eINTERACT

User Guide | July 07, 2017

This document covers the use of the eINTERACT features in PointClickCare.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>eINTERACT</td>
<td>3</td>
</tr>
<tr>
<td>eINTERACT Quick Reference Guide</td>
<td>3</td>
</tr>
<tr>
<td>Overview of eINTERACT</td>
<td>5</td>
</tr>
<tr>
<td>Using eINTERACT Tools</td>
<td>5</td>
</tr>
<tr>
<td>Creating eINTERACT Stop &amp; Watch and Change in Condition Alerts</td>
<td>7</td>
</tr>
<tr>
<td>Creating an eINTERACT Change in Condition Evaluation</td>
<td>7</td>
</tr>
<tr>
<td>Managing eINTERACT Change in Condition Evaluation Notifications</td>
<td>8</td>
</tr>
<tr>
<td>Managing eINTERACT Change in Condition Evaluation Notifications from the Clinical and Resident Dashboards</td>
<td>9</td>
</tr>
<tr>
<td>Viewing eINTERACT Care Paths and Change in Condition File Cards</td>
<td>10</td>
</tr>
<tr>
<td>Printing the eINTERACT SBAR Form</td>
<td>10</td>
</tr>
<tr>
<td>Creating and Completing the eINTERACT Transfer Form</td>
<td>10</td>
</tr>
<tr>
<td>Generate CCD (Continuity of Care Document)</td>
<td>11</td>
</tr>
<tr>
<td>Overview of eINTERACT QI Tools</td>
<td>12</td>
</tr>
<tr>
<td>Creating eINTERACT QI Reviews</td>
<td>12</td>
</tr>
<tr>
<td>Viewing eINTERACT QI Analysis</td>
<td>13</td>
</tr>
<tr>
<td>Hospital Transfers Admission Log</td>
<td>14</td>
</tr>
<tr>
<td>Hospital Transfers Transfer Log</td>
<td>15</td>
</tr>
<tr>
<td>Hospital Transfers Trends</td>
<td>17</td>
</tr>
<tr>
<td>Hospital Transfers Hospital Rates</td>
<td>18</td>
</tr>
<tr>
<td>Management Console Rehospitalization Report</td>
<td>19</td>
</tr>
<tr>
<td>Facility Level Rehospitalization Report</td>
<td>19</td>
</tr>
</tbody>
</table>
**eINTERACT**

**eINTERACT Quick Reference Guide**

This quick reference guide describes the eINTERACT workflow.

![eINTERACT Workflow Diagram](image)

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in everyday practice in long-term care facilities.

eINTERACT program goals include preventing unnecessary hospitalization of residents by promoting early identification and assessment of changes in resident condition, and managing changes when feasible and safe for the resident.
<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>eINTERACT Stop and Watch Alerts</strong> - Early identification of resident changes are communicated through eINTERACT alerts. These alerts are visible on the Clinical and Resident Dashboards in the eINTERACT Stop &amp; Watch And Change In Condition Alerts pane, for you to review alerts related to a resident's present condition. Alerts are generated through POC, and the Clinical and Resident Dashboards.</td>
</tr>
</tbody>
</table>
| 2.   | **eINTERACT Change In Condition Evaluation** - The eINTERACT Change in Condition Evaluation, SBAR and Care Paths assist you in analyzing eINTERACT alerts to facilitate a quick and appropriate response to a possible change in condition of the resident.  
  - **SBAR** - The SBAR (Situation, Background, Assessment, Recommendation) is available for printing from the Assmnts tab through the eINTERACT Change in Condition Evaluation print link.  
  - **eINTERACT Reference Guides** - The eINTERACT Care Paths and Change in Condition File Cards are available in each section of the eINTERACT Change In Condition Evaluation for quick reference to assist in ensuring best practice.  
  **NOTE**  
  The appropriate course of action is determined through Change in Condition Evaluation findings, and consultation with the physician.  
  - **Transfer not indicated** - If the resident can be managed feasibly and safely in the facility, STOP here. Revert back to Step 1 for early identification of changes in resident condition.  
  - **Transfer necessary** - If hospital transfer is indicated, proceed to Step 3. |
| 3.   | **eINTERACT Transfer Form** - The eINTERACT Transfer Form helps to clearly communicate the information that is critical for the emergency room and other hospital staff to care for the resident. You can also print an Audit Report and an Acute Care Document Checklist which can be sent with the resident indicating all documentation accompanying the resident to the hospital. |
| 4.   | **Hospital Transfers Portal QI Tools** - The Quality Improvement (QI) Tools are available in the Hospital Transfers Portal to help you analyze hospital transfers and identify opportunities to reduce transfers in the future. The QI Tools consist of a Hospital Transfer QI Review, Quality Improvement Tool for Review of Acute Care Transfers, and QI Analysis with trending graphs. The QI Review is completed for each resident, or a representative sample of hospital transfers, to conduct root cause analysis and identify common reasons for transfers. Examining trends in this data can help you focus on educational and care process improvement activities. |
| 5.   | **Hospital Transfers Portal**  
  - **Admission Log** - The Admission Log shows all residents who are within 30 days of admission to the facility and residents that had a discharge or transfer to the hospital within the first 30 days of admission.  
  - **Transfer Log** - The Transfer Log allows you to view all resident transfers or discharges to the hospital that occurred within the specified date range.  
  - **Trends** - The Trends section takes the admission and transfer data to plot various trends so you can identify patterns.  
  - **Hospital Rates** - The Hospital Rates section shows the hospitalization metrics or rates for your facility. |
Overview of eINTERACT

