PointClickCare®

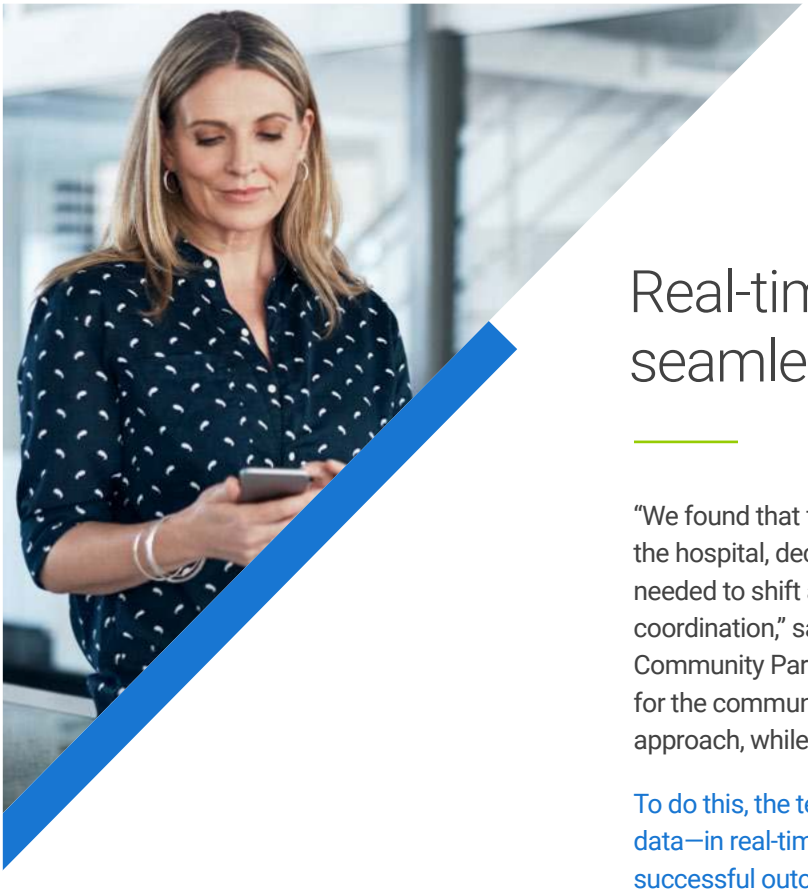
Strengthen Post-acute Network Collaboration and Improve Patient Care

How One University-based Regional Healthcare System Achieved this with PointClickCare

Executive Summary

With 25,000 employees and 4,000 affiliated physicians, this university-based regional healthcare system provides care across more than 150 locations and 13 hospitals. To meet the evolving needs of its providers and patients, the healthcare system has shifted to a more holistic approach to care with an increased focus on post acute collaboration.

Part of the shift includes the creation of a newly defined team responsible for managing relationships and quality data between hospitals and post acute care providers to improve care coordination and better manage patient transitions between facilities. The effort is backed by a team of transitional nurse navigators (TNNs) who manage patients after discharge and about 20 professionals funded by a federal grant provided to support COVID-19 prevention measures in post acute facilities.



Real-time — facilitating seamless care transitions

"We found that for our patients to be successful—to stay out of the hospital, decrease utilization and not be readmitted—we needed to shift away from a discharge focus to holistic care coordination," says the organization's Director of Quality and Community Partnership. "We're now focussed on being a provider for the community and taking more of a population health approach, while also being efficient and cutting costs."

To do this, the team needs to access and share important patient data—in real-time— facilitating seamless care transitions and successful outcomes for patients.

Integrated Care Coordination platform

"We need to know if a patient is in the right place and has the resources needed for a successful outcome," they said. "If the patient is sent to a skilled nursing facility (SNF), we need to ensure that he or she can successfully transition back to the community."

