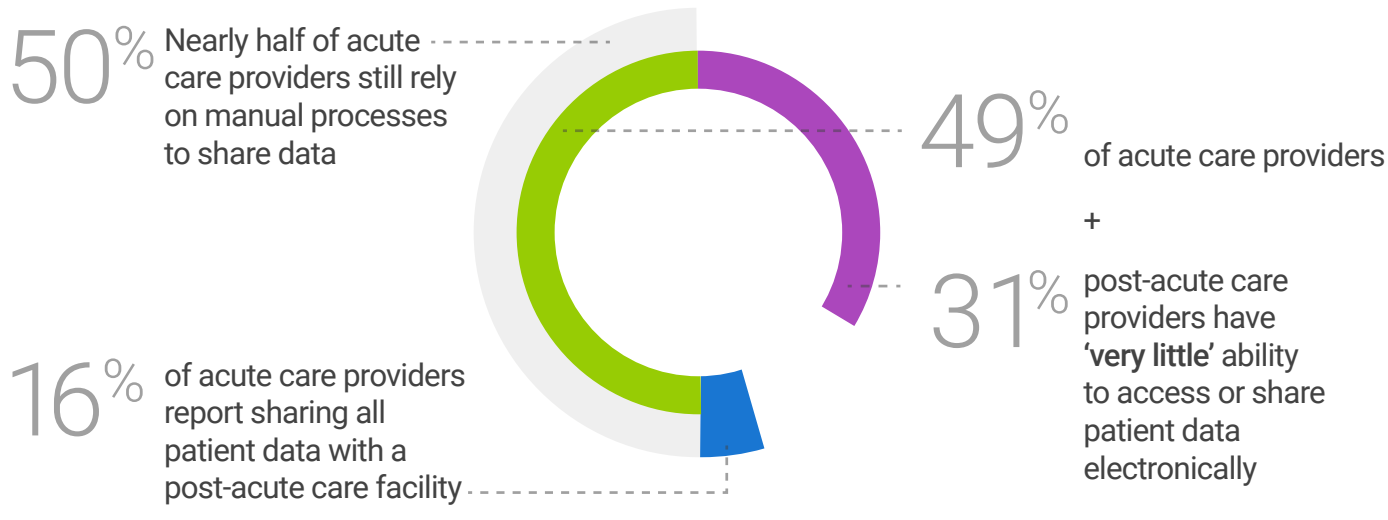
Transitioning to Post-Acute Care:

The Patient Journey

A change in care setting from acute to post-acute is one of the most vulnerable times in the patient journey.

That's why it's important for care providers to master their care transition process to drive better outcomes, earn more referrals, and maintain a healthy census.

A new patient transition study[1] reveals that many healthcare organizations still struggle with the seamless exchange of information.



The Hard Reality SNF Providers Face Today

40% of patients over 65 have medication errors after leaving the hospital[2]

18% Medicare patients discharged from a hospital were readmitted within the first 30 days[2]

Four Ways to Overcome Gaps in Transitions with Technology

Coordination
Improve coordination with other providers in your network with data sharing

Visibility
Gain full visibility into your patient prior to admission

Finances
Understand the full financial impact of your potential residents

Relationships
Form strong relationships with network partners by proving your outcomes

A Care Transition Scenario

Name: **Jane**
Age: **85**
Condition: **Kidney failure**
ER Admission: **Dialysis infection**
Comorbidities: **Dementia, Hypertension**

Manual, Disjointed Scenario	Streamlined Scenario
Scenario 1 Hospital staff don't communicate full patient picture (treatments or follow-up appointments) resulting in hours of administrative work. Nurse isn't aware of important details around previous care or lab work needed.	When Jane arrives, her assigned nurse: Understands her background Immediately gets started on a care plan Baseline plan completed within the first 48 hours
Scenario 2 Jane arrives at without a discharge summary or medical history. Nurse does not have full context into the necessary pre-admission information.	Jane arrives with a hard copy of pre-admission history SNF staff already have access to her history Completes a successful transfer
Scenario 3 Nurse must comb through multiple documents, potentially overseeing critical information about medications.	SNF nurse receives a full list of medication prior to Jane's arrival Immediately writes orders to pharmacy
Scenario 4 SNF admits Jane without proper insurance coverage. Leading to negative impact on census and bottom line.	SNF understands the full financial picture prior to arrival. Remains profitable with better understanding of ideal payer-mix Revenue goals not impacted with costly readmissions

Streamline Transitions Today

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Footnotes for citations
1 Technology Use During Transitions of Care (Study) Definitive Healthcare 2019, commissioned by PointClickCare | 2 The National Investment Center for Seniors Housing and Care (NIC)