PointClickCare®

Solution Sheet

PAC Management for Health Plans

By tracking and managing members during and after their skilled nursing facility stays, health plans can simplify patient transitions, reduce unnecessary hospital readmissions, and enable better post-discharge outcomes.

Optimize Care Management Workflows with Post-Acute Care Insights

With outdated and disconnected clinical data in various electronic health records (EHRs) and workflows, care managers experience challenges in exchanging critical member information with broader care teams. Lacking visibility and accurate member information, care managers exhaust limited resources to care for their post-acute populations.

Health Plans require a solution that can create workflow efficiencies, save time, and improve outcomes for their members. PAC Management helps health plans improve clinical and financial outcomes through increased visibility and improved collaboration with their post-acute care providers.

How Does Our Solution Help?

See where your members are and how they are doing in real time

Ensure smooth post-acute transitions with access to real-time data on SNF admissions

Identify high-risk members and populations of interest to improve member outcomes and experiences

Collaborate with post-acute providers and deliver real-time insights into member conditions and status

Manage members easily through customizable alert criteria and enable care managers to act immediately upon patient transitions or readmissions

Maximize savings by monitoring inpatient readmissions and SNF length of stays

What You Can Expect with PAC Management

Actionable and Timely Information from the Largest Post-Acute Care Network in the U.S.

Track members in real time as they move across the care continuum. Health Plans can tap into the largest post-acute network in the U.S. – a national network of more than 27,000 long-term and post-acute care providers – connecting patient data across all 50 states for accurate, real-time visibility into where members are and their clinical status as they transition to, and during, their post-acute stay.

Improve Outcomes and Reduce Total Cost of Care

Identify high-risk members early and prevent unnecessary hospital readmissions by leveraging timely risk insights to proactively manage care collaboration efforts. Prioritize members by length of stay (LOS), discharge date, and readmission risk using insights from the clinical record to predict which members are at highest risk of readmissions or complications.

Improve Post-Acute Care Transitions

Enhance post-acute care transitions and discharge planning with real-time visibility into clinical data, including member location, clinical status, and medication reconciliation, optimizing care manager workflows to facilitate seamless collaboration with your post-acute network.

About PointClickCare

PointClickCare is a leading healthcare technology platform enabling meaningful care collaboration and real-time patient 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.

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.