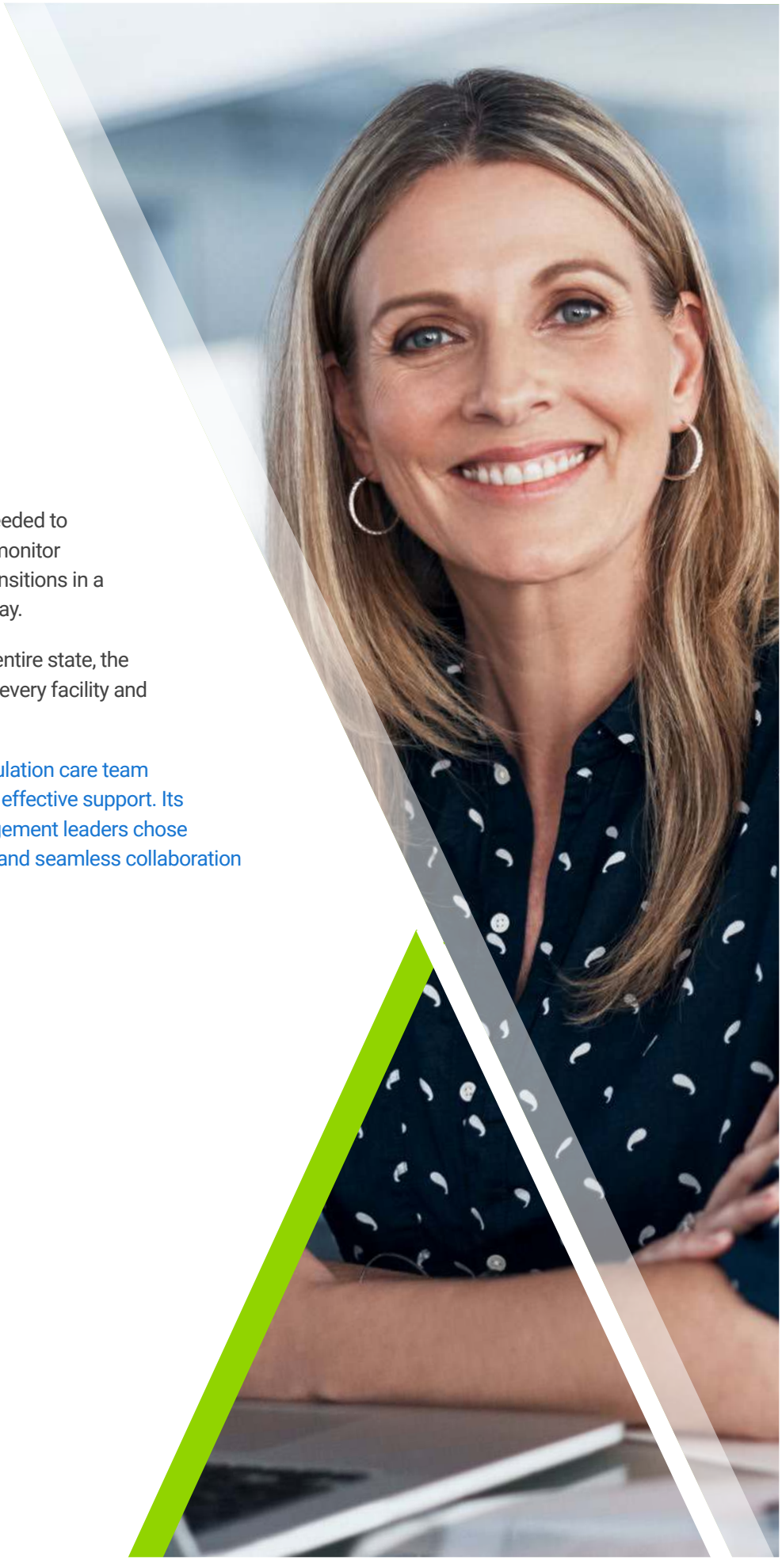
The team needed technology for support and turned to PointClickCare's award-winning Integrated Care Coordination platform.

