Suffolk Care Collaborative
Interventions to Reduce Acute Care Transfer Program

2bvii. Implementation of the INTERACT (Interventions to Reduce Acute Care Transfers) project to reduce Skilled Nursing Facility (SNF) transfers to hospitals

Project Charter

Through the Delivery System Reform Incentive Payment (DSRIP) Program, a grant waiver administered by the NYS DOH, $6.42 Billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of program life, the aim is for the newly-transformed system to be sustainable. Project efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Objective Statement:

Skilled Nursing Facilities within Suffolk County will implement the evidence-based INTERACT 4.0 Toolkit developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation. INTERACT 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. Implementation of the project will begin in January 2016 and end March 31st, 2017, at which time all 42 facilities within Suffolk County will have initiated implementation of the INTERACT Toolkit.

High Level Deliverables:

- Implement INTERACT at each participating SNF.
- Identify a facility champion who will engage other staff and serve as a coach and leader of the INTERACT program.
- 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.
- Educate all staff on care pathways and INTERACT principles.
- Implement Advance Care Planning tools to assist residents and families in expression and documenting their wishes for near end of life and end of life care.
- Create coaching program to facilitate and support implementation.

- Educate patient and family/caretakers, to facilitate participation in planning of care.
- Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.

Benefits: According to a national study published in the Journal of the American Medical Directors Association in 2014, "the INTERACT program has been associated with up to a 24% reduction in all-cause hospitalizations of nursing home residents over a 6-month period" (Ouslander et al., 2014). Overall goal of DSRIP is to reduce preventable hospital readmissions by 25% and INTERACT will contribute to that decrease.

Assumptions:

- Evidence based strategies will be implemented at each SNF in the PPS
- Stakeholder commitment and buy in to the project is strong as they feel implementation of the INTERACT Toolkit is an added benefit to their facility
- Each Director of Nursing will be the facility champion and trained as a Certified INTERACT Champion by INTERACT T.E.A.M. Strategies, LLC.

Constraints:

- Project budget, available workforce, and resources to contribute to implementation and the sustainability of the project
- Lack of EHR and connectivity between SNFs, hospitals and the community

High-Level Risks:

Of those who currently utilize INTERACT, most do so on paper. Additionally, wide variation in EMR systems exists among the PPS partners that have them. Among these facilities, many different EHR platforms are utilized. The PPS will develop a simple interface (e.g., using Direct Messaging, etc.) 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 weekend staff learn to properly use INTERACT tools may prove cumbersome. The PPS will create and disseminate a Provider Engagement strategy to support facility training of weekend staff in proper use of INTERACT tools and documentation through the PPS wide IT infrastructure.

Patients/families may be skeptical, or unaware, of the benefits from avoiding readmission. 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.

Success Criteria:

- Successful completion of all Domain 1 requirements, including meeting patient engagement and project engagement commitments
- Improvement throughout DSRIP Measurement Years across all Domain 2-3 outcome measurers (achievement of 10-20% gap to goal)
- Engagement of PCPs, non-PCPs, and BH providers in implementation of the Million Hearts Campaign
- Overall achievement of project objective
- Sources that influenced the development of the program is accepted by public, community and key project stakeholders

Stakeholder Analysis:

- 42 Partner Skilled Nursing Facilities within Suffolk County will be implementing the INTERACT 4.0 Toolkit to reduce the number of admissions to hospitals.
- Hospitals within Suffolk County will be oriented to the INTERACT principles and tools to enhance communication between facilities.

Closeout Criteria:

- Close out will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all Archive Data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 - 4
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

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. Analyses suggest that a high percentage of hospitalizations from SNFs are avoidable. According to a national study published in the Journal of the American Medical Directors Association in

2014, “the INTERACT program has been associated with up to a 24% reduction in all-cause hospitalizations of nursing home residents over a 6-month period” (Ouslander et al., 2014). To reduce the number of admissions from SNFs to hospitals, the INTERACT 4.0 will be implemented at each PPS SNF. Hospitals will be oriented to the INTERACT principles and tools to enhance communication between facilities. SNF Directors of Nursing will be facility champions and trained by INTERACT T.E.A.M Strategies, LLC to become Certified INTERACT Champions. Nurse Educators at each facility will also be trained to become Certified INTERACT Champions and will assist the Directors of Nursing in implementation, training of staff and instilling the value of the INTERACT program within their respective facility. Facility champions will work with Medical Directors to build acceptance among SNF and community physicians.

During implementation, SNF staff will be trained on the INTEACT Care Pathways to ensure consistent patient monitoring, early identification of potential instability, and intervention to avoid transfer. Each SNF will also complete the Capabilities List which will be given to partner hospitals to ensure understanding of what conditions can be treated within SNFs to avoid admissions. Learning collaboratives will be formed with SNF partners and hospitals to share lessons learned, best practices, and to monitor outcomes using the Quality Improvement Tool from the INTERACT 4.0 Toolkit. SNFs will also initiate INTERACT Advance Care Planning tools or NYS DOH-approved MOLST forms to assist patients and families in documenting wishes for end of life care to avoid unnecessary transfer.

References

Ouslander, JG., Bonner, A., Herndon, L. The Interventions to Reduce Acute Care Transfers (INTERACT) Quality Improvement Program: An Overview for Medical Directors and Primary Care Clinicians in Long Term Care. JAMDA 15 (2014) 162-170. http://www.interact2.net/docs/publications/Overview%20of%20INTERACT%20JAMDA%202014.pdf

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