

**INTERACT + EHR =  
reduced hospital re-admissions**

## eINTERACT Overview & Update

### Contact Us

[www.pointclickcare.com](http://www.pointclickcare.com)

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# Introduction to eINTERACT™

# 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 care team; proactively address issues and concerns with automated alerts in real time

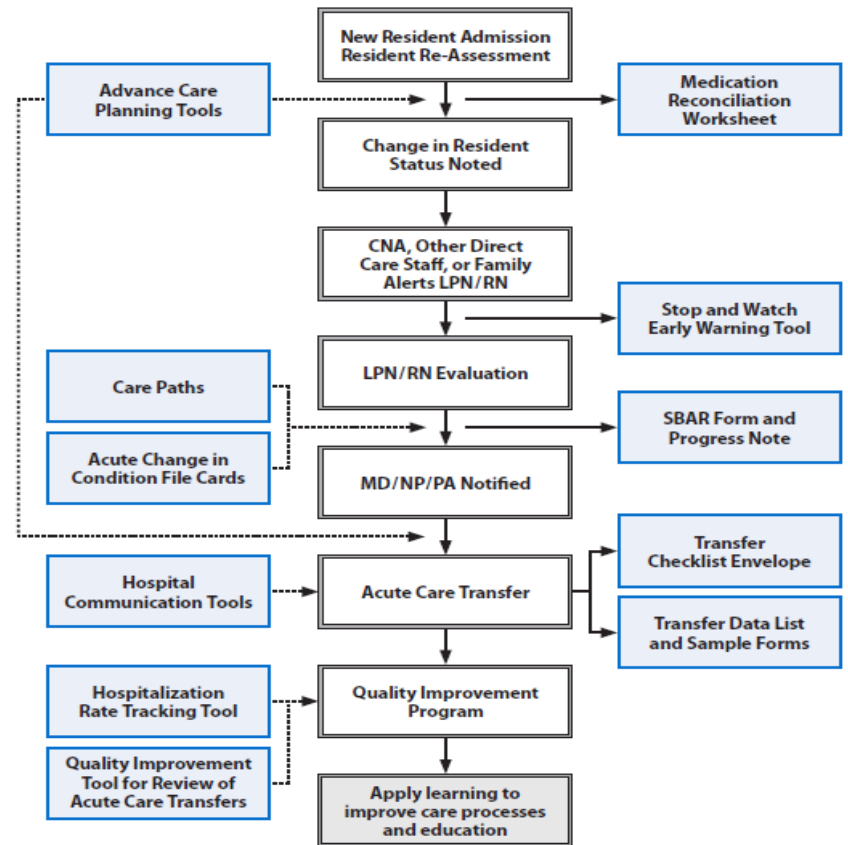
eINTERACT™

# Vision & Roadmap

# INTERACT Version 3.0 Tools

The INTERACT Version 3.0 Tools are available at:  
<http://interact2.net>

## Using the INTERACT Tools In Every Day Care



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OUTCOME

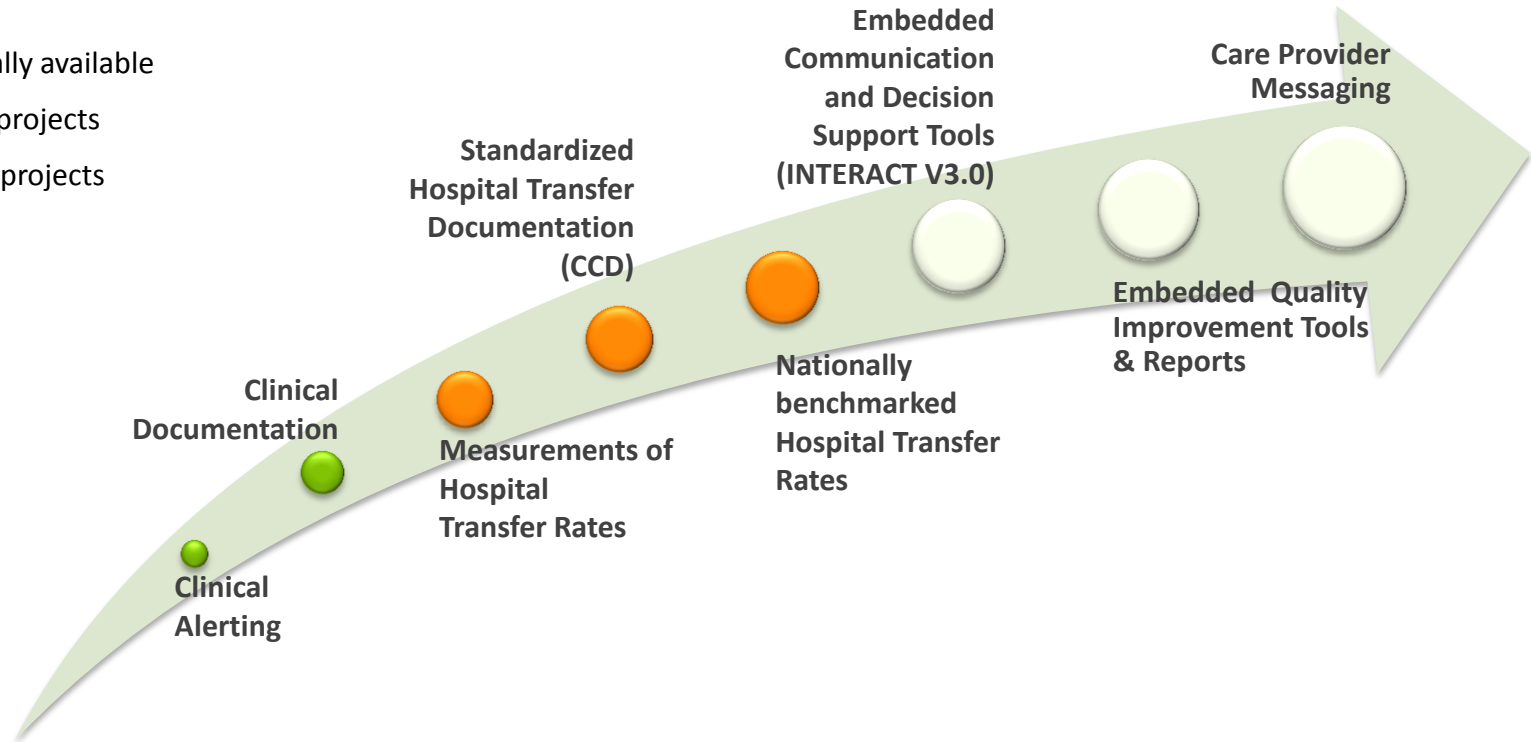


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# eINTERACT Roadmap

- Generally available
- Active projects
- Future projects



\*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

PointClickCare® Home Admin Clinical QIA GL / AP Marketing Welcome Dirk | Logout | Help | Today is June 11, 2013

COMPANY5 Admission Log Transfer Log Trends Hospital Rates

### Hospital Transfers [Set as My Default View](#)

*Italics: These items will not be included in the Hospital Rates.*

Admission Log Export

Display Filters

Date of Admission: 05/12/2013 to 06/11/2013 Resident:

Admitted From:

Refresh Reset

Resident	Date of Admission	Admission Status	Admitted From	Primary Physician
Boyd, Shannon(924COBB)	05/23 Thursday Night	Chronic Long-Term	Romanth	
Hogan, David(ALPCODE1)	05/28 Tuesday Night	Post Acute	Daniel	Dr. Dale Pellyn

# Hospital Transfer Portal

Admission Log   Transfer Log   Trends   Hospital Rates

## Hospital Transfers

[Set as My Default View](#)

*Italics:* These items will not be included in the Hospital Rates.

