Caring for the Ages

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Telehealth Advances Provide Innovative Solutions to Complex Resident, Facility Needs

Brian Ellis

The pressure has been mounting for skilled nursing facilities to prevent avoidable hospitalizations, and a statistic from the Centers for Medicare & Medicaid Services (CMS) explains why. According to CMS, among Medicare-Medicaid enrollees in long-term care facilities, 45% of hospital admissions could have been avoided. And these hospitalizations, in addition to increasing expenditures for CMS and SNFs, can have dire consequences for residents.

"We see this happen all the time, where somebody who has been fairly stable gets a small thing like a minor respiratory infection, is sent to the emergency room [ER], and the patient is never again the same — even after just an 8-hour ER visit, for whatever reason. And there is good evidence behind it," said Karl E. Steinberg, MD, CMD, HMDC, chief medical officer for Mariner Health Central in California, and vice president of AMDA — The Society for Post-Acute and Long-Term Care Medicine. "So a big goal of ours is to treat people in place."

Photo by Linda Whitman

Experts are optimistic about the prospects of telehealth and are convinced that it will become a necessary part of delivering care.

One way to help accomplish this goal, according to many in the post-acute and long-term care (PALTC) space, is through telehealth, which involves the use of technology to deliver health care services. Telehealth systems typically include bidirectional video conferencing, ancillary devices (e.g., a stethoscope or otoscope), a doctor or other practitioner on the other end of the communication,

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10 Years of INTERACT: The Push for Better SNF Care

Christine Kilgore

Ten years ago, Joseph G. Ouslander, MD, a geriatrician at Florida Atlantic University (FAU), published the findings of a pilot project that tested tools and strategies to help nursing home staff reduce potentially avoidable hospitalizations. The six-month quality improvement project in Georgia led to a 50% reduction in overall hospitalizations in three nursing homes selected based on their high hospitalization rates (*J Am Med Dir Assn* 2009;10:644–652).

Interventions to Reduce Acute Care Transfers (INTERACT), the quality improvement program born of that Georgia pilot project and supported by the Centers for Medicare & Medicaid Services (CMS), is a familiar name today throughout much of the skilled nursing community. Under the tutelage of Dr. Ouslander, now the senior associate dean for geriatric programs at FAU and executive editor of the *Journal of the American Geriatrics Society*, the program has been further developed.

Now in its fourth version, INTERACT focuses on the early recognition and management of acute changes in condition. It incorporates a dozen tools for communication and documentation (such as the Stop and Watch tool, the SBAR

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Communication Form and Progress Note), for advance care planning and hospital communication, for decision support (Care Paths), and for quality improvement (the Hospitalization Rate Tracking Tool and a tool for retrospective review of acute care transfers).

It's not clear how many are using INTERACT today, but the program clearly has a foothold in the new landscape of value-based care and quality assurance performance improvement. Its components were widely implemented throughout CMS's seven-site Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, begun in 2012. The components also are being embedded into electronic health record (EHR) software by over a dozen vendors who have license agreements with FAU, which owns the intellectual property of INTERACT. (The paper tools are publicly available at www.pathway-interact.com.) A version of INTERACT for assisted living has recently been developed as well.

The main challenge with INTERACT, according to Dr. Ouslander and several users of the program, lies in its implementation. "INTERACT is really just a program that people can use to meet quality goals, but it has to be implemented effectively," said Dr. Ouslander. "I don't think that using a couple of tools some of the time will work ... you have to make providing good quality care part of your everyday practice."

Buy-in from leadership is important, as is a true grassroots effort, said Albert Lam, MD, a California geriatrician who founded a program called SNF 2.0 to teach and empower frontline team members to embrace and implement INTERACT. "Grassroots efforts have cultural memory that outlasts changes in leadership," he said.

Josie Enriquez, MSN, RN-BC,NE BC, CNL, FACDONA, CIC, CDP, CADDCT, credits her own successful implementation of INTERACT in two separate skilled nursing facilities (SNFs) largely to the on-the-ground coaching and nurse/doctor roleplaying exercises that gave the nurses confidence in using the SBAR tool (which stands for Situation, Background, Assessment, Recommendation) to communicate with attending physicians. She also hung Stop and Watch tools "all over the buildings" so that all staff, including housekeeping, would be reminded of their role in alerting nurses to changes in the residents' conditions. She was vigilant about using the full range of INTERACT tools, including the quality improvement components.

