PointClickCare®

From Insights to Impact:
Driving Reductions in ED and Acute Costs While Improving Outcomes

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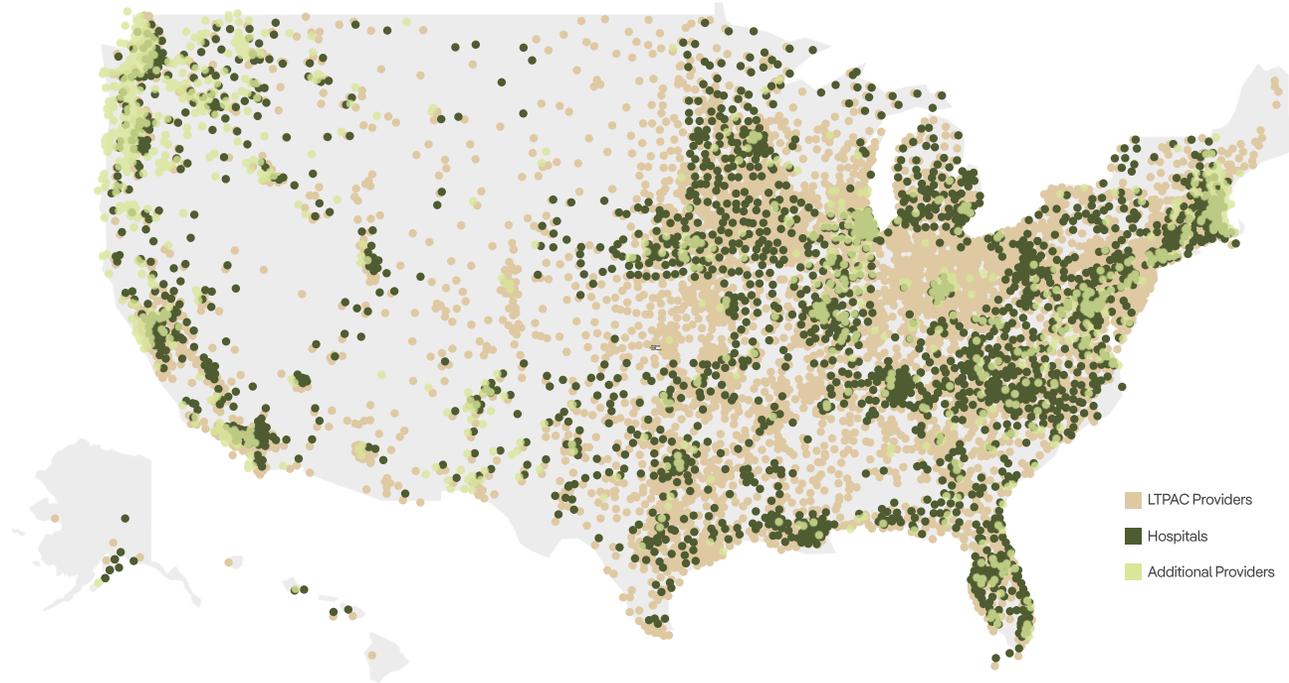backed by PointClickCare

