

Despite recent technological advancements, clinicians still struggle to coordinate with their peers outside of a hospital's four walls.

This challenge poses a particular barrier when discharging patients to post-acute organizations, such as skilled nursing facilities or home health agencies. Clinicians not only need to hand off patient data from one organization to the other, but also must work with each other to establish appropriate discharge and long-term care plans.

“Having all the relevant information about a patient in one place and having the ability to review documentation in prior care settings reduces administrative burdens for clinicians and reduces the risk of error or delays for patients,” explains Heather O’Sullivan, chief clinical officer at naviHealth, a Cardinal Health company that manages post-acute care transitions.

Read the full article [here](#).