eINTERACT Overview & Update

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Introduction to eINTERACT™

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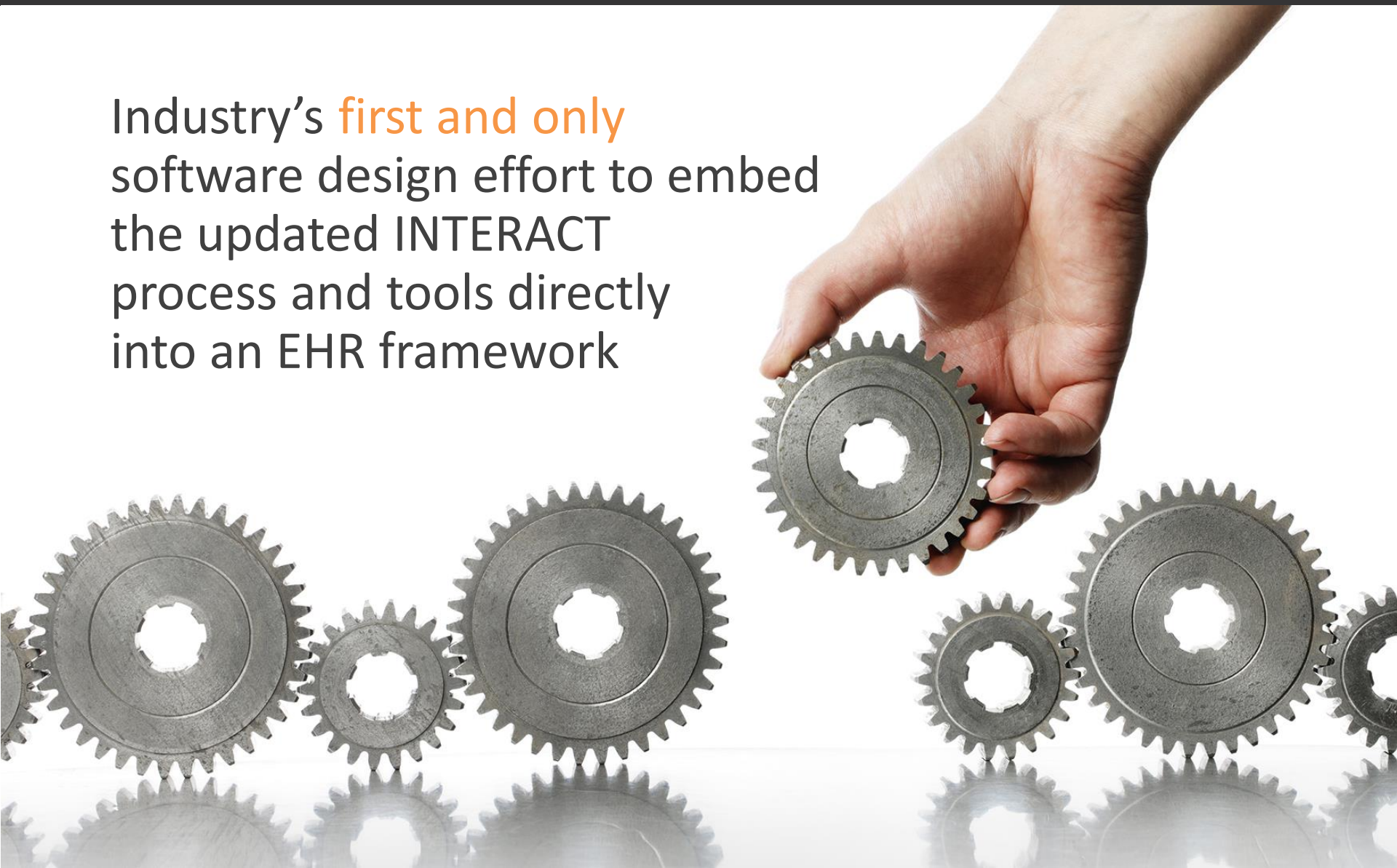
What is eINTERACT™?

Joint initiative between Florida Atlantic University's INTERACT project team and PointClickCare

What is eINTERACT™?

