2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)

Project Objective: Skilled nursing facilities (SNFs) will implement the evidence-based INTERACT program developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation, with the support of a contract from the Centers for Medicare and Medicaid Services (CMS).

Project Description: INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program focusing on the management of changes in a resident's condition, with the goal of stabilizing the patient and avoiding transfer to an acute care facility. The program includes clinical and educational tools and strategies for use in everyday practice within long-term care facilities. The current version of the INTERACT Program was developed by the INTERACT interdisciplinary team under the leadership of Dr. Ouslander, MD, with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) and supported by the Commonwealth Fund. This DSRIP project will further increase the impact of INTERACT by integrating INTERACT 3.0 tools into SNF health information technology through a standalone or integrated clinical decision support system.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.
2. Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.
3. Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4. Educate all staff on care pathways and INTERACT principles.
5. Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.
6. Create coaching program to facilitate and support implementation.
7. Educate patient and family/caretakers, to facilitate participation in planning of care.
8. Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.
9. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
10. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Analyses suggest that a high percentage of hospitalizations from SNFs are avoidable. Most studies use ambulatory care sensitive conditions - pneumonia, UTI, CHF etc. - to estimate numbers of avoidable hospitalizations. In one, 23% of $972,000,000 spent on hospitalization of NY SNF residents was attributable to ACS conditions. In another, 37% of hospitalizations from SNF were for ACS and potentially avoidable. The USDHHS OIG estimates that nationally, 25% of SNF patients are transferred into acute care, up 154% from 1996 to 2010. In addition to increasing cost, SNF to hospital transfers increase risk of negative patient outcomes. Locally, a SNF transfer avoidance project (NYRAH) reports that +/- 70% of residents are admitted when transferred to the hospital. Although the PPS was unable to document the percentage of SNF transfer patients that could have been returned to SNF, the planning group indicated this number was significant. A national study documented that through use of INTERACT tools, readmissions can be reduced by 17-24%, and so to reduce the number of admissions from SNFs, the PPS will fully implement INTERACT in all partner SNFs and hospitals. The PPS will build/deploy a team of trainers to fully implement INTERACT among SNFs. These RNs will train SNF inservice staff, preparing them to train/update all staff (all shifts). The team will monitor and evaluate use of the tools, conducting chart reviews to ensure that tools are used for all acute changes of condition (not just those resulting in transfer). To improve off-hour shift compliance, engagement and training at per diem agencies will be pursued. SNF Nursing Directors will be “facility champions,” oversee implementation, and instill the value of INTERACT among all staff. “Champions” will work with Medical Directors to build acceptance among SNF and community physicians. SNF staff will be trained in INTERACT Care Pathways, to ensure consistent patient monitoring, early identification of potential instability, and intervention to avoid transfer. SNFs will complete and share the Capabilities List with relevant staff at partner hospitals to ensure understanding of what conditions can be treated within SNFs to avoid admission.Using a “learning collaborative”, SNF and hospital representatives will meet regularly, share successes and difficulties, evaluate ideas and monitor outcomes. Working together, SNF, ED, hospitalists and discharge planners will build understanding of capabilities and reduce readmission. This group will monitor outcomes, including cause of transfer, using the Quality Improvement Tool, to identify opportunities for improvement. ED visits by SNF patients will be reviewed routinely to determine if service or staffing enhancements at SNFs or other strategies - mobile diagnostics, clinical consultation teams and “captive staffing agencies” - could reduce ED use. Use of INTERACT tools will be monitored to ensure that all staff flag potential status changes, reporting these to nursing, and that SBAR is used consistently to alert physicians to status changes and reviewed at the facility’s “24-hour report”. SNFs will implement the INTERACT Advance Care Planning tools or NYS DOH-approved MOLST forms to assist

patients/families in documenting/expressing wishes regarding end of life care, to avoid unnecessary transfers.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