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program focusing on management of acute change in resident condition. It includes clinical and educational tools for use in everyday practice in long-term care facilities.

The eINTERACT components are designed to work together to assist you in preventing unnecessary hospitalizations and to promote positive resident outcomes.

**eINTERACT Goals:**

- Preventing unnecessary hospitalization of residents by promoting early identification and assessment of changes in resident condition.
- Managing changes in condition of the residents in the facility when it is feasible and safe.
- Expediting pertinent documentation to communicate resident condition to acute care hospital staff in the event of a necessary transfer.

**eINTERACT Tools:**

- Stop & Watch Alerts
- Change in Condition Alerts and Change in Condition Evaluation (must be enabled by a PointClickCare representative).
- Transfer Form
- QI Tools
- Hospital Transfers Portal

**Using eINTERACT Tools**

The eINTERACT tools work together to assist in preventing unnecessary hospitalizations through early identification and assessment of changes in resident condition. The following shows the workflow of the eINTERACT Program:

<table>
<thead>
<tr>
<th>Change in resident status identified and communicated</th>
<th>Early identification of observed changes in resident condition are communicated through eINTERACT Stop &amp; Watch Alerts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Evaluation of Change in Condition</td>
<td>The alerts show on Clinical and Resident Dashboards in the eINTERACT Stop &amp; Watch and Change in Condition Alerts pane and are reviewed by nursing staff. Alerts are evaluated via completion of the eINTERACT Change In Condition Evaluation. The Care Paths and Change in Condition File Cards are embedded in the evaluation to help determine if further evaluation and notification of the resident’s condition to the practitioner is indicated. Nurse prints the SBAR form prior to calling the physician.</td>
</tr>
<tr>
<td>Physician Notification</td>
<td>Nursing staff communicate the summary of pertinent change in condition findings to the physician using the SBAR.</td>
</tr>
</tbody>
</table>
Determination of appropriate action

<table>
<thead>
<tr>
<th>Transfer to hospital not indicated</th>
<th>Resident change in condition can be successfully managed in facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer to hospital necessary</td>
<td>Nurse completes eINTERACT Transfer Form and Acute Care Document Checklist. Transfer Form and CCD are printed and sent with resident to acute care hospital.</td>
</tr>
</tbody>
</table>

Quality Improvement through QI Tools

| Nursing staff complete QI Reviews to identify opportunities to reduce transfers. |

eINTERACT Tools:

The following describes the eINTERACT Tools:

1. **eINTERACT Stop and Watch Alerts and eINTERACT Change in Condition Alerts** - Early identification of resident changes are communicated through eINTERACT alerts. These alerts are visible on the Clinical and Resident Dashboards in the eINTERACT Stop & Watch And Change In Condition Alerts pane for you to review an alert related to a resident's present condition. Alerts are generated through POC and the Clinical and Resident Dashboards.

2. **eINTERACT Change In Condition Evaluation** - The eINTERACT Change in Condition Evaluation, SBAR and Care Paths assist you in analyzing eINTERACT alerts to facilitate a quick and appropriate response to a possible change in condition of the resident.
   - **SBAR** - The SBAR (Situation, Background, Assessment, Recommendation) is available for printing from the Assmnts tab through the eINTERACT Change in Condition Evaluation print link.
   - **eINTERACT Reference Guides** - The eINTERACT Care Paths and Change in Condition File Cards are available in each section of the eINTERACT Change In Condition Evaluation for quick reference to assist in ensuring best practice.

3. **eINTERACT Transfer Form** - The eINTERACT Transfer Form helps to clearly communicate the information that is critical for the emergency room and other hospital staff to care for the resident. You can also print an Acute Care Document Checklist which can be sent with the resident indicating all documentation accompanying the resident to the hospital.

4. **Hospital Transfers Portal QI Tools** - Help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable.
   - **QI Reviews** - The QI Review is completed for each resident, or a representative sample of hospital transfers to conduct root cause analysis and identify common reasons for transfers.
   - **QI Analysis** - Examining trends in this data can help you focus on educational and care process improvement activities.

5. **Hospital Transfers Portal**
   - **Admission Log** - The Admission Log shows all residents who are within 30 days of admission to the facility and residents that had a discharge or transfer to the hospital within the first 30 days of admission.
   - **Transfer Log** - The Transfer Log enables you to view all resident transfers or discharges to the hospital that occurred within the specified date range.
   - **Trends** - The Trends section plots the admission and transfer details so you can identify patterns.
Hospital Rates - The Hospital Rates section shows the hospitalization metrics or rates for your facility.

Creating eINTERACT Stop & Watch and Change in Condition Alerts

Early identification of resident changes are communicated through eINTERACT alerts. These alerts are visible on the Clinical and Resident Dashboards in the eINTERACT Stop & Watch And Change In Condition Alerts pane for you to review an alert related to a resident's present condition. Alerts are created through POC, and Clinical and Resident Dashboards. eINTERACT Alerts sent to the dashboard allow you to complete a Change in Condition Evaluation if required.

Procedure

Creating an eINTERACT Alert from POC

1. Log into POC.
2. Click the POC tab.
3. Select Resident.
4. Click New Alert.
5. Select eINTERACT Stop & Watch Alerts or eINTERACT Change in Condition Alerts.
6. Click Save.

Creating an eINTERACT Alert from Clinical or Resident Dashboard

1. Do one of the following:
   • Clinical > Dashboard.
   • Clinical > Resident > Dash tab.
2. Navigate to eINTERACT Stop & Watch and Change in Condition Alerts pane.
3. Click New Alert.
4. Select eINTERACT Stop & Watch Alerts or eINTERACT Change in Condition Alerts.
5. Click Save.

Creating an eINTERACT Change in Condition Evaluation

Creating an eINTERACT Change in Condition Evaluation - 6 minutes.
The eINTERACT Change in Condition Evaluation is a system assessment to support the eINTERACT Decision Support Tools, CARE PATHS, and Change in Condition File Cards. You can manually create the eINTERACT Change in Condition Evaluation in two ways.

**Procedure**

**From an alert:**

1. Do one of the following:
   - Clinical > Dashboard.
   - Clinical > Resident > Dash tab.
2. Navigate to the eINTERACT Stop & Watch and Change in Condition Alerts pane.
3. Select an alert for a resident.
4. Click **Assess**.
5. Complete fields as required.
6. Click **Save**.

**From Assmnts tab:**

2. Click New.
3. Select the eINTERACT Change in Condition Evaluation.
4. Click Save.

**Hints and Tips**

- When creating a new assessment from the Assmnts tab of the resident's chart, all of the sections/questions are blank because the manually created assessment was not triggered by either Stop & Watch or Change in Condition Alerts.
- The **Change in Condition Evaluation** can also be triggered via another assessment or a configured schedule.

**Managing eINTERACT Change in Condition Evaluation Notifications**

Managing eINTERACT Change in Condition Notifications - 7 minutes.

In the eINTERACT Change in Condition Evaluation, certain questions or responses may trigger a notification. If triggered, a red **Notifications** link appears. Clicking on the link shows all Question(s)/
Response(s) that triggered the notification. Notifications alert the clinical staff to notify the practitioner of the resident's change in condition.

**NOTE**
Notifications must be acknowledged before the Change in Condition Evaluation can be locked.

**Procedure**

1. Click **edit** for the Change in Condition Evaluation.
2. Click **Notifications**.
3. Select Response(s).
4. Click **Acknowledge**.

**Hints and Tips**

- The Notifications link changes from Red to Black after items are acknowledged.
- You can print the eINTERACT SBAR Form and eINTERACT Notifications Report from the print link of the eINTERACT Change in Condition Evaluation.

**Managing eINTERACT Change in Condition Evaluation Notifications from the Clinical and Resident Dashboards.**

**Managing eINTERACT Change in Condition Notifications - 7 minutes.**

When triggered from the eINTERACT Change in Condition Evaluation, a Notify MD/NP/PA: Immediate or Notify MD/NP/PA: Non-Immediate alert shows on the Clinical Alerts Panel on the Clinical and Resident Dashboards as a High Risk Alert.

**NOTE**
The Notify MD/NP/PA: Immediate and Notify MD/NP/PA: Non-immediate alerts do not show in the Standard Alert Library or in any other areas for selection in the creation of alerts.

**Procedure**

1. Clinical or Resident Dashboard, navigate to the Clinical Alerts pane.
2. Click **View** for the alert.
3. To clear alert, select alert and click **Clear Alert**.

**Viewing eINTERACT Care Paths and Change in Condition File Cards**

eINTERACT Care Paths and Change in Condition File Cards are available in each section of the eINTERACT Change In Condition Evaluation for quick reference to assist you in ensuring best practice.

**Procedure**

1. In each section of the eINTERACT Change In Condition Evaluation, on the assessment section header, click **eINTERACT Reference Guide(s)**.
2. Select documents.
3. Click **View**.

**Printing the eINTERACT SBAR Form**

The eINTERACT SBAR (Situation, Background, Assessment, Recommendation) summarizes pertinent information needed to provide to the physician regarding the resident’s change in status. As the eINTERACT Change in Condition Evaluation is completed, triggers may generate to notify the practitioner. The SBAR is automatically populated with the summary of the change in condition and outcomes as the assessment is completed.

**Procedure**

2. Click **print** for the Change in Condition Evaluation.
3. Select **eINTERACT SBAR Form**.
4. Click **Print**.

**Creating and Completing the eINTERACT Transfer Form**

Creating an eINTERACT Transfer Form - 14 minutes.

The eINTERACT Transfer Form is a best practice tool which assists you in the transfer of the resident's healthcare information across facilities. Based on transfers or discharge to hospital, eINTERACT Transfer Forms can automatically be scheduled to be completed at the time of census/QADT entry.

**Procedure**

**From Census Entry:**
1. Create census line (either QADT or Admin) in which Action Type is set to Transfer or Discharge with To/From Type of Acute Care Hospital.

2. Click **Save**. The eINTERACT Transfer Form message shows with two options.

   - **Schedule and Complete Later** - Select to schedule the assessment to be completed later. The Transfer Form shows in the resident's chart in the Assmnts tab under **Next Assessment Due** and can also be accessed in the Scheduled tab of the UDA portal.

   - **Create the eINTERACT Transfer Form** - Select to complete assessment now. The eINTERACT Transfer Form appears, listing all sections of the assessment.

3. Complete the eINTERACT Transfer Form as you would any other assessment.

   **From Assmnts tab:**

   2. Click **New** > Select **eINTERACT Transfer Form**.
   3. Complete the fields as required.
   4. Click **Save**.

   **Hints and Tips**

   - Some information in the assessment is autopopulated from other modules in the chart or you can access this information by clicking the search icon.

   - Advance Directives show as Code Status and appear on the forms as they are described and entered into the resident’s chart. A refresh option is available for the Code Status question to repopulate responses if all answers are cleared, or new orders are entered prior to locking the assessment.

**Generate CCD (Continuity of Care Document)**

The Continuity of Care Document (CCD) is a core data set of the most pertinent administrative, demographic, and clinical information about a resident's healthcare.

The primary use for the CCD is to provide one document with consolidated data for a specific resident to support the continuity of care across the healthcare spectrum. You can create and save a CCD in PDF or XML file format.

**NOTE**

Race, Ethnicity, Primary Language and a Contact must be in the resident chart in order to generate the CCD. You must also have a complete address in Admin > Facility Configuration.
Procedure

2. Click Print in the Resident Header.
3. Click Generate CCD.
4. Click Save PDF or Save XML to save to the Documents tab of the resident's chart. Click Download to save to your computer files if required.

Hints and Tips

- The Smoking Status is pulled from the Care Profile.
- Allergies show a status of No Longer Active for allergies resolved within the previous 90 days.
- Problems show a status of Inactive for diagnoses resolved within the previous 90 days.
- Vital signs, with the exception of the blood sugar, show from the previous 90 days.
- Lab and radiology results show from the previous 90 days.
- Medication information shows from the previous 90 days.
- Medications on the CCD may show a status field. A blank status is an On Hold or Active medication and a status of Aborted is a Discontinued medication.

Overview of eINTERACT QI Tools

Overview of eINTERACT QI Tools - 4 minutes.

QI Tools help you to analyze hospital transfers and identify opportunities to reduce transfers that might be preventable.

The QI Tools consist of a hospital transfer QI Review, (Quality Improvement Tool for Review of Acute Care Transfers), and QI Analysis with trending graphs. The QI Review is completed for each resident, or a representative sample of hospital transfers to conduct root cause analysis and identify common reasons for transfers. Examining trends in this data can help you focus educational and care process improvement activities.

Creating eINTERACT QI Reviews

Creating New QI Review - 7 minutes.

There are two different paths to create an eINTERACT QI Review: from the Transfer Log or QI Reviews tabs in the Hospital Transfers Portal.
Procedure

- Clinical > Hospital Transfers.

From the Transfer Log tab:
1. Click the white QI icon.
2. Select Create QI Review Now >. click Save.
3. Click edit next to each section and complete as you would any other assessment.

From the QI Reviews tab:
1. Click on the QI Reviews tab to view tabs based on assessment status.
2. Click the Not Started tab.
3. Click create and Save to open the review.
4. Complete as you would with any other assessment.

Hints and Tips

- In the Transfer Log, the QI icon is yellow if the review is in progress, red if there are errors, and green when the Review is completed and locked.
- The QI Review has autopopulated answers from the eINTERACT Transfer Form, including weight and vital values present in the eINTERACT Transfer Form at the time of transfer.
- On occasion, it may not be necessary to complete a QI Review for a resident. Instead of Create QI Review Now, select QI Review is Not Required, type reason, and Save.

Viewing eINTERACT QI Analysis

Analyzing QI Review Information - 8 minutes

The QI Analysis section of the Hospital Transfers portal provides graphs allowing you to analyze data gathered within the QI Reviews. These QI tools assist you with root cause analysis for hospital transfers and identify common reasons for transfers. Data gathered within the QI Reviews is used for calculating totals and percentages for all indicators and is based on each section of the QI Review. Only completed QI Reviews for residents are included within the metrics.

The QI Analysis section contains five tabs that directly correlate with each section of the QI Review

- Resident Characteristics
- Changes in Condition
• Actions Taken
• Hospital Transfer Info
• Improvement Opportunities

Procedure

1. Clinical > Hospital Transfers.
2. Click the QI Analysis tab.

Hints and Tips

• Each tab contains graphs (Pre-V4.0 and V4.0) showing a count and percentage of residents based on the categories found in the QI Review.
• Trends are calculated for all five tabs based on the following details:
  ▪ Date of Transfer (within the dates specified in the filters).
  ▪ Responses selected in completed QI Reviews.
• Clicking directly on the green bars in the graphs allows you to see more detail, including a link to the resident record and the QI Worksheet completed for the resident.

