PointClickCare®

Reducing Hospital Readmissions with eINTERACT™

Reduce readmissions and emergency room visits with better clinical decisions support in senior care residences.

The readmission rate for patients discharged to a skilled nursing facility is 25% within 30 days[1]. What can senior care providers do to reduce these hospital readmissions?

Although hospitalizations are necessary for a variety of reasons, experts suggest that up to 68%[1] of readmissions could be avoided.

With eINTERACT™, there is a new industry-standard for Health Information Technology (HIT), designed to reduce unnecessary hospitalizations. A joint effort between Florida Atlantic University (FAU) and PointClickCare, eINTERACT is the industry's first initiative designed to bring the proven methodology of the INTERACT® quality improvement program to Electronic Health Record (EHR) software platforms.

As numerous research studies have shown, manual use of the INTERACT program and tools can successfully reduce acute care transfers. Incorporating the tools into an EHR presents providers with enhanced opportunities to impact the reduction of readmission rates and to access timely data for quality improvements.

Early warning of changes in a resident's condition is critical.

Early identification of changes in condition is key to managing and preventing unnecessary resident transfers to hospitals. The sooner a change in condition is identified, the quicker interventions can be implemented to prevent decline and avoid potential transfers. PointClickCare's platform offers the eINTERACT Stop and Watch Early Warning Tool, enabling any staff who are in a position to observe resident changes, including nursing aides, rehabilitation therapists, environmental services and dieticians to document observations of early changes in a resident's condition, including those identified by visiting family members. Those observations are communicated to the licensed nursing staff through automatic alerts in the PointClickCare EHR.

Stop and Watch is easily accessible through the PointClickCare Point of Care (POC) kiosk and mobile applications, enabling aides and caregivers to quickly alert licensed staff to changes in a resident's condition as part of their normal documentation workflow. These real-time alerts to nursing staff can significantly reduce incidents where changes in resident condition would otherwise be reported too late or perhaps not at all.

68% of readmissions could be avoided[1]

1. **How many readmissions are occurring in your organization – by shift, practitioner, or admission source?**
2. **Are staff identifying and reporting a potential change in a resident's condition?**
3. **Are staff getting the right information upon admission to properly care for a new or returning resident? Are they sending the right information with the resident on transfer?**

When transfers do occur, an effective transition requires the participation of *all* care providers involved.

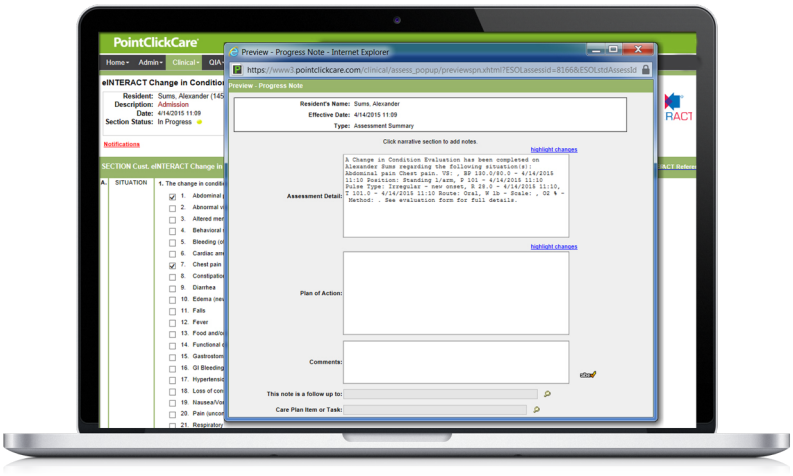
Simplify evaluating changes in resident condition.

Having the right clinical decision support tools can mean the difference between keeping a resident on site or having to transfer them to an acute care facility. Through work with FAU, PointClickCare integrated the INTERACT SBAR tool with Care Paths and with Change in Condition Cards, to create a single online tool that delivers more streamlined communications between clinicians and practitioners.

The **eINTERACT Change in Condition Evaluation** is an industry first and unique to PointClickCare. This specialized assessment enables a comprehensive review of resident condition, leveraging INTERACT version 4.0 tools. As information is updated anywhere in the PointClickCare EHR, real-time notifications indicate when a practitioner should be called. The Change in Condition Evaluation also ensures expedited SBAR communication, providing vital information to the practitioner in determining the need to transfer, while also alerting the entire care team via the eINTERACT dashboard. This new tool ensures everyone is kept apprised of a resident's condition, ensuring action is taken when time is of the essence.

Deliver the right information during transitions of care.

PointClickCare has incorporated the NH-Hospital Transfer Form into the PointClickCare EHR as the eINTERACT Transfer Form.
It is automatically triggered when a resident is discharged or transferred to the hospital. The eINTERACT Transfer Form enables providers to clearly communicate vital information in a consistent manner, which helps to ensure the emergency room and other hospital staff can begin accurately treating the resident upon arrival. Efforts in completing the form are reduced by auto-populating it with available data from the EHR, reducing documentation time and risk for transcription error, while improving efficiencies in time to transfer. The form can be printed or transferred electronically through secure Direct Messaging to quickly share information with other providers during the transfer.



Improve quality management capabilities.

