FQHC Practice: Improving Transitions of Care

One of the largest risks for readmission after hospital discharge is lack of timely follow-up with their PCP. A challenge is to know when a patient has been discharged in order to provide ongoing support during this critical time.

Use Case: Use Event Notifications so providers and care teams can create the best outreach and treatment plan. Access to Point of Care for clinical data.

Project Details

- Leverage existing ADT feed to SDHL
- Subscribe to event-based notifications
- Upload specialized patient list
- Use Point of Care to access post-discharge instructions, and to schedule follow-up appointment to support continuity of care.

Impact

- Enhanced ability to spend less time on administrative work and more time on supporting and coaching the patient as event occurs.
- Patient: improves safety and reduces exposure for adverse drug or medical events
- Allows for opportunities to increase reimbursement rates for chronic care management

SOUTH DAKOTA Health Link
Exchanging information. Changing lives.