Network Fast Facts

2,800+
Hospitals

350+
ACOs & Risk-Bearing
Provider Organizations

3,600+
Ambulatory Clinics

27,000+
Long-Term & Post-Acute
Care Providers
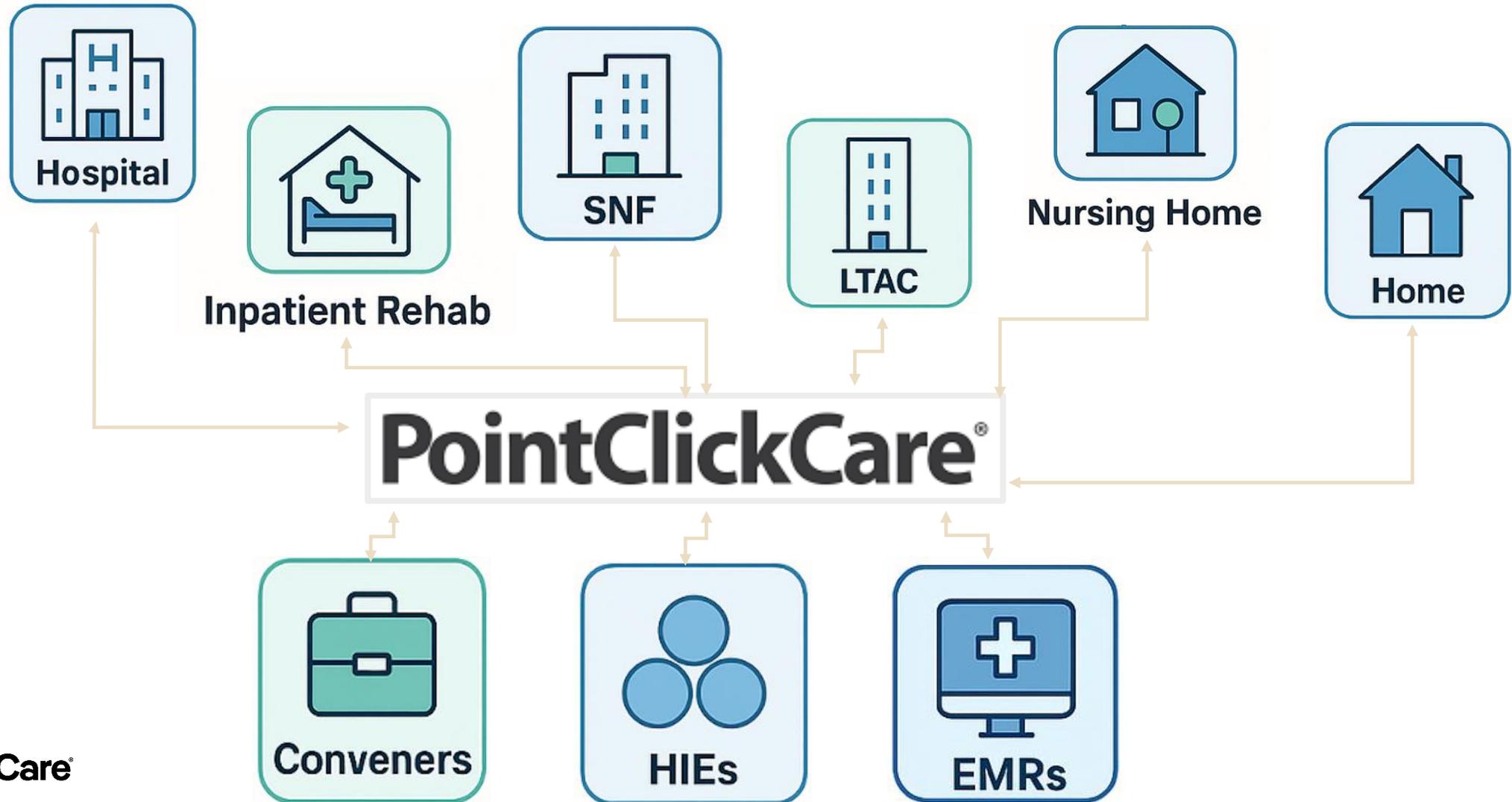
70+
State & Government
Agencies

Every
Major U.S. Health Plan

LTPAC Providers
Hospitals
Additional Providers

400+ integrated solutions as part of the Marketplace

105M+ health plan lives

100+ national and regional association partnerships with organizations such as CMS, AHCA, Argentum, LeadingAge, HIMSS, and AHIP

PointClickCare®

PointClickCare Enables Collaborative Micro-Networks

PointClickCare

Hospital · Inpatient Rehab · SNF · LTAC · Nursing Home · Home

Conveners · HIEs · EMRs

3

Across Many Use Cases

Care Transition Alerting: Real-time alerting of key encounter events

Care Plan Collaboration: Care plan collaboration and sharing across EMRs and other systems

Addressing Rising Clinical Risk: Automated data analysis across care settings to identify rising clinical risk with especially deep clinical and performance information on SNFs

Surfacing ED Care Insights: Actionable tidbits of information on complex / chronic patients tailored for the ED, automatically pushed to the ED provider with an alert on the ED track board, that reduce medically unnecessary workups and admissions

Protecting Behavioral Health / SUD / Sensitive Data: Sharing of sensitive data via 42 CFR Part 2 compliant consent

More / Customizable Use Cases: Additional capabilities and standardized use cases to support the various provider types

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Acute & Risk-Bearing Entity Solutions