The Challenge

Simply put, this healthcare system needed to improve and streamline its ability to monitor patients and coordinate their care transitions in a thoughtful, intelligent, and scalable way.

With five case managers across the entire state, the team knew that they could not touch every facility and manage every patient directly.

In 2019, the healthcare system's population care team started researching options for more effective support. Its executive leadership and care management leaders chose PointClickCare for the real-time data and seamless collaboration it provides.



Our Solution: Elevating Care Management with Real-time Collaboration

PointClickCare empowers the team to streamline patient transitions and create more efficient processes for its staff, ultimately leading to better care for patients.

"The PointClickCare team helped train our skilled nursing facilities and the staff at those buildings readily embraced the new solution," said the clinical operations leader. "Now they don't have to spend time chasing paper and contacting hospitals, and they have real-time access to the information they need to care for and manage patients."

PointClickCare helps the Transitional Nurse Navigators short-list which patients are at the highest risk at any given moment by looking at clinical data in real-time and empowers staff to intervene when necessary. Staff no longer waste time looking through stacks of medical records to find the information they need and attempting to identify, on their own, the patients who most need their attention.

"What's so attractive is the functionality PointClickCare provides," they added. "Teams now have easy access to data about each patient right into the clinical workflow at the skilled nursing facility, including medications they are taking, immunizations, lab and treatment orders, and they know who is at high risk during transitions of care. We can get facilities—even the ones that we only send a handful of patients to each year—the info they need, when they need it, leading to better outcomes for our patients."

PointClickCare enables each TNN to manage a caseload of about 60 patients, yet as the transition to PointClickCare unfolds, the team expects to be able to easily handle more. "We are scaling to meet the needs of more patients because now our nurses know who to focus on and can shift their attention as high acute patients change."

PointClickCare also shows teams where risk is trending, so they operate a step ahead. "We no longer need to call a facility and bother them for updates on a patient. Instead, we can check PointClickCare to see when an issue is trending down and we can rest assured that facilities have it under control and don't need our intervention. It enables us to turn our attention to someone who needs us."