Industry's first and only software design effort to embed the updated INTERACT process and tools directly into an EHR framework



Objectives of eINTERACT

- Improve quality of care
- Proactively address resident issues and concerns
- Gain workflow efficiencies
- Eliminate duplication of work
- Improve adherence to program and tools
- Increase access to all resident information
- Higher likelihood of success of the INTERACT program

Expected Benefits of eINTERACT

Save Time & Money

Eliminate multiple systems and/or paper charts; no need for multiple disparate solutions; reduces time spent on manual tasks; no additional software or training costs for separate system

Ensure Compliance

Embeds INTERACT protocols directly within the workflow of the EHR; ensures compliance with INTERACT tools and protocols; higher likelihood of success through sustainable usage in core EHR

Resident Safety

Instant access to INTERACT information with rest of the resident charge for entire care team; proactively address issues and concerns with automated alerts in real time

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eINTERACT™ Vision & Roadmap

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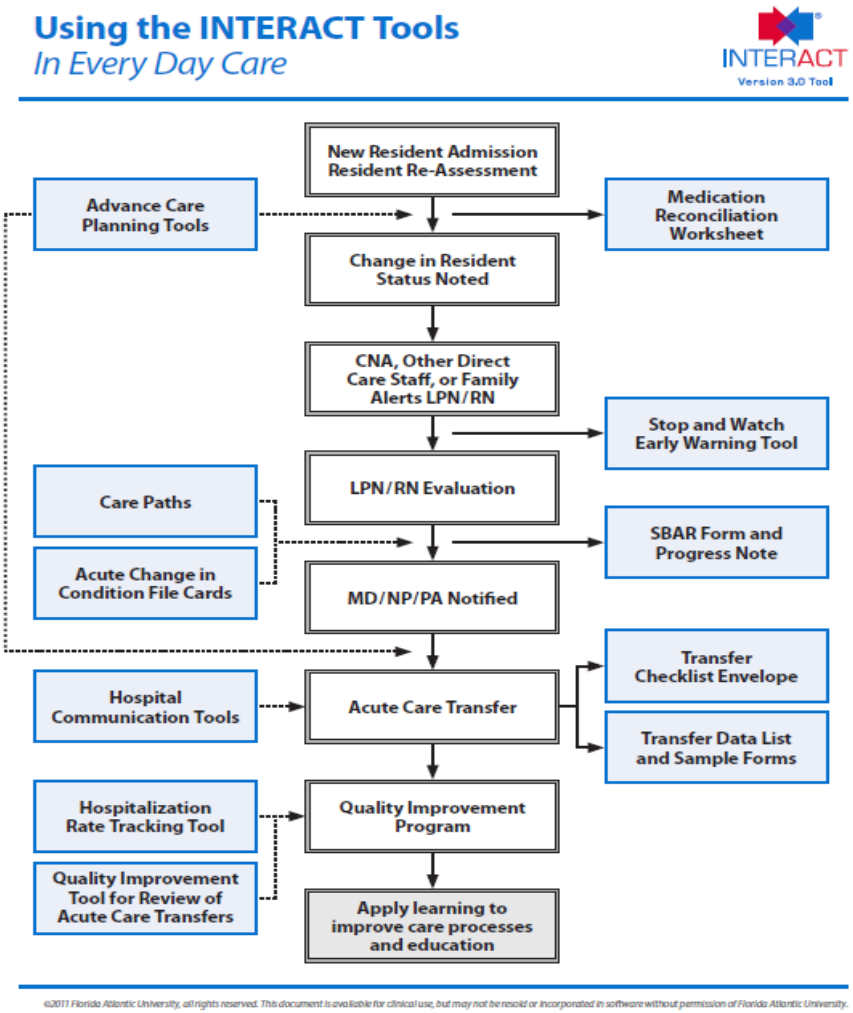
INTERACT Version 3.0 Tools

