoidable. Additionally, they were able to use the information for teaching staff how to improve their assessments and communication with physicians.

Gathering interdisciplinary support was not as easy as Regina Health Center leaders had hoped. The social worker and admissions director completed their modules online. The DON scheduled one hour sessions for the activities staff and housekeeping/laundry staff to be trained. What was most difficult was rallying the physicians to participate in the training.

## Lessons Learned/Advice to Share with Others

Regina Health Center made INTERACT and reducing unnecessary transfers a priority and now it is the way they do business every day. Management buy-in and leadership support is important, but the staff and rest of the care team need to be part of the process.

### Here are some of those lessons learned at Regina Health Center:

1. Training is important and needs to be provided to all levels of staff – starting with management. The process needs to be all encompassing, which means everyone needs to be involved to ensure optimal outcomes.

2. Doctors must be on-board. Even the part-time and locums. Doctors have a huge impact on readmissions – the more they know, the better the outcomes. Make sure they can access the EHR remotely.

3. Advanced directives are important. Have them clearly identified but don't treat them like they are written in stone. They are worth considering with every transfer. Things change.

4. There needs to be more conversation at the bedside about the transfer – be sure to include the resident in decision-making regarding a possible hospital return. Sometimes explaining to the residents and their family that you have the resources to take care of them in their current home is enough to have them stay.

5. Use technology to support your goals. PointClickCare provides an avenue for management to see what is going on where, focus attention where it is needed and automate workflows, removing the hassle of manually managing the process.

Implementing any new strategy, policy, procedure, or program can always be a chore but INTERACT makes it easy by providing all the necessary tools. PointClickCare augments this by building it into the workflow within the EHR. The two together bring INTERACT to life and enabled Regina Health Center to make it the way they do business to improve outcomes and keep readmissions at bay.

**Janet Cinadr** - RN, MSN, Director of Nursing, Regina Health Center

PointClickCare has helped over 12,000 skilled nursing and senior living facilities meet the challenges of senior care by enabling them to achieve the business results that matter – enriching the lives of their residents, improving financial and operational health, and mitigating risk. PointClickCare's cloud-based software platform takes a person-centered approach to managing senior care, connecting healthcare providers across the senior care continuum with easy to use, regulatory compliant solutions for improved resident outcomes, enhanced financial performance, and staff optimization. For more information on PointClickCare's ONC certified software solutions, please visit www.pointclickcare.com

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