"What I've learned is that you can't teach INTERACT in a typical lecture setting ... and that you need to include everyone — the whole interdisciplinary team — if you really want to have a cohesive and comprehensive process for preventing hospitalizations," said Ms. Enriquez, now the regional director of health services at Lifespace Communities. "You also can't pick and choose a tool. If you want to be successful, you have to try your best to incorporate them all."

What Research Has Shown

INTERACT's second major test — after the successful 2009 pilot project and subsequent refinements made with the input of nursing home providers and other experts — was a larger quality improvement project supported by the Commonwealth Fund. This time the program was implemented at 25 community-based nursing homes in Florida, Massachusetts, and New York (including several Lifespace Communities in

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Caring *for Consumers*

Deprescribing: A Systematic Approach to Downsizing Your Drug Regimen

Daniel Haimowitz, MD, FACP, CMD, a Pennsylvania-based multifacility medical director, talks about deprescribing done right.

You may have heard the term "deprescribing," but it's important to know what it means — especially for you and your older loved ones. Deprescribing is a planned, organized process of dose reduction or stopping of medications that may no longer be needed or match someone's goals of care, that might be causing harm or increasing the risk of complications (such as falls or sleeping problems), or that may have risks that outweigh the benefits.

The average person over age 65 takes between nine and 13 prescription medications, and that number is even higher for those with multiple illnesses and chronic conditions. Taking lots of medications is known as *polypharmacy*, and it has many negative consequences. These can include excessive costs, adverse drug events, emergency department visits, hospitalization, and even death. Most commonly, people who are taking many drugs may experience depression, weight loss, memory problems, sedation (feeling tired and lethargic), and a reduced quality of life.

Of course, medicines are prescribed to help you or your loved one. However, one practitioner may not know what others have prescribed for you or how long you have been taking various medicines or why. It is important to keep an updated list of medicines you take — including over-the-counter medicines, herbal and alternative products, and vitamins and supplements. Give a copy of this list to every new practitioner you see. Don't assume that they know what you're taking and why.

As people age, get sicker, and have more illnesses and health problems, the risks and benefits of various medications can change. Your practitioner can work with you to weigh the value of any drug you or your loved one may be taking.

You should never just stop taking a medication on your own, even if you think it is causing side effects or other problems. This could make you feel even worse and may cause great harm. If you are having any problems (such as dizziness, nausea, diarrhea, constipation, rash, etc.), tell your practitioner right away. Don't assume that the problem isn't a big deal or will go away on its own. Your practitioner will work with you on the safest, best course of action, which might mean stopping a drug, tapering down off it, changing to a different drug, or adjusting doses. Sometimes a medicine is prescribed for a side effect of another medication, and the best solution might be to stop both drugs.

Questions to Ask Your Practitioner

- How many medications are too many?
- How do I know if I'm taking the right medications?
- Would it be safe and possible to stop any of these medications?
- Medications are so expensive. How can I cut my loved one's or my drug costs?
- If a drug makes me feel bad, why shouldn't I just stop taking it?

What You Can Do

- Keep an up-to-date list of all the prescription drugs and over-the-counter products you or your loved one are taking.
- Tell every practitioner who cares for you what medications you are taking before you get a new prescription. Let him/her know about any bad reactions to a medication in the past.
- Don't change or skip a dose or stop taking a prescription medication without talking to your practitioner first.
- Take all medications as prescribed. Follow the special instructions such as taking with food or before bedtime.