The INTERACT Version 3.0 Tools are available at:

http://interact2.net



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OUTCOME

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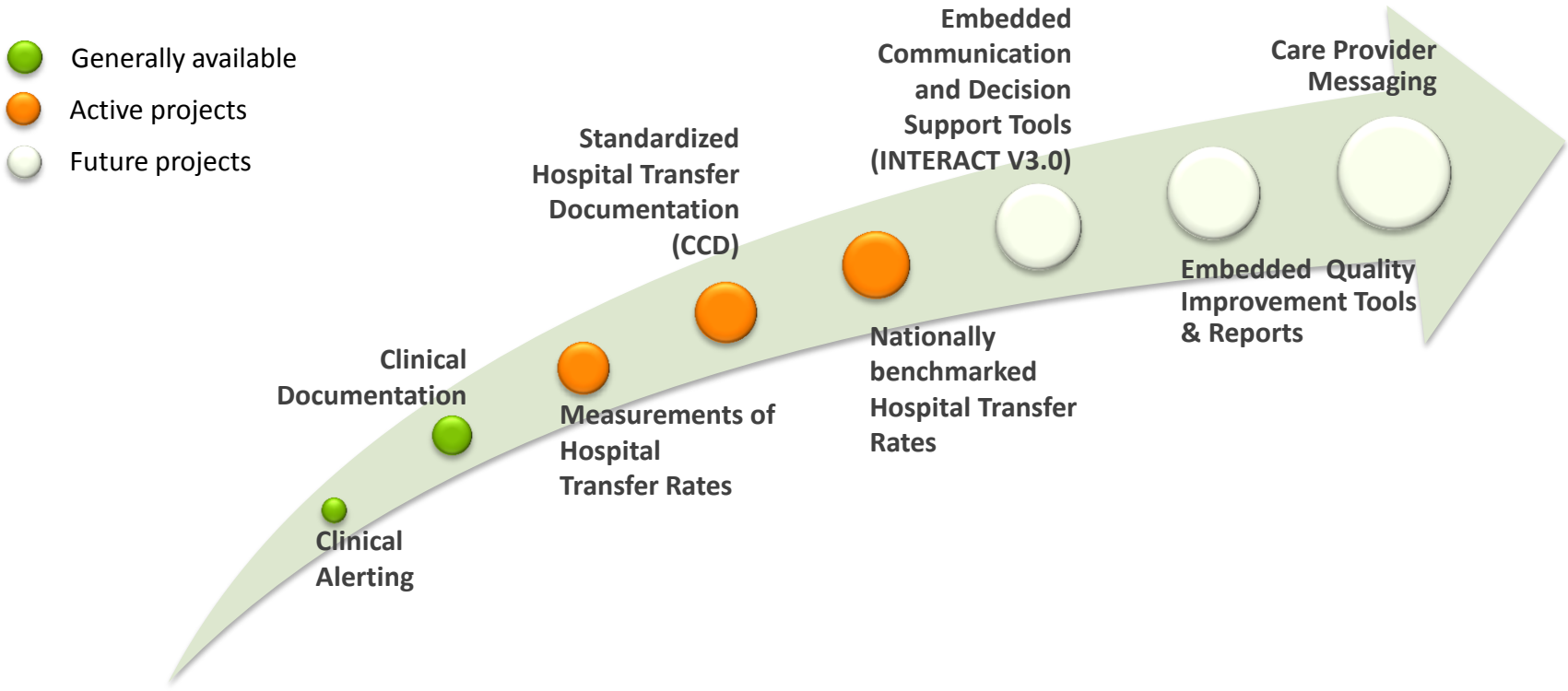
eINTERACT Roadmap



*This roadmap is based on current information as of June 11, 2013 and is subject to change or withdrawal by PointClickCare at any time without notice. The information in this roadmap is intended to outline PointClickCare's product direction related to eINTERACT. All information in this Product Roadmap is for informational purposes only and is not deemed to be incorporated into any contract. PointClickCare assumes no responsibility for the accuracy or completeness of the information.