The success of any Quality Assurance and Performance Improvement (QAPI) program depends on the ability to track outcomes and to measure the overall effect that changes to policies and procedures have on the provider's results.

Understanding baseline metrics and comparing against results obtained post-implementation are integral to determining program success. eINTERACT gives providers the tools they need for to design and manage effective quality improvement programs.

Reduce transfers and readmissions with integrated analytics

As part of the eINTERACT initiative, PointClickCare has incorporated the functions of the INTERACT Hospital Trend Tracker into the PointClickCare EHR. The data required to track rehospitalization rates is captured automatically during census events, including the admitting and transferring practitioner, transfer destination, and resident condition for transfer. This data is available for online analysis, and to export to reports, including:

Admission Log

A view of all residents who are within 30 days of admission, as well as residents who have been discharged/transferred to a hospital within the first 30 days of admission.

Transfer Log

A view of all resident transfers to the hospital with the ability to filter for trends.

Hospitalization Rates Tracking

A view of all outcomes for 30-day readmission rate, transfers resulting in admission, transfers resulting in emergency department visit only and transfers resulting in observation stay only.

Trend Tracking

Plotting of various trends for pattern identification, including admissions/transfers by hospital, practitioner, outcome, reason, day-of-week and time-of-day.

All transfers that occur within the 30-day period after admission are automatically logged for a quality improvement review. Such reviews are needed to drive changes in care delivery processes, with the goal to further reduce acute care transfers.

Quality improvement tools for review and analysis of acute care transfers.

Individual transfer details, as well as trends across multiple transfers, need to be analyzed to determine patterns and areas for improvement. The eINTERACT Hospital Transfer Quality Improvement Review Tool assists with the analysis of hospital transfers, identifying opportunities to reduce preventable transfers. The eINTERACT Quality Improvement Worksheet for Review of Acute Care Transfers should be completed for, at minimum, a sample of hospital transfers, so a root cause analysis and identification of common reasons for transfers can be conducted.

As QI reviews of transfers are completed, the data is automatically displayed for analysis in exportable reports in the eINTERACT QI Analysis Tool, including analysis by:

Resident characteristics

Age, conditions increasing risk of rehospitalization, other hospitalizations, and transfers to the emergency department without admission to hospital.

Changes in condition

Length of time between identification of change of condition and transfer to hospital, new or worsening signs and symptoms, abnormal findings from the lab, and by diagnosis or presumed diagnosis.

Actions taken

Tools used to evaluate change in condition, medical evaluations, and types of diagnostic testing used pre-transfer, medical and nursing interventions, advanced care planning tools and types of directives in place.

Hospital transfer data

Length of stay prior to transfer, transferring clinician, day of week and time of day, outcome including resident death and receiving institution.

Improvement opportunities

Improvement opportunities, transfers rated as preventable, the resources needed to improve, and determination on whether the transfer should have occurred sooner in the process.

Examining trends in these data sets with the eINTERACT QI Analysis Tool can help an organization focus education and care process improvement activities to prevent unnecessary transfers or to expedite transfer when it is appropriate.

By including this information and data analysis directly within the PointClickCare EHR, staff have admission, readmission and transfer statistics, based on an accepted national standard, at their fingertips. These statistics can assist with root cause analysis and gap identification in an organization's quality improvement program. Additionally, these key measurements can be leveraged when creating ongoing partnerships with acute hospitals, and in providing definitive outcome data for participating in Accountable Care Organizations (ACOs).

How do providers benefit?

A joint initiative between the Florida Atlantic University's INTERACT project team and PointClickCare, eINTERACT is the industry's first and only software design effort to embed the INTERACT quality improvement process and tools directly into an EHR platform. eINTERACT can help providers:

Improve resident safety

By ensuring potential changes in condition are captured and documented in a timely fashion. This enables licensed staff to proactively address any actual changes in condition. If a transfer is necessary, all critical resident information can be provided to the hospital to ensure a smooth transition of care.

Save time and money

By eliminating manual admission/transfer logs and manual readmission rate calculations using a national standard for rate calculation. Plus, required information is automatically captured by the system during the admission and transfer process without disrupting staff workflow.

Ensure compliance

With easy access to accurate and complete transfer information for all residents. Nationally accepted standards and documentation policies are built into the system. Plus, alerts are provided to monitor compliance throughout. As information seamlessly flows within the PointClickCare EHR platform, resident data continually remains current, enabling staff to act quickly and reduce the potential of hospital readmissions.

To learn more about the eINTERACT program, contact your PointClickCare Account Representative today, call 1.800.277.5889 or complete the form www.pointclickcare.com/contact-us.

[1]CMS & AoA: https://acl.gov/Programs/CIP/OICI/BusinessAcumen/docs/AoA_ACA_Slides_032712.pdf

PointClickCare Technologies Inc. is helping over 14,000 long-term and post-acute care (LTPAC) providers meet the challenges of senior care by enabling them to achieve the business results that matter – enriching the lives of their residents and patients, improving financial and operational health, and mitigating risk. PointClickCare's cloud-based software platform is advancing senior care by enabling a person-centered approach to care, connecting healthcare providers across the care continuum with easy to use, regulatory compliant solutions for improved resident outcomes, enhanced financial performance, and staff optimization. For more information on PointClickCare's ONC certified software solutions, please visit www.pointclickcare.com.