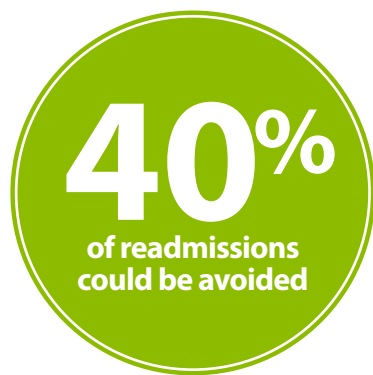




1 in 7 people aged 65 and up and more than 2 in 5 of those 85 years or older require nursing home care annually.<sup>1</sup>



**Experts suggest that up to 40% of readmissions, and emergency room visits could be avoided with better care in the senior care home.**

## Reducing Hospital Readmissions

**Approximately 60%<sup>2</sup> of senior care residents are sent to emergency rooms and 25%<sup>2</sup> are admitted to hospitals each year. What is your organization doing to reduce hospital readmissions?**

Although hospitalizations are required for a variety of reasons, experts suggest that up to 40%<sup>2</sup> of readmissions, as well as emergency room visits and observation stays, could be avoided with better care setting transitions and enhanced care in the senior care home. Now with eINTERACT™, there is a new industry-standard for

HIT, designed for providers to reduce unnecessary hospitalizations. A joint initiative between Florida Atlantic University 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, use of the INTERACT program and tools in manual processes successfully reduce acute care transfers. Incorporating the tools into an Electronic Health Record presents providers with additional opportunities to impact the reduction of readmission rates.

## Early warning of changes in a resident's condition



**Is your staff identifying and reporting a potential change in a resident's condition?**

**Are you sending the right information with a resident upon transfer?**

Early identification of changes in condition is the key to managing and preventing unnecessary transfers. The INTERACT™ Stop and Watch™ Early Warning Tool can be used by nursing aides to identify early warning observations of changes in a resident's condition and such changes can be communicated to the licensed nursing staff. This tool can also be used by any staff who are in a position to observe resident changes, including rehabilitation therapists, environmental services and dietary staff. It is also useful in notating changes in condition that have been identified by visiting family members.

PointClickCare has incorporated the Stop and Watch content into the PointClickCare Point of Care (POC) application. Staff can

quickly identify and alert licensed staff to changes in a resident's condition as part of their normal documentation workflow. All staff, including Dietary, Housekeeping, and Maintenance, should also be trained on how to use the Stop and Watch tool in the Point of Care (POC) application. The Stop and Watch Alerts can also be generated from daily observation tools and communicated to nursing staff outside of POC. This can significantly reduce incidents where changes in resident condition get reported too late or not at all.

After they are enabled, Stop and Watch Alerts are available in the Standard Alert Library for the direct care staff to utilize to notify nursing staff about a resident's change in condition.

## **\*NEW\*** The Right Information During Transfer

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

PointClickCare has incorporated the NH-Hospital Transfer Form into the PointClickCare EHR as the eINTERACT™ Transfer Form and it is automatically triggered when the nurse discharges or transfers the resident to the acute care hospital. The eINTERACT™ Transfer Form leverages the content of the INTERACT NH-Hospital Transfer Form and helps providers clearly communicate high quality information that is critical for the emergency room and other hospital staff to care for the resident. Efforts in completing the form are reduced by auto-populating as much data as available from the EHR, reducing documentation time and risk for transcription error while improving efficiencies in time to transfer. The form can be printed quickly to assist staff in performing the transfer as efficiently as possible, or transferred electronically through secure email.

## Solution Sheet

The INTERACT program can also assist with hospital to nursing home transfers through the use of the Hospital-NH Transfer form. This will improve the transition of care during transfers back from post acute providers. The PointClickCare platform is currently testing electronic communication of the data elements of the INTERACT NH-Hospital Transfer form to provide additional workflow and operational efficiencies to providers during transfers from acute care settings.