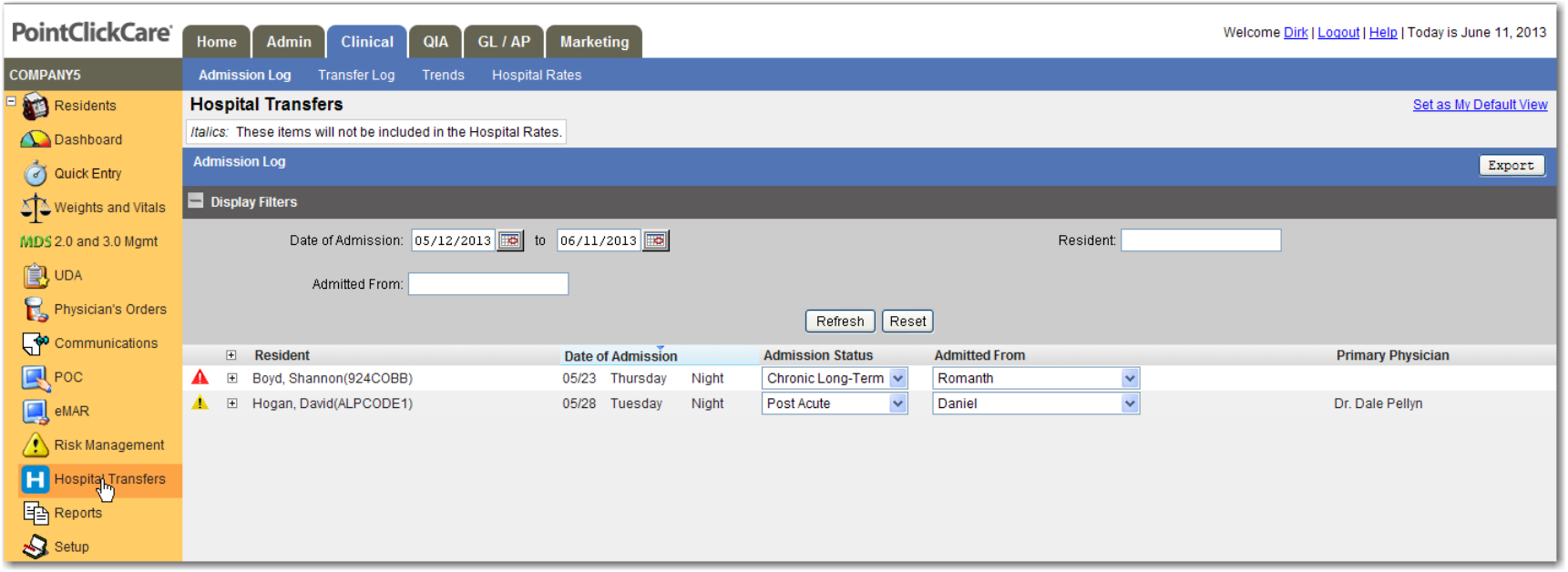
Measurements of Hospital Transfer Rate

- Provide a detailed Acute Care Transfer Log to support root cause analysis
  - Update census event workflow to include capture of relevant resident transfer data

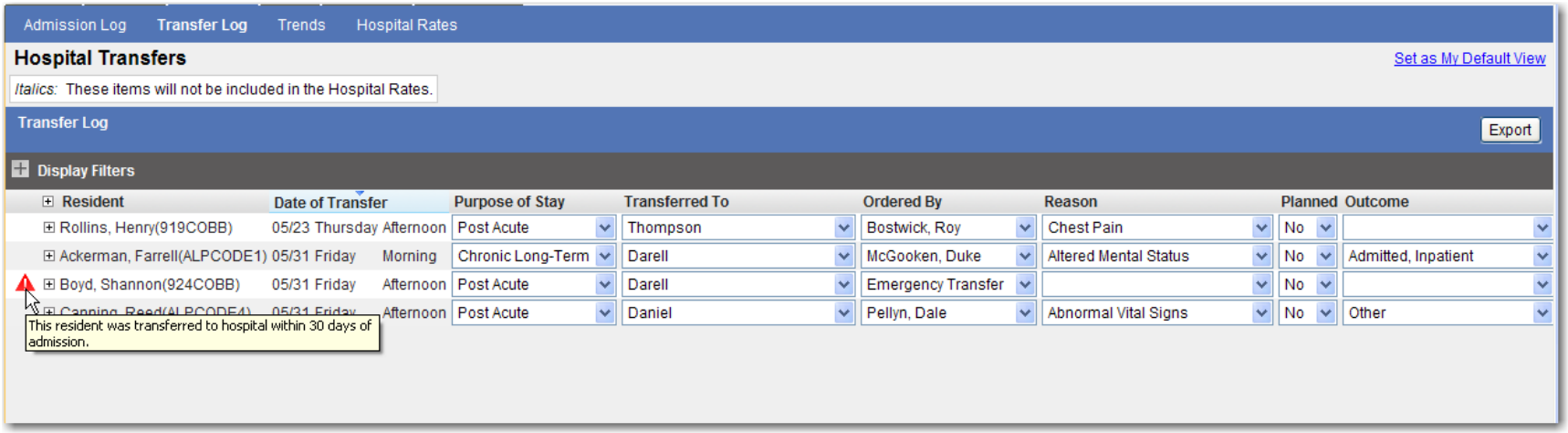
    ✓ physician ordering transfer
    ✓ reason for transfer
    ✓ indication of planned/unplanned event
    ✓ *require* hospital transfer destination
    ✓ outcome of transfer
- Provide Measurements of Hospital Transfer Rates reporting & analytics to monitor outcomes

