Bending the Curve

Real-Time Strategies to Reduce Readmissions, Boost Quality Ratings and Drive ROI When Coordinating Post-Acute Care

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It's a balancing act every health plan knows intimately: How do you contain costs while still advancing quality care for members?

Is it possible for health plans to do more with less while still delivering quality care for members? That question is top of mind as the healthcare expenditure grew once again in 2023 by 7.5%, reaching $4.9 trillion — $14,570 per person — and accounting for 17.6% of the country's gross domestic product. Medicare and Medicaid spending have grown at an even faster clip, at 8.1% and 7.9% respectively.[1] At the same time, in 2024, the National Association of Insurance Commissioners reported that the health insurance industry saw a significant decline in revenue and profit margins driven by increased medical costs and record-high use. Profits fell from 2.2% in 2023 to 0.8% in 2024.[2]

As the need for medical care grows along with costs, health plans are continually grappling with how to do more with less, while advocating for the best outcomes for members — and striving for the highest ratings.

"Health plans are feeling the squeeze between rising utilization and increasing regulatory pressure," says Kate Selbitschka, MBA, DPT, PT, principal product manager at PointClickCare. "Medical loss ratios are rising, and leaders are looking for the highest quality care to be delivered at the lowest cost. To achieve that, they need real-time insights and visibility to act decisively, optimize outcomes and manage risk in the moments that matter most."

While some rising costs are beyond the control of payers, there are specific areas in medical spend and administrative costs where small actions can lead to significant change, particularly in areas such as post-acute care. By focusing on proactive care management, leveraging predictive analytics and streamlining workflows, health plans can improve both financial performance and member outcomes, ultimately enhancing overall care quality while boosting HEDIS and Star ratings.

Reducing readmissions by coordinating care

Of the $3.7 trillion spent on healthcare in 2022, Medicare was the largest purchaser of personal healthcare in the U.S. at 24%, followed by Medicaid at 19%. Among those members, unsurprisingly hospital readmissions — which are key measures when it comes to evaluating inpatient and post-discharge care — are more common than among the general population.[3] A 2023 study found that the 30-day hospital readmission rate among Medicare recipients (Part A and Part C) was 17 per 100, followed by Medicaid at 13.9 per 100, compared with those with private insurance, which was 8.5 per 100.[4] Many of those readmissions, says Selbitschka, are preventable when the right systems are in place.

"Post-acute care is a powerful lever for value," says Selbitschka. "When managed holistically and proactively with the right technology, readmissions are prevented and outcomes improved — at scale."

Further, she adds that there can be significant savings to plans and benefits to members when technology enables seamless care transitions. Members' post-acute care journey often includes transitioning through multiple settings. As the medical complexity of members discharging from hospitals continues to increase, members often require a skilled nursing facility stay before transitioning to less restrictive settings, and, ultimately, their home. Real-time visibility during these transitions is critical to ensuring they receive the support they need at the right time.

Readmissions by the Numbers

14.67%

Average hospital readmission rate[5]

25%

Likelihood of readmission within 30 days for skilled nursing facility patients[6]

$15,200

Average cost of readmission, per patient[7]

$17.4 Billion

Annual cost to Medicare Advantage plans due to member readmission within 30 days[8]

Post-acute transitions are vulnerable moments. Members need coordinated support as they move between care settings, and real-time data can help make sure no step is missed. Members will need different types of support, whether they're transitioning from receiving inpatient care in the ICU or emergency department, recovering from surgery or leaving a supportive care facility. Whatever the path, it's critical that their providers and their health plan have insights into where they've come from, what treatments they've received and where they're headed, to surround them with the care and services they need to achieve the best outcomes.

Too often, communication is lacking. "In each one of those settings, the native systems are disparate from one another," says Selbitschka. "Interoperability is the bridge that connects providers with one another and with plans to keep care continuous and prevent members from experiencing preventable complications or adverse events."

In any transition, as a member moves from one setting of care to the next, they're in a susceptible state. The right technology can transform a sense of chaos into coordination by enabling all parties — including members, caregivers, providers and payers — to be on the same page.

