Suffolk Care
Collaborative

Consolidated Project Information

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

Contents

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

2.b.vii Project Objective & Requirements

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).

The project must clearly demonstrate the following 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.

2.b.vii Requirements Matrix by Provider Type

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
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.							X		X
2) Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.							X		
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.									X
4) Educate all staff on care pathways and INTERACT principles.							X		
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.									X

	Primary Care Physicians	Hospitals	Clinics	Health Home/Care Management	Behavioral Health	Substance Abuse	Skilled Nursing Facilities/ Nursing Home	All Other	PPS Project Level
6) Create coaching program to facilitate and support implementation.							X		
7) Educate patient and family/caretakers, to facilitate participation in planning of care.									X
8) Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	X						X		X
9) Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.									X
10) Use EHRs and other technical platforms to track all patients engaged in the project.									X

2.b.vii Milestones & Metrics

Color Legend
Project System Changes
Project Requirements with Specific Time Periods
Project Requirements tied to PPS Speed and Scale Commitments

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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.	INTERACT principles implemented at each participating SNF.	Quarterly reports demonstrating successful implementation of project requirements	Project
		Nursing home to hospital transfers reduced.	Baseline nursing home to hospital transfer volume with periodic reports demonstrating decrease in transfers	Provider (SNF)
		INTERACT 3.0 Toolkit used at each SNF.	Evidence of INTERACT 3.0 toolkit use and rationale	Provider (SNF)
2	Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Facility champion identified for each SNF.	Role description; CV (explicating experience with INTERACT principles); Contract; Certifications	Provider (SNF)
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.	Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Documentation of care pathway and clinical tool(s) methodology	Project
		PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Documented strategic plan for monitoring of critically ill patients and hospital avoidance; Implementation plan; Written training materials; List of training dates along with number of staff trained	Project
4	Educate all staff on care pathways and INTERACT principles.	Training program for all SNF staff established encompassing care pathways and INTERACT principles.	List of training dates along with number of staff trained; Written training materials	Provider (SNF)
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.	Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Evidence of tool(s)/Toolkit materials	Project
6	Create coaching program to facilitate and support implementation.	INTERACT coaching program established at each SNF.	List of training dates along with number of staff trained; Written training materials	Provider (SNF)

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
7	Educate patient and family/caretakers, to facilitate participation in planning of care.	Patients and families educated and involved in planning of care using INTERACT principles.	Patient/family education methodology; Patient/family involvement methodology	Project
8	Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification from CMS or NYS Medicaid	Project
		EHR meets connectivity to RHIO's HIE and SHINNY requirements.	QE participant agreements; sample of transactions to public health registries; use of DIRECT secure email transactions.	Provider (SN: PCP & SNF)
9	Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Quality committee membership list with indication of organization represented and staff category, if applicable	Project
		Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes	Project
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Project
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Documentation demonstrating distribution of quality outcomes	Project
10	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

2.b.vii Active Engagement Definition

For this project, Actively Engaged is defined as: The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
2.b.vii	1,914	148,118	1.3%	Avoided hospital transfer due to INTERACT	3

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 3:

- Counted within a DSRIP year; resets each year
- Patients are to be counted only once
- So long as "at least" one encounter with the patient resulted in A.E. definition being met, it counts towards total

e.g., if a patient visits the PCP 5 times a year but get a1C tested just one of those 5 times, she is actively engaged

2.b.vii Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 2.b.vii

Project	DY 0 (2014)		DY 1 (2015)		DY 2 (2016)		DY 3 (2017)		DY 4 (2018)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
2.b.vii						X				

Patient Engagement Speed for Project 2.b.vii

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	478	1148	765	1914	957	1914	957	1914
Expected # of Actively Engaged Patients	1914	1914	1914	1914	1914	1914	1914	1914	1914	1914

Rationale for Project 2.b.vii

The rationale related to project 2.b.vii implementation speed is as follows:

- INTERACT is already implemented at a number of locations so project implementation can occur earlier across the PPS

The rationale related to project 2.b.vii patient engagement speed is as follows:

- For this project, the number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.
- Patients are counted as those who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years**.**

The patient scale rationale is calculated as detailed below.

Patient Scale Rationale			
Readmission reductions		**ED Visit Reductions**	
Annual unique patients in SNF bed	8,332 Patients	**Annual unique patients in SNF bed**	8,332 Patients
Hospital Transfer Rate (65%)	5,409 Patients	**10% of patients avoid ED visits due to INTERACT**	832 Patients
Reduction rate in readmission due to INTERACT (20%)	1,082 Patients	**Total**	832 Patients
Total	1,082 Patients		
Expected # of Actively Engaged Patients	=	**1,914 Patients**	

References

Please see pages 24-30 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf