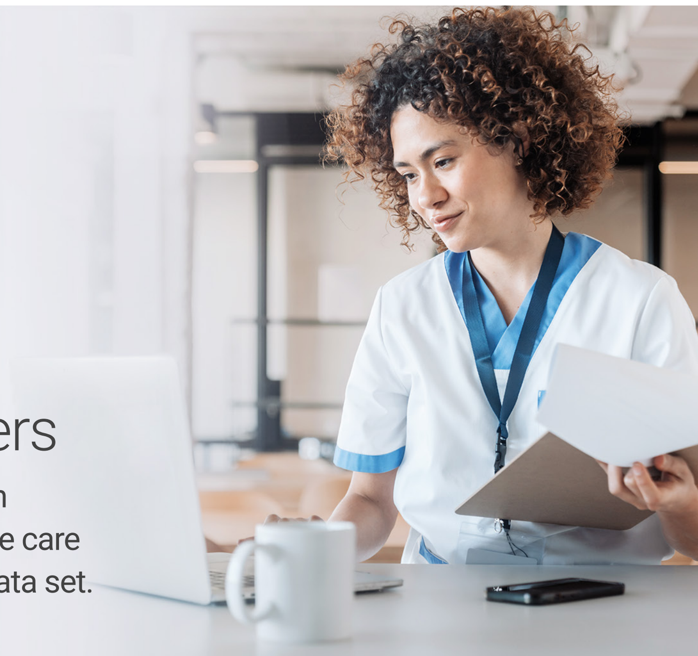
PointClickCare®



Solution Sheet

PAC Management for ACOs & Risk-Bearing Providers

Improve clinical and value-based outcomes through increased visibility and collaboration with post-acute care providers, powered by an unparalleled post-acute data set.

PAC Management connects hospitals, ACOs and other risk-bearing providers with post-acute partners to facilitate seamless transitions, enhanced care collaboration and better post-discharge outcomes through easy access to real-time patient data.

Gain Visibility Into a Patient's Condition and Post-Acute Readmission Risk

Patient transitions from the hospital to a skilled nursing facility (SNF) often result in reduced visibility into their condition and limited ability to influence their care.

PAC Management enables hospitals, health systems, Accountable Care Organizations (ACOs), and other risk bearing providers to better monitor their post-acute populations, quickly identify patients of concern, provide timely intervention, and better manage value-based performance.

Coordinated transitions of care are crucial to value-based performance. Care and case managers can easily follow their patient populations, stay informed, take immediate action, and ensure the best care delivery and outcomes.

How does our solution help?

- Reduce avoidable readmissions and SNF length of stay (LOS) with access to patient risk, vitals, and other chart-level data from the SNF
- Drive timely collaboration between hospitals, PCPs, specialists, and their SNF partners with real-time patient data
- Easily monitor transitioning patient populations to ensure proper admission and intake at the SNF
- Eliminate time spent searching and calling for patient status updates
- Optimize skilled nursing LOS by identifying patients ready for discharge
- Easily identify patients, groups, and diagnoses driving LOS or readmissions
- Improve patient outcomes and value-based program performance with more integrated, collaborative care

What You Can Expect With PAC Management

Monitor and Manage Patients Across Your Care Ecosystem

Arm physicians and care managers with information and key insights as patients move to post-acute care. Get confirmation of SNF admissions, intake and medication reconciliation with detailed chart-level patient data. Real-time hospital readmission risk scores are informed by our Predictive Return to Hospital (pRTH) machine learning model, trained from the largest senior care dataset in North America. This helps care teams zero in on patients requiring immediate attention, allowing for proactive care collaboration between acute and post-acute settings.

Advance Transitional Care Management

Automating the transition handoff of medications and orders between care settings ensures consistency and helps to reduce readmissions. In the event of a transfer back to the hospital, ED clinicians can receive the latest relevant data and medications within the ED track board ahead of the patient's arrival, helping to triage and stabilize patients faster. Providing the right information to case managers when they need it further ensures successful and safe transitions and avoids readmissions.

Improve Value-Based Performance

Drive quality score improvements, reduce penalties, and maximize reimbursements through collaborative care and reduction of unwanted outcomes. Further impact value-based performance at a macro level by improving relationships with post acute providers. Streamlined access and visibility to up-to-date CMS quality scores, rehospitalization, and ED visit rates as well as other metrics equips your teams with key data points and trends for transparent discussions with skilled nursing facilities.

North America's Most Comprehensive Care Collaboration Network

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PointClickCare®

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