PointClickCare®

Customer Story

# TriHealth Improved Post-Acute Transitions and Reduced Readmissions by 68% with Real-Time Data

> What started out as a focus on reducing medication errors transformed into a holistic view of healthcare for patients transitioning to a post-acute setting. We gained visibility into the patients' progress and were able to be more proactive supporting them across the continuum. We are notified when a patient is discharging to identify possible risks and help set them up for success while preventing negative outcomes, like readmissions. This has improved patient outcomes and satisfaction.

**Lori Baker**
Director of Population Health Care Management and Post-Acute Network TriHealth

TriHealth

Integrated, not-for-profit, health system and ACO

140+
Four hospitals and 140+ sites of care

200+
Network of 200+ skilled nursing facilities

Located in Cincinnati, OH

## The Challenge

### TriHealth Needed Visibility into Patient Post-Discharge Progress

TriHealth is an integrated health system and accountable care organization (ACO) responsible for the full risk of a traditional Medicare population and ACO REACH program. They are always looking for ways to better support their patients and value-based care goals.

TriHealth's internal assessments identified a need to improve care transitions from inpatient to post-acute to discharge to home, long-term care, hospice, or the next destination. Primary care providers and ambulatory care managers could not see their patients' progress when they were discharged to a skilled nursing facility (SNF), and if their patient was discharged from a hospital outside the TriHealth system, they couldn't see which SNF was caring for them. In addition, patient data didn't flow with them, causing gaps in care or miscommunication that increased their readmission risk.

While TriHealth initially focused on gaining visibility into the patient's discharge list of medications to prevent errors, they worked with PointClickCare and identified PAC Management as the right solution to improve transitions of care.

## The Solution

### Real-Time Data for More Insights and Better Collaboration

The **PAC Management** solution provides TriHealth with a simple, automated way to exchange clinical insights between their care management teams and post-acute facilities. TriHealth care teams can see patient progress at the SNF, current status, and risk profile, allowing them to act quickly to plan for successful discharges and to avoid unwanted outcomes.

Since TriHealth took a multipronged approach, they also made investments in key nursing roles responsible for monitoring patient progress and managing the collaborative relationships with their SNF partners. “Our nurse care manager utilizes PAC Management daily to determine patient needs while still in the SNF or post-discharge, and she agrees she cannot do her job without it. This has been a game changer!” Lori Baker, Director, TriHealth

## The Outcome

### Improved Metrics, Relationships, and Patient Care

TriHealth has deployed PAC Management at 45 locations so far. The health system has seen benefits in the form of reduced inpatient readmissions, dropping from 25% down to 8%. SNF lengths of stay, previously tracking at 25 days, went down to 18 days on average.

The solution unlocked new levels of staff efficiency, giving clinicians time back to focus on patient care while enabling more robust and collaborative relationships with the SNFs in their network. Dedicated nurse case managers now work closely with SNF partners to align goals and metrics and highlight new areas of focus to continue improving outcomes for other patient groups in their care.

"PAC Management helped us to reduce readmissions by 68% and SNF lengths of stay by 28%, and at the same time stimulated more meaningful working relationships with our post-acute partners. But what makes this solution so valuable to every hospital system and nursing facility, is that it not only impacts outcomes and drives success, but helps us all fulfill our purpose of caring for vulnerable patients,” said Baker.

## Learn More

If you’re interested in implementing PAC Management to help your organization achieve results like those experienced by TriHealth.

Scan or click QR code to discover more

## How PAC Management Helped

Enhanced visibility across care settings

Improved SNF relationships and continuous collaboration

68%

Reduction in hospital readmissions

28%

Reduction in SNF length of stay

## About PointClickCare

### North America’s Most Comprehensive Care Collaboration Network

PointClickCare is a leading healthcare technology platform enabling meaningful collaboration and access to real-time insights. More than 27,000 long-term and post-acute care providers, 3,600 ambulatory clinics, 2,800 hospitals, 350 risk-bearing providers, 70 state and government agencies, and every major U.S. health plan use PointClickCare for care collaboration and value-based care delivery for millions across North America.

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