  - 30-day Readmission Rate
  - Hospital Admission Rate
  - Rate of Transfers to Emergency Department Only
  - Rate of Transfers Resulting in Observation Stay

Hospital Transfer Portal



Hospital Transfer Portal



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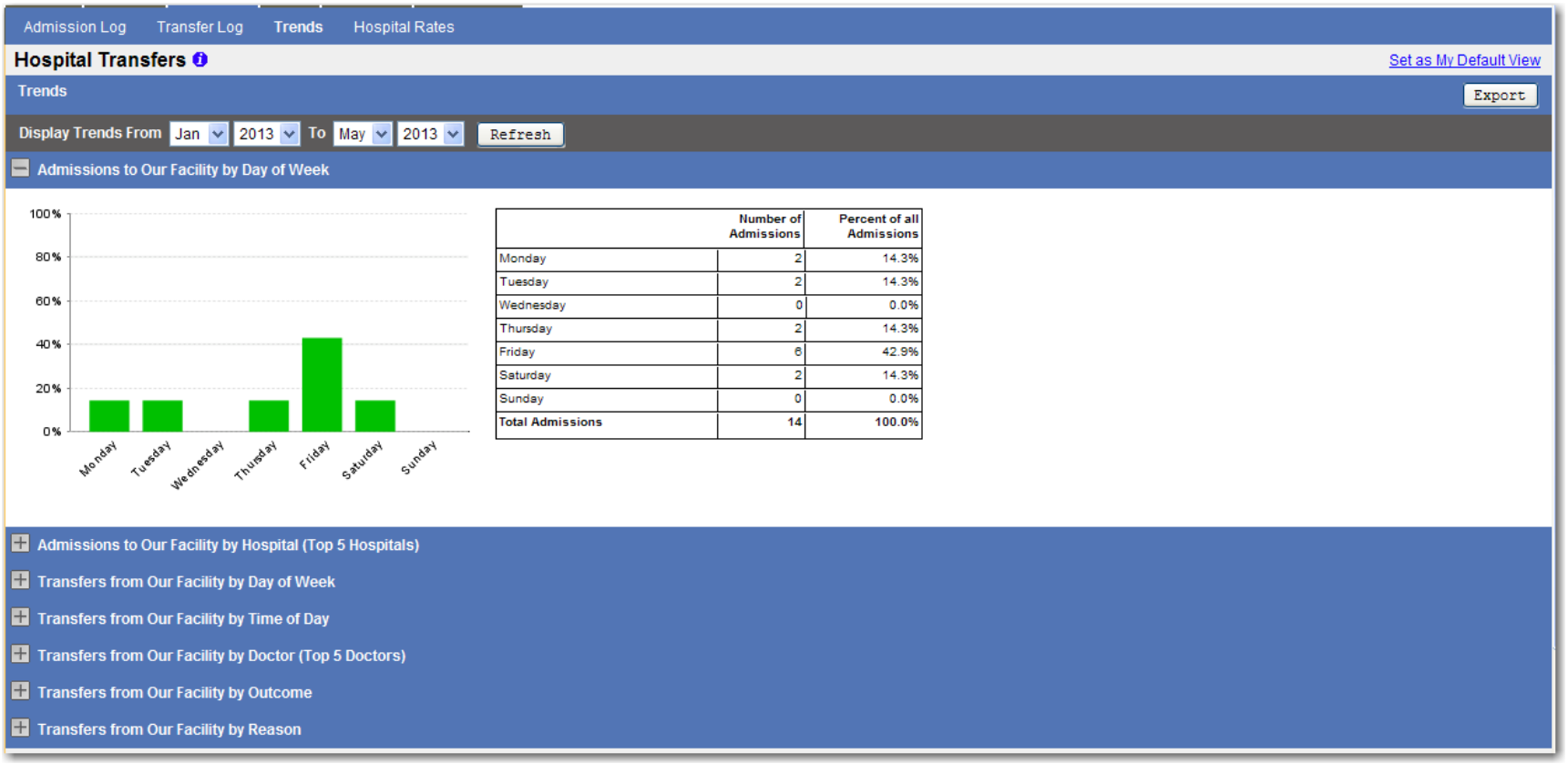
Hospital Transfer Portal