### Embedded Quality Improvement (QI) Tools

The success of any quality improvement program depends on the ability to measure and track the associated outcomes and overall effect that the changes have on the home. Understanding the baseline measurements and comparing against results obtained after implementation will be integral to determining the success of the program.

### eINTERACT™ Hospital Transfers Rate Tracker

As part of the eINTERACT™ initiative, PointClickCare has incorporated the functions of the INTERACT Hospital Trend Tracker into the PointClickCare EHR. The required data to track rehospitalization rates is captured automatically in the EHR during admission and/or transfer census events including admitting and transferring practitioner, transfer destination, and resident condition for transfer. This information is then available for analysis by providers to track and trend key indicators and view or export to reports including:

#### Admission Log

A view of all residents who are within 30 days of admission to the home 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 (ED) 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 quality improvement team or committee review. Such reviews are needed to drive changes in the care delivery processes with the goal to further reduce acute care transfers.



**Are there improvements you can make in the transfer process to prevent unnecessary readmissions to hospital?**

## **\*NEW\*** Quality Improvement Tools for Review and Analysis of Acute Care Transfers

Not only do trends across transfers need to be analyzed, but individual transfers should be reviewed to determine patterns and areas for improvement on a case by case basis. The eINTERACT™ Hospital Transfer Quality Improvement Review Tool is designed to help with the analysis of any hospital transfers and identify opportunities to reduce transfers that might be preventable. eINTERACT™ Quality Improvement Worksheet for Review of Acute Care Transfers is intended to be completed for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers.

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

### **Resident Characteristics**

View transfers grouped by age, conditions increasing risk of rehospitalization, other hospitalizations, and transfers to the emergency department without admission to hospital.

### **Changes in Condition**

View transfer data 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**

View data from QI reviews indicating trends on tools used to evaluate change in condition, medical evaluations, types of diagnostic testing used pre transfer, medical and nursing interventions, advanced care planning tools and types of directives in place.

### **Hospital Transfer Data**

View data grouped by LOS prior to transfer, transferring clinician, day of week and time of day, outcome including resident death and receiving institution.

### **Improvement Opportunities**

View 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 you focus educational and care process improvement activities throughout the care continuum to prevent unnecessary transfers or expedite transfer when it is appropriate.

By including this information and data analysis directly within the PointClickCare EHR, providers now have admission, readmission and transfer statistics, based on an accepted national standard, at their finger tips. These statistics can be used for root cause analysis and gap identification as part of the organization's quality



**Research indicates that nearly one-fifth of all Medicare recipients were hospitalized within 30 days of discharge. Nearly 90%<sup>3</sup> of these hospitalizations were classified as unplanned.**

# Solution Sheet

improvement program. Additionally, these key measurements can be leveraged by providers when creating ongoing partnerships with acute hospitals, and in providing definitive outcome data for participating in Accountable Care Organizations (ACOs).

## How do you 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 the PointClickCare EHR.



**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 your staff to reduce the potential of hospital readmissions.

## About PointClickCare

PointClickCare helps healthcare providers meet the challenges of senior care by enabling them to achieve the business results that matter – enriching the lives of their residents, improving financial and operational health, and mitigating risk. PointClickCare's cloud-based software platform takes a person-centered approach to managing senior care, connecting healthcare providers across the senior care continuum with easy to use, regulatory compliant solutions for improved resident outcomes, enhanced financial performance, and staff optimization. Over 9,000 skilled nursing and senior living facilities use PointClickCare today, making it the North American healthcare IT market leader for the senior care industry. For more information on PointClickCare's ONC certified software solutions, please visit [www.pointclickcare.com](http://www.pointclickcare.com).



PointClickCare Version 3.7 is now compliant with the ONC 2014 Edition criteria and was certified as an EHR Module on October 23, 2013 by the Certification Commission for Health Information Technology (CCHIT®).



Scan this QR code for additional information



@pointclickcare



/pointclickcare



pointclickcareEHR

# PointClickCare®

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

06/14