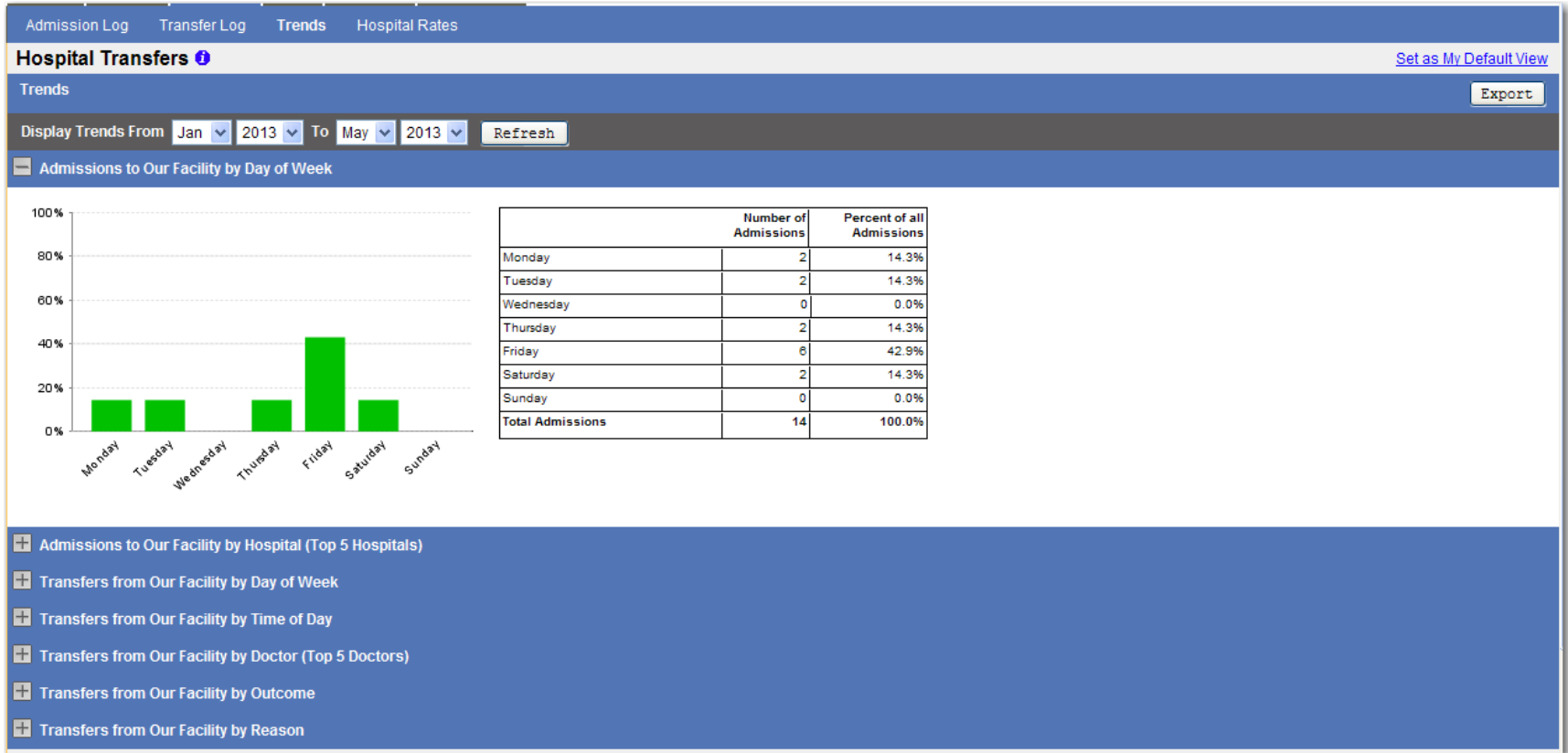
Transfer Log Export

+ Display Filters

Resident	Date of Transfer	Purpose of Stay	Transferred To	Ordered By	Reason	Planned Outcome
Rollins, Henry(919COBB)	05/23 Thursday Afternoon	Post Acute	Thompson	Bostwick, Roy	Chest Pain	No
Ackerman, Farrell(ALPCODE1)	05/31 Friday Morning	Chronic Long-Term	Darell	McGooken, Duke	Altered Mental Status	No Admitted, Inpatient
Boyd, Shannon(924COBB)	05/31 Friday Afternoon	Post Acute	Darell	Emergency Transfer		No
Canning, Reed(ALPCODE4)	05/31 Friday Afternoon	Post Acute	Daniel	Pellyn, Dale	Abnormal Vital Signs	No Other

This resident was transferred to hospital within 30 days of admission.

# Hospital Transfer Portal



# Hospital Transfer Portal

Admission Log   Transfer Log   Trends   Hospital Rates

**Hospital Transfers** [Set as My Default View](#)

Hospital Rates

Display Metrics From Jan 2013 To May 2013

**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	2567	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

# 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