For More Information

- Bruyère Research Institute, "What Is Deprescribing?" Deprescribing.org, Nov. 2015, https://deprescribing.org/what-is-deprescribing/
- Lisa Esposito, "Deprescribing Medications for Older Adults," *U.S. News & World Report*, Jan. 17, 2018, http://bit.ly/2WbLIOI
- Jesse Jansen et al., "Too Much Medicine in Older People? Deprescribing Through Shared Decision Making," *BMJ* 2016;353:i2893, https://doi.org/10.1136/bmj.i2893

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Caring for the Ages is the official newspaper of AMDA – The Society for Post-Acute and Long-Term Care Medicine and provides post-acute and long-term care professionals with timely and relevant news and commentary about clinical developments and about the impact of health care policy on long-term care. Content for *Caring for the Ages* is provided by writers, reporters, columnists, and Editorial Advisory Board members under the editorial direction of Elsevier and AMDA.

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Florida). Over a six-month period, there was a 17% reduction in all-cause hospitalizations among all participating nursing homes and a 24% reduction among those who were most "engaged" in the program (*J Am Geriatr Soc* 2011;59:745–753).

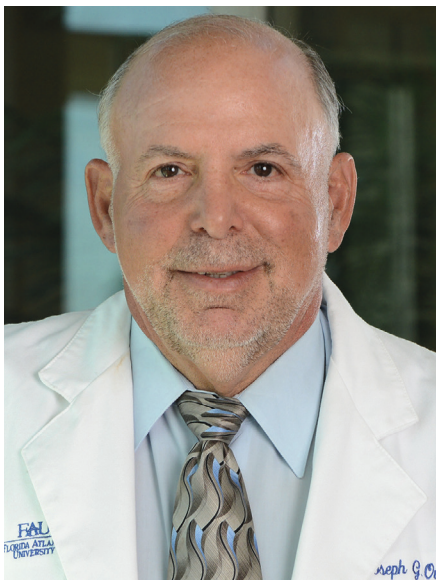
A subsequent randomized trial of the program produced disappointing results, however. The 85 nursing homes that received remote training and support for implementing INTERACT had no significant reduction in overall hospital admissions compared with the nursing homes that received no training or support. They also had no significant differences in readmission rates or emergency department visits. The one positive result was a reduction in hospitalizations that were deemed potentially avoidable (although it wasn't a statistically significant difference after correction for multiple comparisons). "The magnitude implied a nearly 15% reduction in potentially avoidable hospitalizations relative to the pre-intervention rate for intervention nursing homes," the investigators led by Robert Kane, MD, reported (*JAMA Intern Med* 2017;177:1257–1264).

Dr. Ouslander said the latter study was affected by the passage of time and a change in the national policy climate shortly before it began. Medicare had implemented its policy of penalizing 30-day readmissions, and there was evidence that some of the nursing homes in the control group were using parts of the INTERACT program on their own. On the flipside, many of the nursing homes in the intervention group did not fully utilize or participate in the training curriculum. Both these issues muddied the evaluation, he said.

Since then, a handful of recently published secondary analyses supported by the National Institute for Nursing Research have validated INTERACT's content and value, Dr. Ouslander said. One analysis combined the intervention and control groups and compared their outcomes according to the degree of INTERACT use. The SNFs that reported an increased use of the tools had significantly greater reductions in all-cause hospitalizations and potentially avoidable hospitalizations compared with those that stayed the same or decreased their use of the tools (*J Am Geriatr Soc* 2018;66:1830–1837).

Another secondary analysis of the randomized trial data looked at all the reported acute changes in condition (*J Am Geriatr Soc* 2018;66:2259–2266). Most changes were nonspecific and multifactorial (e.g., altered mental status or shortness of breath), and only 10% resulted in a hospital transfer between 72 hours and 7 days after the change. "Ninety percent of the [residents with changes in condition] stayed in the facility and were managed there," Dr. Ouslander pointed out. According to another secondary analysis, the providers in the trial rated almost 25% of the transfers that did occur as potentially avoidable (*J Am Med Dir Assn* 2016;17:256–262).

With respect to resident safety during the implementation of INTERACT, an analysis of the Minimum Data Set (MDS) data for eight different measures — including dehydration, pressure ulcers, changes in fall rates, and septicemia — found no significant differences in the percentage of residents with these outcomes when comparing the intervention and control SNFs in either the year preceding the intervention or during the intervention, and no differential change in these measures for intervention SNFs relative to controls (*J Am Med Dir Assn* 2018;19:907–913).



