PointClickCare®

Solution Sheet

PAC Management for Hospitals and Health Systems

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

PAC Management connects hospitals and health systems 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 allows hospitals and health systems to better monitor their post-acute populations, quickly identify patients of concern, provide timely intervention, and better manage partner network performance.

Care and case managers can easily follow their patient populations, stay informed of their progress, and ensure timely care interventions to improve outcomes.

How does our solution help?

- Reduce readmissions and SNF length of stay (LOS) with patient risk, vitals, and other chart-level data from the SNF
- Optimize skilled nursing LOS by identifying patients ready for discharge
- Drive timely collaboration between hospitals, health systems, and their SNF partners with real-time data
- Easily monitor transitions to ensure proper admission and intake at the referred SNF
- Eliminate time spent searching and calling for patient status updates
- Improve patient outcomes and quality metrics with greater collaboration across settings
- Easily identify patients, groups, and diagnoses driving LOS or readmissions
- Measure facility performance and trends to drive continuous improvement

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. Providing timely and relevant information and resources to case managers further ensures successful and safe transitions and helps improve clinical outcomes. In the event of a transfer back to the hospital, emergency department (ED) clinicians can receive the latest relevant data and medications within their ED track board ahead of the patient's arrival, helping to triage and stabilize patients faster.

Improve Partner Network Performance

Enhance network performance at a macro level by improving collaboration and accountability with post-acute partners. Streamlined access and visibility into 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. This supports transparent discussions and bench-marking opportunities with skilled nursing facilities in your network.

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