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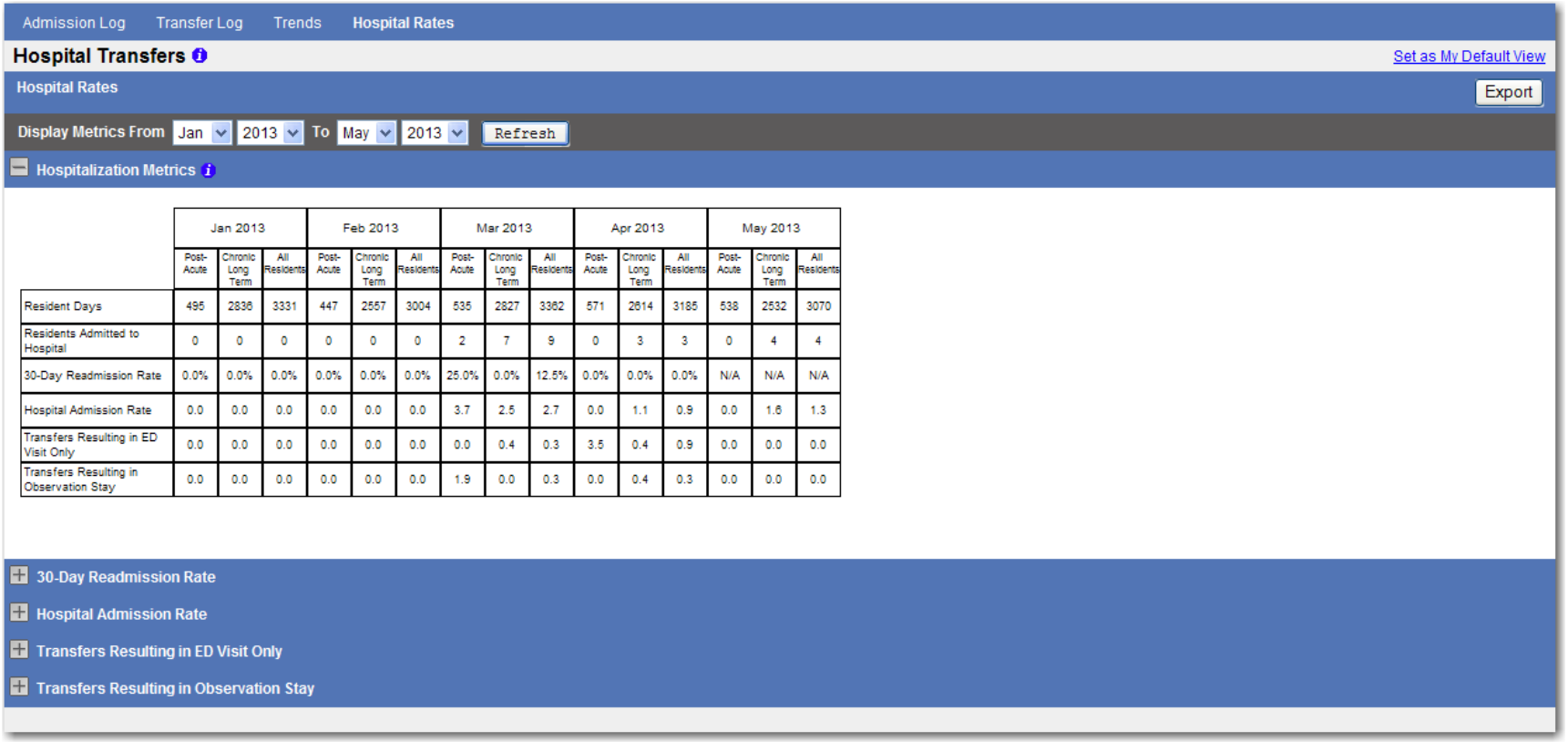
Hospital Transfer Portal