Joseph G. Ouslander, MD

"We were concerned that when staff try to manage sicker people in the facility, this could have an impact on quality measures," Dr. Ouslander said. "Fortunately, this did not occur."

What Experience Tells

In Dr. Lam's SNF 2.0 program, a nurse practitioner trained in INTERACT and in key mentoring and teaching principles visits the SNF over a six-month period to conduct group training and work one-on-one with nurses and aides in order to understand their jobs and point out opportunities for integrating INTERACT tools into the daily workflow. "The goal is to pique curiosity," Dr. Lam said. "To look for teachable moments."

Dr. Lam, who chairs the Department of Geriatric Medicine at the Palo Alto Foundation Medical Group, built the program after talking with colleagues and realizing that many SNFs faced similar issues with changes in condition going unnoticed and unaddressed. He looked into INTERACT in 2012 and "saw that the program was powerful," but he worried about the ability of SNFs to implement it.

"I realized that those who didn't know about it might not even be equipped to do it, and that those who had started to do it weren't really embracing the whole program," he said. With initial funding from the California Health Care Foundation and subsequent funding from the California Association of Long Term Care Medicine (CALTCM) — as well as funding from some of the SNFs that got involved — Dr. Lam built and tested SNF 2.0. He incorporated parts of various change-management and educational theories. And as facilities began to use the program, he documented significant reductions (33% to 66%) in their admissions and readmissions.

Today, over 50 facilities have implemented INTERACT using SNF 2.0, and the program has made a home at CALTCM, where Dr. Lam and colleagues have more recently created a broader "ecosystem" of hospitals, health plans, and medical groups that speak the INTERACT language and support quality improvement in SNFs. Facilities are now paying for the program themselves.

Outside California, in the SNFs of Lifespace Communities (or "health centers" as they are called there) INTERACT has empowered frontline staff — not only nursing aides but staff who work in the culinary, maintenance, and housekeeping departments as well — to have a voice in the well-being of residents, said Sara Elizabeth Hamm, DNP, RN, senior vice president of successful aging and health services at the West Des Moines, IA–based company. "Our frontline team members are the eyes and ears of our nurses," she said. "This system gives them wings."

Lifespace last year adopted PointClickCare for each of its 12 campuses, and as part of its EHR agreement it purchased the eINTERACT platform. Parts of INTERACT are being embedded into various EHR products, but PointClickCare's eINTERACT was developed by the company in partnership with FAU.

Dr. Ouslander considers EHR integration to be the most significant milestone thus far in the history of the program, and Dr. Hamm said that for her facilities it will move the needle even further toward better SNF care and fewer hospitalizations. "Before we converted ... there were some INTERACT tools that were not being utilized simply because it was difficult," she said. In the meantime, the "lessons we've learned using INTERACT in our health centers are really helping us in assisted living and residential living," Dr. Hamm added. "We identify changes in condition when they're early and subtle so residents won't be prematurely admitted to the health center or sent to the hospital."

Kevin W. O'Neil, MD, CMD, helped develop and test a modified version of INTERACT for assisted living and memory care while he was chief medical officer with Brookdale Senior Living. Today, as chief medical officer with Affinity Living Group of Hickory, NC, he is implementing it stepwise in Affinity's assisted living communities. The Stop and Watch tool is basically the same, he noted, but the SBAR form has been changed to Appearance & Request.

"What gets us into the most trouble [in SNFs and throughout health care] are usually communication gaps — things falling through the cracks," said Dr. O'Neil. "The INTERACT program creates a discipline around the processes that are needed to reduce avoidable hospitalizations."

Dr. Ouslander disclosed that he receives royalties and serves as a paid advisor to Pathway Health, which has a license agreement with FAU for use of INTERACT materials and training.

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Parkinson's

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scale for assessment of positive symptoms (SAPS-PD) — a 37% improvement — with use of the drug, although the rating scale used in the study had not been previously validated (*Lancet* 2014;383:533–540).

PD dementia is also common, especially with a longer duration of PD (>70% at 5 years), Dr. Gammack noted. Research has looked at stimulants, cholinesterase inhibitors, and memantine in patients with PD (all off-label), and thus far cholinesterase inhibitors have the "best evidence" for a small improvement.

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