Hospitals

Visibility into patients medical and utilization history **upon ED arrival, integrated into the EMR and provider workflow**
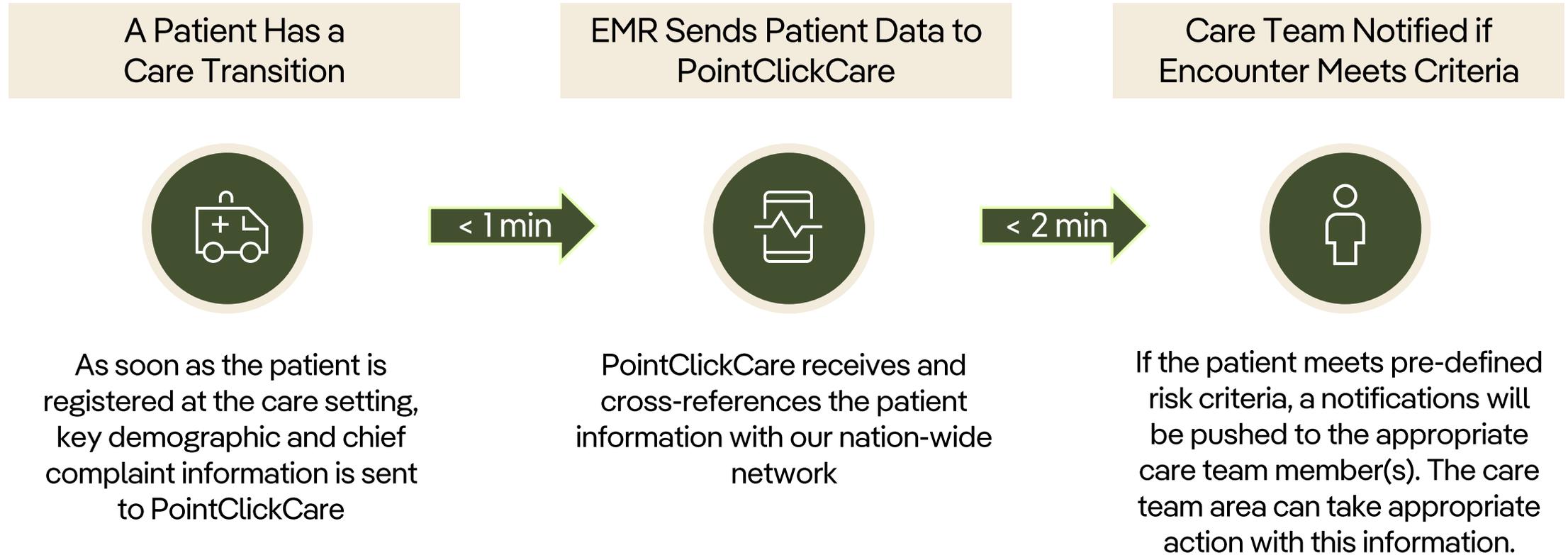
Value Based Care

Track and manage patients as they move **across** the **care continuum**

PAC Management

Visibility into what's happening with patients when in a **post-acute care setting**

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Enabling Critical, Real-time Insights to be Automatically Pushed to the Appropriate Care Team Member

A Patient Has a Care Transition	EMR Sends Patient Data to PointClickCare	Care Team Notified if Encounter Meets Criteria

< 1 min

< 2 min

As soon as the patient is registered at the care setting, key demographic and chief complaint information is sent to PointClickCare

PointClickCare receives and cross-references the patient information with our nation-wide network

If the patient meets pre-defined risk criteria, a notifications will be pushed to the appropriate care team member(s). The care team area can take appropriate action with this information.

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ED Optimization

Improved Staff Safety

Multi-channel alerts to appropriate ED staff when a patient with a history of violence registers in the ED

Improved Point of Care Decisions

ED-specific care insights, based on the hospital's chosen risk criteria, automatically pushed to the EMR with an alert on the ED track board

Reduced Medically Unnecessary Inpatient Readmissions and ED Length of Stay

Key clinical insights from the PCC SNF EMR, automatically pushed the EMR with an alert on the ED track board.

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Top Insights Delivered to the ED

- History of Violence, Safety/Security Events
- Recent Post-Acute Discharge or Transfer
- Patterns of High ED Utilization
- Mental and Behavioral Health Events
- Substance Use Disorder or Overdose Events
- ED Care Recommendations and Care Plans
- Acute Readmission Risk
- Social Determinants: Housing insecurity
- Traveling Patients
- PDMP controlled substance tracking

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ED Optimization Notifications

Promotes faster evaluation, stabilization, admission or return to SNF

Implemented to dovetail into the provider's workflow:

- Alert on ED Track Board
- FHIR-based app that runs within the EMR
- Single page summarizations of what the ED provider needs to know
- Meant to be digested by the provider in 60-90 seconds
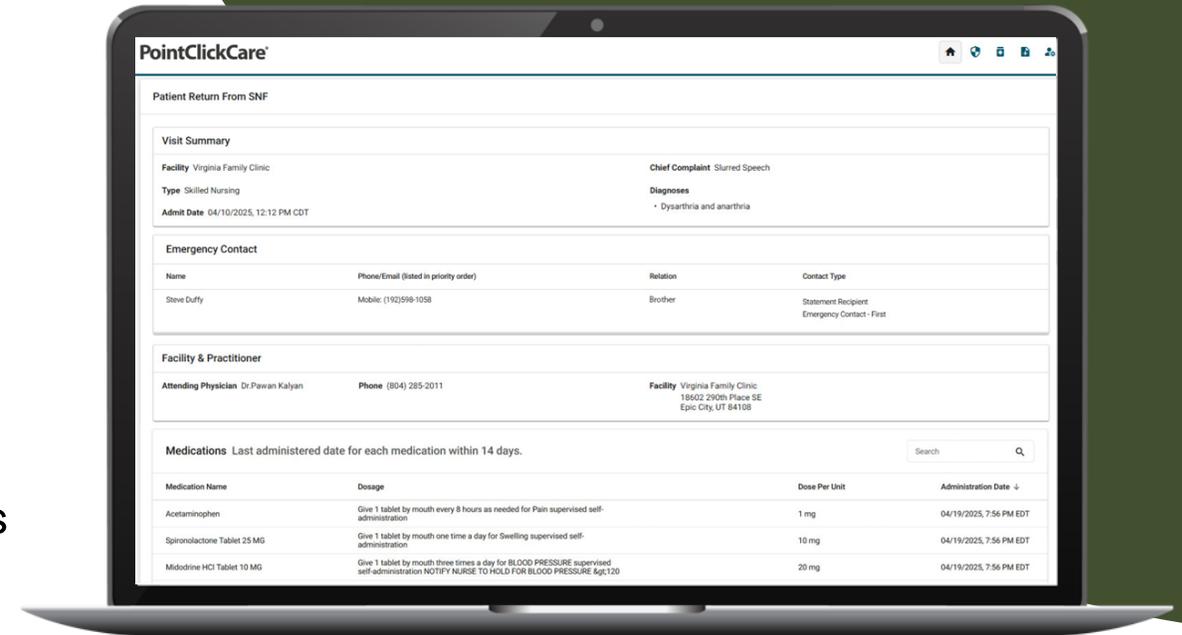
For Organizations With a Challenging Integration Environment

PointClickCare also supports notification approaches to engage care team members outside of an EMR. Some of the supported methods are:

- Fax
- Printer
- Text
- Email

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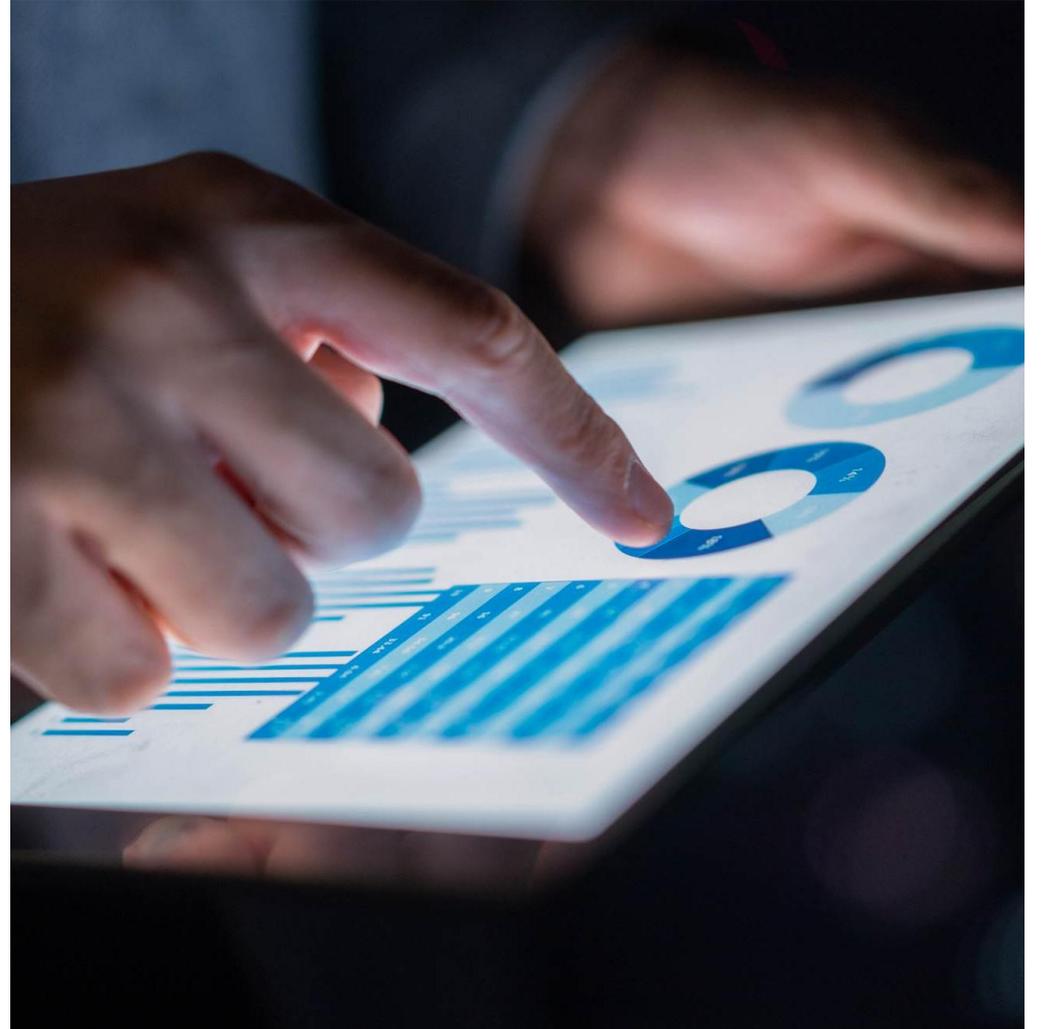
PAC Management Solution

