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## INTERACT™



### Project goal

**Immediate:** Implement the INTERACT 4.0 Toolkit, demonstrated by active use of the toolkit, through the establishment of a facility champion and coaching, education & training program for SNF staff, patients and family members, and establish enhanced communication with acute care hospitals.

**Long-term:** Reduce potentially preventable emergency room visits (3M) and potentially preventable readmissions (3M).

### Interventions

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 early identification of potential instability and intervention to avoid transfer to an acute care hospital. Analyses suggest that a high percentage of hospitalizations from SNFs are preventable. 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 fully implemented at each PPS SNF. Hospitals will be oriented to the INTERACT principles and tools to enhance communication between facilities. Directors of Nursing will assist in the 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 INTERACT 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. During implementation, SNFs will also initiate INTERACT Advance Care Planning tools or NYS DOH-approved MOLST/eMOLST forms to assist patients and families in documenting wishes for end of life care to avoid unnecessary transfer.

### Patient Engagement Metric

The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.

### Clinical Metrics

- Potentially Preventable Emergency Room Visits - The number of preventable emergency visits as defined by revenue and CPT codes
- Potentially Preventable Readmissions - The number of readmission chains (at risk admissions followed by one or more clinically related readmissions within 30 days of discharge)
- PQI 90 - Composite of all measures - The number of people, age 18 and older, with an admission meeting one of the adult prevention quality indicators
- PDI 90 - Composite of all measures - The number of people age 6 to 17 meeting one of the pediatric prevention quality indicators
- Primary Care - Usual Source of Care - (CGCAHPS Survey -Q2) - Percent of Responses Yes
- Primary Care - Length of Relationship - (CGCAHPS Survey - Q3) - Percent of Responses at least 1 year or longer
- Adult Access to Preventive or Ambulatory Care - 20 to 44 years - The number of people age 20 to 44 who had an ambulatory or preventive care visit during the measurement year

(continued on reverse)



## Clinical Metrics (continued)

- Adult Access to Preventive or Ambulatory Care - 45 to 64 years – The number of people age 45 to 64 who had an ambulatory or preventive care visit during the measurement year
- Adult Access to Preventive or Ambulatory Care- 65 and older – The number of people age 65 and older who had an ambulatory or preventive care visit during the measurement year
- Getting Timely Appointments, Care and information (CGCAHPS Survey-Q6, 8, and 10) – The number of respondents who answered they called for appointment or called for information and “Usually” or “Always” got an appointment for urgent care or routine care as soon as needed and got an answer the same day if called during the day
- H-CAHPS – Care Transition Metrics (H-CAHPS Survey Q23, 24, and 25) – The average of Hospital specific results for the Care Transition composite
- Care Coordination (CGCAHPS Survey Q13,17 and 20) – The number of respondents who answered ‘Usually’ or ‘Always’ that the provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines
- Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement– The dollars paid by Managed Care Organizations under value based arrangements.
- Meaningful Use Certified Providers, who have a participating agreements - The number of eligible providers meeting meaningful use criteria, who have at least one participating agreement with a qualified entity (QE).
- Meaningful Use Certified Providers who conduct bidirectional exchange - the number of eligible providers meeting meaningful use criteria, who both 1) make data available and 2) access data using SHIN-NY with a QE.
- Medicaid Spending on ER and Inpatient Services – The total spending on ER and IP services.
- Medicaid Spending on Primary Care and community based behavioral health care - The total spending on Primary Care and Community Behavioral Health care as defined by MMCOR categories.

Tools to be employed: INTERACT 4.0 Toolkit

## References/Guidelines

1. INTERACT Version 4.0 Tools:  
<http://www.pathway-interact.com/tools/>
2. 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.pathway-interact.com/wp-content/uploads/2017/04/Overview-of-INTERACT-JAMDA-2014.pdf>