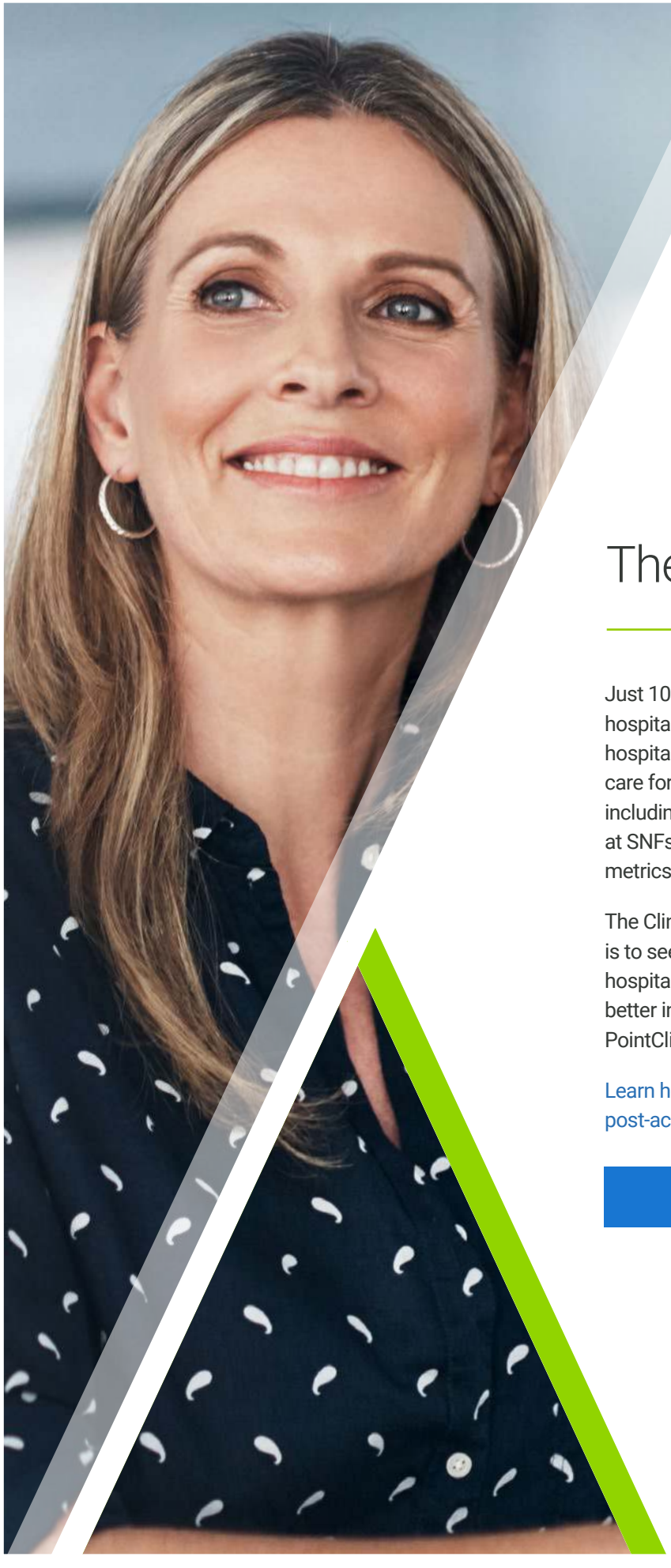
Managing Care Through COVID-19

PointClickCare enabled skilled nursing facilities to capture the medical records of SNFs and find the metrics they needed to report on the grant and helped them manage the incredibly complex logistics created by the pandemic

It goes without saying that the COVID-19 pandemic has put immense burden and risk on hospital systems that were already managing increased workloads and cost-cutting pressures. Fortunately, this hospital system received a federal COVID-19 relief grant just months after implementing PointClickCare, which helped to alleviate some of the pressure the pandemic added to SNFs. The system used the grant funding to help manage infection control in its facilities, employing data analysts to continually monitor COVID-19 and community positivity rates, determine potential hot spots, and deploy teams to go onsite at skilled nursing facilities to help where needed, for instance to do fit testing for N95 masks, provide supplies, and set up covid units.

PointClickCare enabled them to capture the medical records of SNFs and find the metrics they needed to report on the grant. It also helped them manage the incredibly complex logistics created by the pandemic, including managing vaccinations—two different vaccines with two different doses—of patients going in and out of SNFs.

“With PointClickCare, we now have the ability to access critical information about COVID-19 vaccinations to know whether a patient has received a vaccine, which vaccine they received, and whether they have yet to receive the second dose,” according to the clinical operations team. “We can share the information bi-directionally between hospitals and SNFs, which puts us far ahead of what other hospital systems are doing.”



The Results

Just 10 months into its transition to PointClickCare, this hospital system has improved collaboration between hospitals and post acute care providers, enabling better care for patients. It tracks key performance indicators, including 30-day readmissions and length of patient stay at SNFs, and expects to continue to seeing decreases in all metrics as it completes its transition to PointClickCare.

The Clinical Operations team believes: “What’s important is to see quality process improvements between our hospitals and SNFs and to see our patients perform better in the SNFs as a result of better collaboration. PointClickCare enables us to do that.”

Learn how our award-winning solution can strengthen your post-acute network performance and improve patient care.

Request More Info

PointClickCare®

Our award-winning Care Coordination solution, improves post-acute network management and patient outcomes with actionable insights about patients and facilities.

We give providers access to the right patient data in their existing workflow without disrupting care teams when discharging or receiving a patient. It helps monitor high-risk patients during their long-term post-acute stay by receiving live updates as patients' health changes. And it prevents readmissions and enhances care outcomes with a single place to monitor post-acute patients across facilities.

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