PointClickCare®

TECH CHECK

Solutions for ACOs and RBEs

Do you have the advanced care coordination tools you need for improved quality performance?

Accountable care organizations (ACOs) and other risk-bearing entities (RBEs) face many challenges when it comes to managing their patients as they move through the care continuum. Lack of awareness around patient activity and utilization can lead to gaps in care, resulting in costly and unwanted outcomes such as avoidable readmissions and emergency department utilization.

For ACOs participating in the ACO REACH Model and RBEs working to improve health equity and quality scores, having the right technology is critical for performance.

There are technology solutions available that can help facilitate better care transitions and collaboration, leading to improved patient outcomes.

Do you have what you need for your organization? Use this checklist to find out.

Challenge	Solution
Visibility during patient transitions of care	✓ Utilize automated reporting of inpatient, emergency department (ED), skilled nursing facility (SNF) admissions, discharges, and transfers for timely follow up and safer care transitions that reduce readmission risk.
Improve care collaboration throughout the network, including post-acute care providers	✓ Gain access to an extensive network of acute and post-acute providers at the point of care and efficiently coordinate across the healthcare continuum.
High-risk patient identification	✓ Access real-time patient data to quickly and easily identify high-risk patients using integrated risk models focused on all patient 30-day readmissions, as well as SNF predictive return-to-hospital algorithms based on the most extensive senior care dataset.
Prioritize patients requiring post-discharge outreach	✓ Create a daily discharge report that can track patients requiring post-discharge follow up after an inpatient stay. The report can help care managers identify patients who are at highest risk of readmission, allowing them to easily know which patients to prioritize for follow up.
Preventing avoidable readmissions	✓ Receive automated, real-time alerts for patients with high readmission risk scores to ensure timely outreach if patients present at the ED, or need more care transition support.
SNF patient discharge & follow up	✓ Access customized cohort reporting to track SNF admissions to help care managers stay aware of patients admitted to a SNF from any hospital on the network.
Tracking patients enrolled in specific care management programs	✓ Implement automated tracking capabilities that can “tag” patients based on care complexity, clinical conditions, and/or frequent ED or inpatient visits and then alert care managers when encounters occur.
Identifying out-of-network encounters	✓ Access customized cohort and reporting features to track “out-of-network encounters” for easy identification of network leakage.

Looking for more information on ACO REACH and finding the right health IT partner for success?

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