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>
> **KATE SELBITSCHKA, MBA, DPT, PT**
> Principal Product Manager, PointClickCare

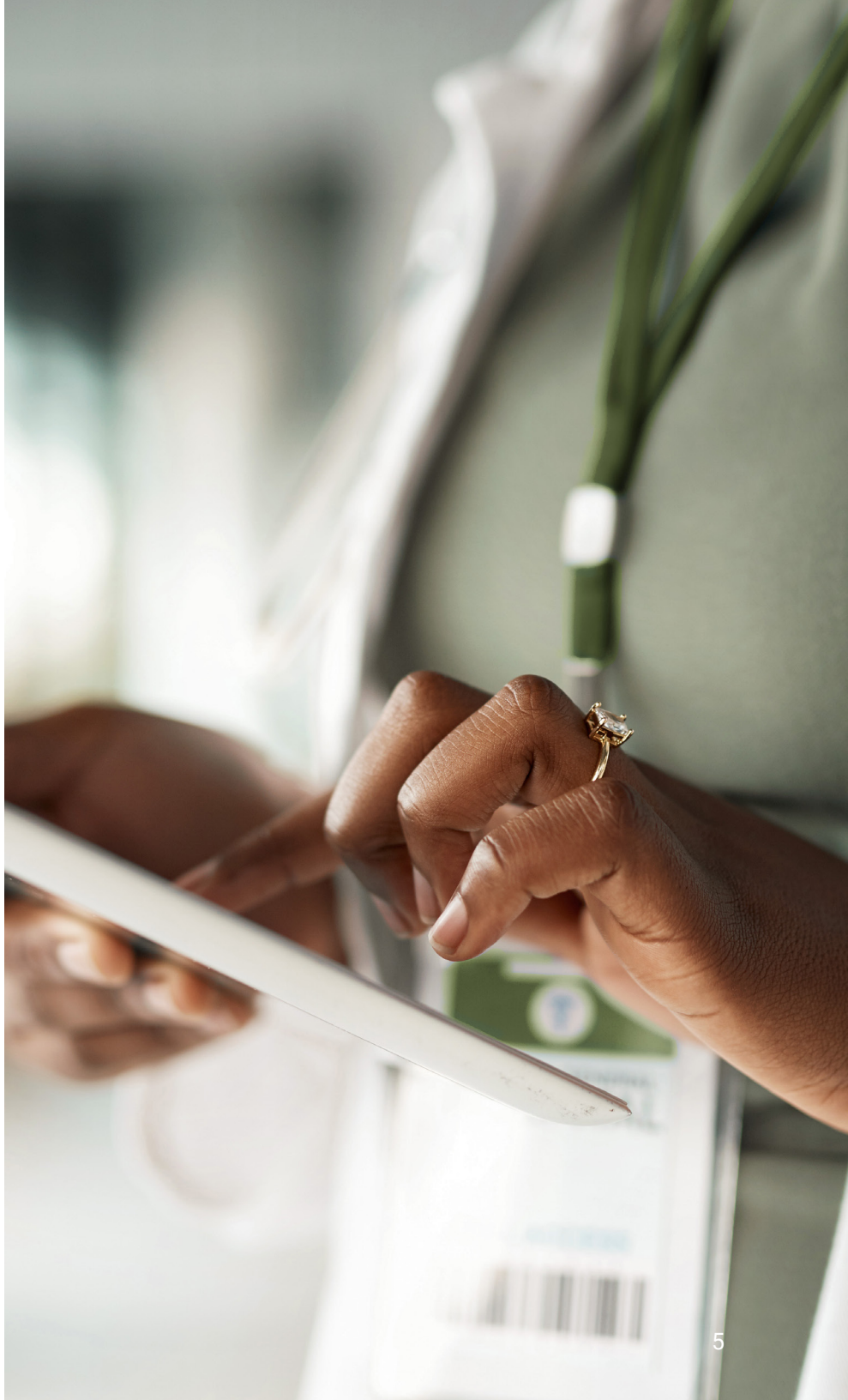
Effective care coordination depends on:

Real-time data visibility. Health plans operate off claims data, which can often have as much as a three-month lag. Access to real-time, clinically in-depth data — especially during transitions from acute to post-acute care, such as skilled nursing facilities or long-term care settings — allows care managers to intervene in the moments that matter most. Those short-term interventions could affect long-term outcomes.

Interoperability. A member's journey can involve many providers and facilities, all of which may use different systems. An interoperable platform is the fabric that pulls that information together and allows for those up-to-the-minute insights that enable better care coordination, better experiences and better outcomes.

Predictive risk insights for proactive intervention. The right predictive analytics, for example, PointClickCare's AI-powered Predictive Return to Hospital, can flag which members are more likely to be readmitted to the hospital so that the health plan can work proactively with the care team to coordinate next steps for that member and prevent readmission, rather than reacting after the member is readmitted. Predictive analytics allow health plans to engage with members most likely to need help versus attempting to engage with those who likely won't.

Using data to holistically manage a person's care — especially during those transitions — could proactively lead to better results.

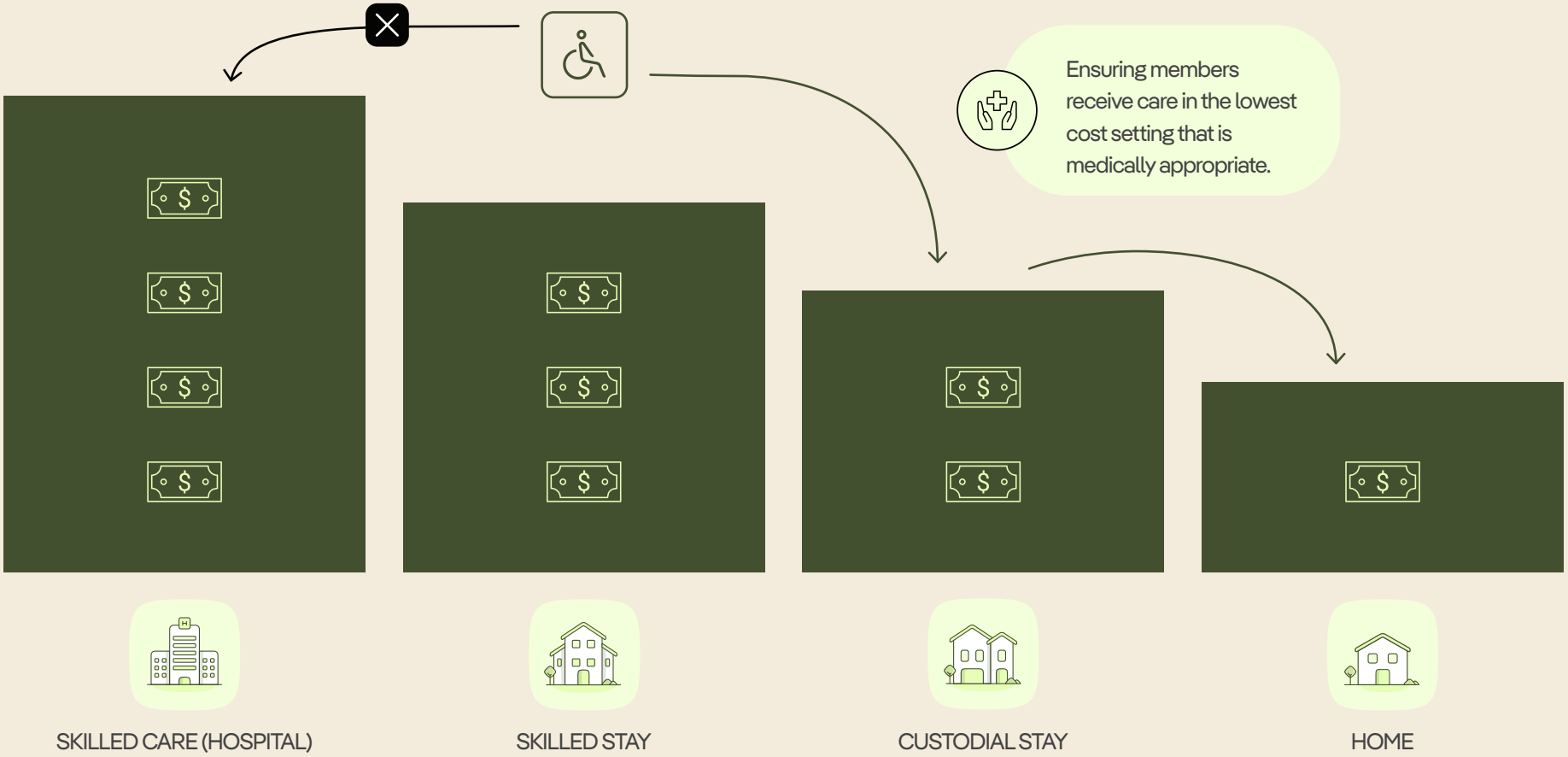


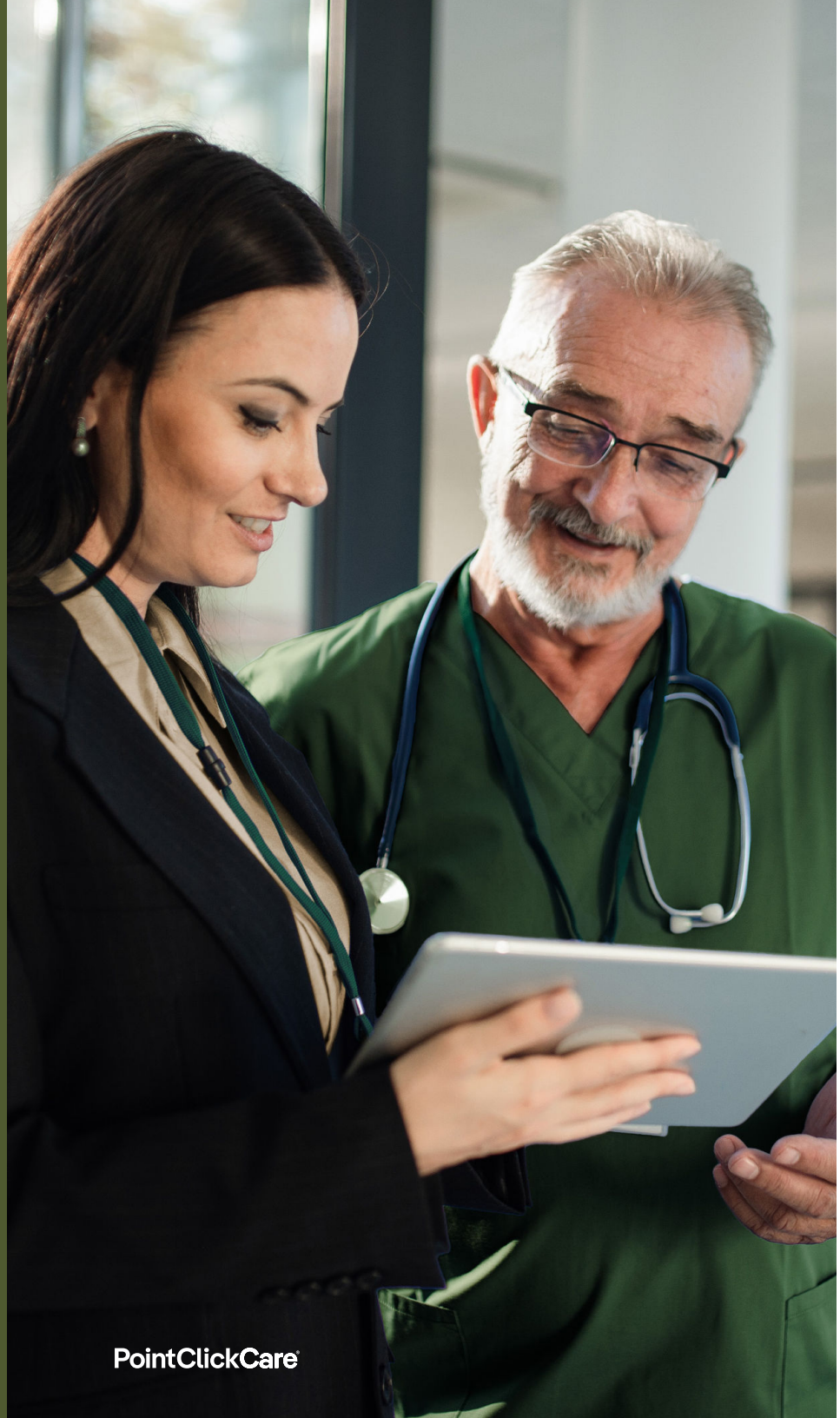
Shifting the Settings

For health plans, ensuring the highest quality care is provided in the lowest cost and least restrictive setting helps contain costs while improving outcomes and member experience.

Preventing avoidable return to higher cost of care settings

Ensuring members receive care in the lowest cost setting that is medically appropriate.





Controlling costs by reducing administrative burdens

With narrow profit margins, plans must control expenditures where they can, including administrative costs. McKinsey reports that there are thousands of hospital and physician groups and more than 900 payers in the U.S. healthcare system. That fragmentation can lead to excessive amounts of time spent on inefficient communications and transactions among the many stakeholders. Administrative simplification, says the report, could potentially save $265 billion across healthcare.[10]

"Case managers spend hours chasing charts instead of coordinating care. They're stuck faxing, emailing and calling just to piece together a member's story," says Selbitschka. "Cross-care setting interoperability changes that by putting real-time insights at their fingertips so they can focus on what matters most: the member."