Hospital Transfers Admission Log

The eINTERACT Admission Log - 8 minutes.

The Admission Log shows all residents who are within 30 days of admission to the facility and residents that had a transfer or discharge to a hospital within the first 30 days of admission.

WARNING
Any changes to the Admission Status or Admitted From field in the Admission Log also changes the census line for those fields.

Procedure

1. Clinical > Hospital Transfers.
2. Click the Admission Log tab.
3. Click + Display Filters and complete fields.
4. Click Search.
Hints and Tips

• The Admission Status is based on the payer for the resident. PPS payers are Post-Acute, whereas all other payers are Chronic Long-Term.

• The Admitted From field shows the hospital the resident came from, selected during census entry in the To/From field.

• In the resident list, there may be icons next to resident names:
  - Yellow icon - Indicates the resident is within 30 days of the admission date. After 30 days if they aren’t transferred or discharged back to the hospital, they are no longer considered at risk and the yellow icon disappears.
  - Red icon - Indicates the resident was transferred or discharged to the acute care hospital within 30 days of admission. After the red icon appears in the Transfer Log, it always remains next to the resident’s name.

• The time of day of the admission shows based on the time in the census event and is based on the following:
  - Morning - if the admission occurred from 07:00am to 11:59am.
  - Afternoon - if the admission occurred from 12:00pm to 6:59pm (18:59).
  - Evening - if the admission occurred from 7:00pm (19:00) to 11:59pm (23:59).
  - Night - if the admission occurred from 12:00am (00:00) to 06:59am.

• The Admission Log can be exported in Excel format by clicking Export. Residents can be de-identified before exporting if needed.

Hospital Transfers Transfer Log

The eINTERACT Transfer Log - 7 minutes.

The Transfer Log allows you to view all resident transfers or discharges to the hospital that occurred within the specified date range. The Transfer Log includes the last 30 days of hospital discharges or transfers of residents who were admitted from an acute care hospital within the last 30 days.

WARNING

There are fields in the Transfer Log that you can edit. Any changes are automatically saved and also update the corresponding census event.
NOTE

To verify the % for the 30 day hospital readmission rate, select the following values in the filters to show the correct records:

- **Transfer Within** - Select the beginning month/day/year for the date range of interest. The end date automatically populates.
- **Planned** - Select No.
- **Outcome** - Select Admitted, Inpatient; Admitted, Observation; and Admitted, Status Uncertain.
- **Length of Stay** - Select <30 days (includes dates less than or equal to 30 days).

Procedure

1. Clinical > Hospital Transfers.
2. Click the **Transfer Log** tab.
3. Click **Display Filters** and complete fields.
4. Click **Search**.

Hints and Tips

- The **Purpose of Stay** is based on the payer for the resident. PPS payers are Post-Acute and all other payers are Chronic Long-Term.
- A red icon indicates the resident was transferred to the hospital within 30 days of admission. After the red icon appears in the Transfer Log, it always remains next to the resident's name.
- The time of day of the transfer shows based on the time in the census event and is based on the following:
  - **Morning** - if the transfer occurred from 07:00am to 11:59am.
  - **Afternoon** - if the transfer occurred from 12:00pm to 6:59pm (18:59).
  - **Evening** - if the transfer occurred from 7:00pm (19:00) to 11:59pm (23:59).
  - **Night** - if the transfer occurred from 12:00am (00:00) to 06:59am.
- The Transfer Log can be exported in Excel format by clicking **Export**. Residents can be de-identified before exporting if needed.
Hospital Transfers Trends

Trends (5 min video)

The Trends section of the Hospital Transfers portal plots the admission and transfer details so you can identify patterns. You can filter by dates to see trends from a selected period of time, by hospital or by physician. A maximum of one year of data shows at one time.

Procedure

1. Clinical > Hospital Transfers.
2. Click the Trends tab.
3. Click + Display Filters and complete fields.
4. Click Search.