While 76% of SNF patient days in NY are paid for by Medicaid, INTERACT implementation will effectively target all partner SNF patients, as policies will be instituted regardless of payor source. The project will target both short-stay patients and long-stay residents at all of the SNFs in the PPS. This will include Medicaid beneficiaries, Medicare beneficiaries, dual-eligibles, those who are receiving Veterans' benefits, and those who are private pay and/or currently uninsured. Over the course of the project, the PPS SNFs expect to engage 100% of their patients through the INTERACT protocol implementation.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Medical Directors, Directors of Nursing (DONs), and in-service staff at all facilities will be mobilized to develop and deploy comprehensive training in and monitoring of INTERACT implementation. The PPS will designate the SNF DON as the facility champion at each SNF, and this individual will become familiar with and conversant in all aspects of the program. Working with the PPS training team and the DON, the in-service staff will train all SNF staff in the use of the complete INTERACT toolkit. The DON and SNF Medical Director will engage all admitting and covering physicians in the project, its function and impact. Achieving support and buy-in of these physicians will be critical to achieving success in reducing admission from SNF to acute care. SNF admission staff will also engage with patients and families to build understanding of the value of "treating in place" for SNF residents. Each hospital Emergency Room (ER) will designate a staff person(s) as SNF transfer liaison. Each time a transfer is in process, this individual will be contacted by the SNF, alerted as to the reason for transfer, and given pertinent clinical details. As the patient is evaluated at the ER, the liaison will communicate with SNF personnel to advise them of patient status, and discuss any questions regarding the SNF's ability to address the patient's needs upon return to SNF. As necessary, ER physician to SNF Medical Director communication will be facilitated.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The PPS conducted several surveys of the SNFs to inform project development. According to the survey results, 74% of the partner SNFs have some experience using the INTERACT program. Of these, however, not surprisingly, regular use of program tools varies greatly, and during project planning it became clear that most – if not all – of the SNFs that have experience with INTERACT

tools have not thoroughly embedded the tools consistently within their operations to maximize impact. For example, some SNFs complete the SBAR only when a hospital transfer occurs, diluting its impact to avoid a hospital transfer. In summary, every SNF will benefit from a more thorough and robust training and monitoring protocol on the use of the various INTERACT tools. INTERACT implementation will address the fact that partner SNFs are at varying stages of EHR adoption. At present, 91% of partner SNFs have or plan to have an EHR in place by April 1, 2015. Among these facilities, many different EHR platforms are utilized. The vast majority of those who use INTERACT tools, do so on paper. Bringing all SNFs onto EHR and creating system-wide connectivity will take time and training. The PPS will develop a simple interface (e.g., using Direct Messaging) to link SNFs to hospital partners in the short term and this will be built upon as full connectivity becomes more or a reality. Consistent with PPS goals, electronic connectivity with hospital partners will be completed over the project lifetime. The SNFs will work with the local RHIO to ensure useful electronic communication. As INTERACT tools are embedded in EHR products, SNFs will move from paper to electronic use of these tools. Efforts to engage the multiple staffing agencies relied upon by SNFs for weekend coverage to ensure that these weekend staff learn to properly use INTERACT tools may prove cumbersome, but will be pursued. Because many family members believe that quality of care is associated with the level of clinical intervention, acceptance by patients/families of the benefits of avoiding readmission may be a significant challenge to project success. All SNFs will provide orientation materials at facility admission outlining the policies and benefits of transfer avoidance, as well as materials on advance care planning.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

There is no other PPS within the service area.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess

speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☐	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. James Rehab. and Healthcare Center	Ny-RAH	9/23/12	9/22/16	Reducing Avodiable Hospitalizations
Long Island Association of AIDS Care	Health Homes			case management

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Suffolk Center for Rehab and Nursing	NY-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations
Gurwin Jewish Nursing and Rehab	NY-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations
Riverhead Care Center	NY-RAH	9/23/12	9/22/16	Reducing Avoidable Hospitalizations

c. Please describe how this proposed DSRIP project either differs from, or significantly expands

upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones &**

Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.