Secure, private, seamless health data exchange for post-acute transitions of care.

Background

When a patient transitions from a hospital to a post-acute care facility, proper care coordination is critical for success. Care coordination for post-acute transitions is often fragmented and can lead to poor health outcomes, increased burden, and increased cost.

Seamless health information exchange will improve communications between patient and providers as well as between providers. Access to longitudinal health information, across health care entities and systems, will improve efficiencies, quality of care, and health outcomes. Health data should be usable across the continuum of care, and beyond the traditional healthcare system into the community.

PatientShare provides a simple secure process to share health data for transitions of care. Health data can be made available at the patient's destination care facility, whether it be a skilled nursing facility (SNF), an ambulatory care facility, inpatient rehabilitation facility (IRF), acute care facility, or home and community-based services (HCBS). The same critical information can be made available to the patient and patient family members, so that the entirety of the patient's support system is on board and has the same information.

Unlike other systems, those receiving access to the patient's health data do not need to be a member of a pre-defined network. We have enabled seamless, dynamic access across the whole health ecosystem using FHIR APIs. This enables the formation of ad hoc networks of choice and need.

With PatientShare

- Reduce readmissions
- Have the right information available when needed, enabling effective care coordination
- Reduce the cost and hassle of transferring data
- Eliminate duplicate tests and procedures
- Improve patient health outcomes
- Increase overall success rates from care at each level
- Increase patient and family satisfaction

Supporting Data

The following are leading causes of readmission

- lack of coordination between emergency departments and SNFs (skilled nursing facilities).
- poorly defined goals of care at the time of hospital discharge
- limited information sharing between a SNF and hospital

- Post-acute care accounted for $60B in Medicare spending in 2015.
- 1 in 4 Medicare patients discharged from Acute Care went to a SNF. Of those, 1 in 4 will be readmitted within 30 days.
- Lack of data interoperability—especially to community organizations like SNF's– is a key barrier to coordinated care

Specifications

- FHIR API R4
- oAuth2, Open ID Connect, User managed access 2.0, HEART profiles
- Consent driven
- Seamless interoperability
- Integrates with NIST security systems
- Secure, private, transparent