Details included in all trends are as follows:

- **Admissions to Our Facility by Day of Week** - Shows admissions by day of the week: Monday through Sunday. The day of the week is based on the date of admission. The percentage of admissions on each day is calculated as Total Number of Admissions for Specific Day / Total Number of Admissions.

- **Admissions to Our Facility by Hospital (Top 5 Hospitals)** - Shows the top five hospitals with the most admissions, in order. This also shows All Other Hospitals as a sixth value and Not Recorded as a seventh value for instances where a hospital was not selected. The hospital is based on the To / From Location for each admission. The percentage of admissions for each hospital is calculated as Total Number of Admissions for Specific Hospital / Total Number of Admissions for All Hospitals.

- **Transfers From Our Facility by Time of Day** - Shows all transfers for the four Times of Day in the following order:
  - Morning (7:00 am - 11:59 am).
  - Afternoon (12:00 pm - 6:59 pm).
  - Evening (7:00 pm - 11:59 pm).
  - Night (12:00 am - 6:59 am).

  - The time of day is based on the time of the admission. The percentage of transfers for each time of day is calculated as Total Number of Transfers for a Specific Time of Day / Total Number of Transfers.

- **Transfers from Our Facility by Doctor (Top 5 Doctors)** - Shows the top five doctors with the most transfers, in order. This also shows All Other Doctors as a sixth value, Emergency Transfer as a seventh value and Not Recorded as an eighth value for times when a doctor is not selected. The doctor is based on the Ordered By for each transfer. The percentage of transfers for each doctor is calculated as Total Number of Transfers for Specific Doctor / Total Number of Transfers for All Doctors.

- **Transfers From Our Facility by Outcome** - Shows all outcomes of transfers, in the order of the Outcome of Transfer list. This also shows Not Recorded as an additional value for times when an
outcome is not selected. The outcome is based on the Outcome of Transfer for each transfer. The percentage of transfers for each outcome is calculated as Total Number of Transfers for Specific Outcome / Total Number of Transfers.

- **Transfers From Our Facility by Reason** - Shows all reasons for transfers, in the order of the Reason for Transfer list. This also shows Not Recorded as an additional value for times when a reason is not selected. The reason is based on the Reason for Transfer for each transfer. The percentage of transfers for each reason is calculated as Total Number of Transfers for Specific Reason / Total Number of Transfers.

**Hints and Tips**

- The trends only include admissions and unplanned transfers where the To/From Type selected is mapped to an External Facility Type of Hospital with Include in Hospital Rates selected.

- You can export Trends in either PDF or Excel format by clicking Export.

**Hospital Transfers Hospital Rates**

Hospital Rates (5 min video)

The Hospital Rates section of the Hospital Transfers Portal shows hospitalization metrics (rates) for your facility. Calculated values are expressed per 1000 resident days. The Hospital Rates view provides four hospital readmission metrics:

- 30-Day Readmission Rate.
- Hospital Admission Rate per 1000 resident days.
- Rate of Transfers to Emergency Department Only per 1000 resident days.
- Rate of Transfers Resulting in Observation Stay per 1000 resident days.

The four metrics are summarized in a table by month. Each metric is also shown in a graph and table showing the monthly trends.

**Procedure**

1. Clinical > Hospital Transfers > Hospital Rates.
2. Click the Hospital Rates tab.
3. Use the Display Metrics from filter to view selected time frames to apply to the available pane for the Hospital Rates.
4. Click Refresh.
Hints and Tips

• The Resident Days in the Hospital Rates are not the same as Census Days. Resident Days will always be greater than Census Days because Resident Days include the day a resident is discharged from a facility, whereas Census Days do not.

• If the current month is selected in the filter, results for that month appear as n/a because a full month is required for calculations.

• You can export Hospital Rates in either PDF or Excel format by clicking Export.

Management Console Rehospitalization Report

The Management Console Rehospitalization Report at the Management Console level provides quick and efficient access to summary level or aggregated data regarding hospital transfers. You can run reports according to selected time periods and report options.

Procedure


2. Select the Report Options as required.

3. Click Run Report.

Facility Level Rehospitalization Report

The Rehospitalization report provides access to summary information related to transfers to the hospital.

Procedure


2. Select the Report Options as required.

3. Click Run Report.