PointClickCare®

Solution Sheet

Intelligent Transitions

Real-time data and intelligence to guide clinical decisions and actions through care transitions.

Intelligent Transitions provides the tools and data to better treat, track and manage patients from the emergency department (ED) to inpatient and post-discharge settings across the care continuum, helping to reduce readmissions, optimize lengths of stay and reduce network leakage.

Make timely, informed clinical decisions with real-time data and visibility.

Even with electronic platforms to keep track of patients, health systems struggle with insight as patients move in and out of the acute continuum. Care teams need greater visibility into the patient journey with more awareness of encounters, inpatient progress, and highlights of risk providing the basis for collaborative intervention and prevention strategies that can also reduce hospital and post-acute stays as well as potential ED visits or rehospitalizations.

Intelligent Transitions gives real-time visibility to the care team for any patient or setting the care managers are monitoring, helping to coordinate care with downstream providers, optimize case management programs, and improve overall outcomes.

How does Intelligent Transitions help?.

- Access care guidelines, care history and care team information at your fingertips.
- Improve care transition workflow and efficiencies, reducing duplicative care.
- Share patient information and care recommendations with other providers.
- Easily identify patients with high and rising readmission risk for proactive intervention.
- Reduce costs and impacts related to readmissions and extended lengths of stay.
- Remain actively engaged in patient care after acute discharge.
- Real-time encounter notifications of admissions and discharges in or out of network.

What you can expect with Intelligent Transitions

Real-time patient insights.

Easily identify patients with long length of stay to support a proactive planning and discharge efforts helping to decrease overall length of stay. Provide care managers and transitions of care coordinators with real-time alerts about acute and post-acute encounters after discharge from your facility. Notifications cover inpatient, emergency department or observation encounters and out-of-network admissions; helping you track and manage patients as they move across the care continuum.

Improved care collaboration.

Leverage data and real-time intelligence to guide clinical decisions and proactively address changing patient needs while in other care settings. Easily share patient information and care recommendations with other providers and broader care teams.

Quality outcomes and reduced penalties.

Readmission risk scores provide care managers the ability to surface high risk patients or encounters of interest. Increased visibility of patients who may need outreach or a higher-touch post-discharge can lead to more proactive engagement, improving patient outcomes and reducing readmission penalties.

North America's Most Comprehensive Care Collaboration Network

Scan or click code to discover more

PointClickCare is a leading healthcare technology platform enabling meaningful collaboration and access to real-time insights at every stage of the patient healthcare journey.