Admission Log | Transfer Log | Trends | **Hospital Rates**

Hospital Transfers ⓘ

Set as My Default View

Hospital Rates

Export

Display Metrics From Jan 2013 To May 2013 Refresh

Hospitalization Metrics ⓘ

	Jan 2013			Feb 2013			Mar 2013			Apr 2013			May 2013		
	Post-Acute	Chronic Long Term	All Residents	Post-Acute	Chronic Long Term	All Residents	Post-Acute	Chronic Long Term	All Residents	Post-Acute	Chronic Long Term	All Residents	Post-Acute	Chronic Long Term	All Residents
Resident Days	495	2836	3331	447	2557	3004	535	2827	3362	571	2614	3185	538	2532	3070
Residents Admitted to Hospital	0	0	0	0	0	0	2	7	9	0	3	3	0	4	4
30-Day Readmission Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	12.5%	0.0%	0.0%	0.0%	N/A	N/A	N/A
Hospital Admission Rate	0.0	0.0	0.0	0.0	0.0	0.0	3.7	2.5	2.7	0.0	1.1	0.9	0.0	1.6	1.3
Transfers Resulting in ED Visit Only	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.3	3.5	0.4	0.9	0.0	0.0	0.0
Transfers Resulting in Observation Stay	0.0	0.0	0.0	0.0	0.0	0.0	1.9	0.0	0.3	0.0	0.4	0.3	0.0	0.0	0.0

30-Day Readmission Rate

Hospital Admission Rate

Transfers Resulting in ED Visit Only

Transfers Resulting in Observation Stay

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Nationally Benchmarked Hospital Transfer Rate

- Provide an avenue to share outcomes with a national repository
- Provide the ability to compare facility outcomes against ‘like’ facilities in the same geographic area
- Provide the ability to identify ‘star performers’ to support continuous process improvements to programs

Standardize Hospital Transfer Documentation (CCD)

- Standardize communication processes between nursing facility and hospital
  - Implement standardized **Transfer Forms and Checklist**
  - Utilize the Transfer Form as the basis for delivering electronic CCD to capable systems
  - Support printing, faxing, and electronic messaging of timely, relevant health information

Embed Communication & Decision Support tools

- Support standardized methodology for capturing Early Warning Signs that is embedded in the resident care delivery workflow
  - Embed Stop and Watch terminology into EHR
  - Support user selection of multiple early warning signs
  - Support alerting/filtering based on early warning signs
- Support trigger events based on early warning signs
  - Support ability to trigger other clinical documentation (i.e. other assessments, care paths, progress notes) and tasks or other orders from early warning signs identified

Embed Communication & Decision Support tools

- Implement standardized Care Paths and SBAR tools
  - Support auto-populated of relevant resident clinical data captured throughout the resident care delivery process (across system and user defined assessments and observations)

- Enhance Care Planning workflow
  - Support prompting for change in advance directives or resident's capacity to make health care decisions

Implement Quality Improvement tools

- Support root cause analysis of hospital transfers
  - Provide **Quality Improvement Tool** for all hospital transfers
- Support process improvement trending and reporting & analytics, with ability to evaluate
  - appropriate use of structured communication tools
  - documentation of advance care planning discussions
  - use of root cause analysis tools

Care Provider Messaging

- Support electronic communication avenues between nursing and physician
  - Provide ‘in chart’ messaging and tracking capability
  - Provide alerting (email/text) to physician when change in condition requires physician review