PAC Management helps hospitals/health systems, ACOs, and post-acute partners facilitate better care transitions and collaborate, leading to improved patient outcomes.

- Patient Monitoring - Enables care management to monitor patients during a SNF stay and proactively identify patients requiring attention & intervention.

- Network Scorecard - Manage your SNF network's performance using real-time dashboards with key metrics and benchmarks

- Clinical Data Exchange - Improves information sharing between hospitals and SNFs around care transitions

Impacts:	- Improve SNF length of stay - Reduce inpatient readmissions - More informed conversations and collaboration between partners

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Enabling Better Communication Between Acute and SNF

Pain Point #1

Disconnected Care: Lacking Visibility Into Data From Skilled Nursing Facility Stay When Patients Present At ED

→ ✓

PCC Provides

ED Trackboard Alerts and Key Insights from the SNF

Pain Point #2

ED providers lack the time to review full medical charts and must make clinical decisions based on a limited subset of data

→ ✓

PCC Provides

ED-specific care insights / recommendations can be pushed to the ED provider

Pain Point #3

Visibility into patient status while at the post-acute provider is very limited

→ ✓

PCC Provides

Extensive visibility into the post-acute EMR to promote better patient outcomes and for network performance

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Community Health Network

Reducing ED Post-Acute Readmissions and ED Length of Stay

Challenge

- ED teams lack critical patient info and access to SNF data, as most facilities aren't in state HIEs
- Avoidable readmissions and duplicate testing due to missing or delayed SNF information
- ED decision-making and throughput delays caused by faxed documents and manual data-gathering

Solution

- **ED Optimization** equips emergency department staff with more comprehensive, timely and relevant patient history and insights for high-risk and vulnerable populations. This real-time information is delivered immediately into their workflow, is standardized and easy to read and includes a summary of the skilled nursing stay so they have key information like stay dates, diagnoses, care teams, and administered medications.

Results

- **33% reduction** in post-acute patient readmissions from ED
- **50-min reduction** in post-acute patient ED length of stay
- **120** unnecessary inpatient admissions avoided in first few weeks

"We've seen a clear impact from ED Optimization and the SNF Summary. It brings key patient information directly into our clinicians' workflow, helping them make faster and more confident decisions. In just a few weeks, we reduced readmissions by about 33 percent, avoided 120 unnecessary inpatient admissions, and cut ED length of stay by almost an hour.

That's a big deal for our staff and our patients. When SNF residents arrive without context, we're often flying blind. This solution closes that gap in real time and helps us deliver better care, avoid unnecessary inpatient stays, and make sure patients are admitted quickly when needed."

Patrick McGill , MD MBA FAAFP
Chief Transformation Officer, Community Health Network

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