Post Care/Care Transition Management Overview

The EcoSoft Health Care Transition Management solution allows health care facilities and their associated network of locations and practices to automate patient follow-up after any type of health care encounter, even an office visit, as well as for chronic disease management. It is designed to assist in the transformation to a value-based care model.

How it works

On receipt of a care encounter notification, which may be from an automated integration with a hospital medical record/patient registration system, the solution initiates a Digital Care Pathway™ that sends one or more follow-up communications to the patient or designated contact at time intervals specific to the type of encounter. Communication pathways can incorporate discharge instructions, reminders, satisfaction surveys, questionnaires, and health status assessments. Ongoing wellness messaging and a tailored interactive patient coaching site, specific to the care delivered, can also be part of the follow-up pathway.

In addition to patient self-administered assessments, pathways can include assessments administered by a medical assistant. Available for dozens of the top discharge diagnoses and chronic conditions, completion of one of these assessments launches an evidence-based, physician-developed expert system. Staff members are empowered to perform a physician-level medical history. Results are immediately synthesized into a physician-friendly post-discharge follow-up note with clinical history, a comprehensive care plan, and personalized patient recommendations and interactive coaching delivered via web browser.

The EcoSoft Health solution provides objective measures of patient health-status, readmission risk and care progress that can generate an immediate alert to any or all members of the patient care team if results exceed set thresholds or detect worrisome trends. Alerts can identify an urgent intervention need or care-plan change that may avoid unnecessary hospital readmissions. Assessment results are stored in a database and analyzed in dynamic real-time dashboards. They can be exported for additional analysis or demographic consolidation if desired.

Why use it

Government at both federal and state level is acting to improve healthcare outcomes using a combination of penalties for excessive readmissions and incentive payments for excellent performance. Hospitals lack the infrastructure to manage patients post-discharge and so are ill-equipped to mitigate the risk of penalties or to capture incentives. Our solution equips the care team with tools to actively manage, track and coordinate patients post-care.

Readmissions are reduced, both through the assessment function (to detect and allow intervention for medical complications or non-adhering patients) and the wellness-nurturing function (to remind and encourage patients of medication or other prescribed treatments).

Health outcomes are improved by implementing post-care follow-up that is automated, consistent, and systematic. Reducing effort and shifting medical duties to staff members with an appropriate level of expertise improves efficiency and cost-effectiveness. Medical efforts are focused on those patients most in need of care.

Patient benefits include not only improved outcomes of their encounters with your facility but also improvement in overall health level and a higher level of satisfaction with their healthcare experience.