Technology can allow for greater efficiencies so that data isn't just accessible, it's actionable. Effective solutions surface the data that a case manager needs and puts it at their fingertips so that they can drive the most value for the members and improve transitions of care, thereby streamlining their workflows, accessing real-time information and working to reduce readmissions. That, in turn, can directly affect HEDIS measures and CMS Star ratings, which can drive membership, retention and reimbursement, including bonuses, and result in better financial outcomes for the plan and the health insurer, at large.

"Post-acute care directly impacts high-stakes measures like Plan All-Cause Readmissions and Hospitalization Following Discharge From a Skilled Nursing Facility, and Transitions of Care (TRC)," says Selbitschka. "The right tech can surface key insights in real time, arming care teams with the information they need to proactively prevent readmissions, closing gaps and improving outcomes where it really counts."

Access to that information, she adds, can also enable case managers to better partner with providers and offer value. "The case manager or plan isn't at the bedside," says Selbitschka. "But technology can keep them connected and engaged with the providers who are, so they can make the best choice for the member at a given point in time, and align with financial decisions, as well."

CASE STUDY

TriHealth Improved Post-Acute Transitions and Reduced Readmissions by 28% With

The Challenge

TriHealth is an integrated health system and accountable care organization (ACO) in Cincinnati, responsible for the full risk of a traditional Medicare population and ACO REACH program. It is always looking for ways to better support its patients, organizational quality and value-based care goals.

TriHealth's internal assessments identified a need to improve care transitions from inpatient to post-acute to discharge to home, long-term care, hospice or the next destination. Primary care providers and ambulatory care managers could not see their patients' progress when they were discharged to a skilled nursing facility (SNF), and if their patient was discharged from a hospital outside the TriHealth system, they couldn't see which SNF was caring for them. In addition, patient data didn't flow with them, causing gaps in care or miscommunication that increased their readmission risk.

While TriHealth initially focused on gaining visibility into the patient's discharge list of medications to prevent errors, it worked with PointClickCare and identified PAC Management as the right solution to improve transitions of care.

The Solution

PAC Management provides TriHealth with a simple, automated way to exchange clinical insights between care management teams and post-acute facilities. TriHealth care teams can see patient progress at the SNF, current status and risk profile, allowing them to act quickly to plan for successful discharges and to avoid unwanted outcomes.

Since TriHealth took a multipronged approach, it also invested in key nursing roles responsible for monitoring patient progress and managing the collaborative relationships with SNF partners. "Our nurse care manager utilizes PAC Management daily to determine patient needs while still in the SNF or post-discharge, and she agrees she cannot do her job without it. This has been a game changer," says Lori Baker, Sr. Director, Population Health and Care Management, TriHealth.

The Outcome

TriHealth has deployed PAC Management at 45 locations so far. The ACO has seen benefits in the form of reduced inpatient readmissions, dropping from 25% to 18%. SNF lengths of stay, previously tracking at 25 days, went down to 18 days on average.

The solution unlocked new levels of staff efficiency, giving clinicians time back to focus on patient care while enabling more robust and collaborative relationships with the SNFs in their network. Dedicated nurse case managers now work closely with SNF partners to align goals and metrics and highlight new areas of focus to continue improving outcomes for other patient groups in their care.

"PAC Management helped us to reduce readmissions by 28% and SNF lengths of stay by 28%, and at the same time stimulated more meaningful working relationships with our post-acute partners. But what makes this solution so valuable is that it not only impacts outcomes and drives success, but helps us all fulfill our purpose of caring for vulnerable patients," says Baker.

PAC Management delivers ROI to health plans by transforming post-acute care from a data blind spot into a coordinated, cost-efficient continuum. Through real-time clinical insights and predictive risk scoring, it enables earlier interventions, reduces avoidable readmissions, and accelerates safe transitions to lower-cost care settings. This not only lowers total cost of care but also improves member satisfaction and operational efficiency.

PAC Management Platform

	Reduce Total Cost of Care		Admin Savings
	Transition members to lower cost of care settings	Prevent hospital re/admissions	Minimize time spent chart chasing & optimize workflow
Identify Members Safe to Transition to a Lower Level			
Facilitate Discharge Planning and Support			
Optimally and Proactively Manage Members who Permanently Reside in Nursing Facilities			
Prevent Members from Transitioning to Higher			
Drive Workflow Efficiencies &			

As use and costs in healthcare continue to rise, health plan leaders will continue to invest in tools and strategies that will enable them to provide the best care at the lowest cost. In particular, for Medicaid and Medicare plans, focusing on real-time care coordination and post-acute management will be essential in the increasingly cost-sensitive landscape.

"The future belongs to health plans that can balance cost containment with long-term member health," says Selbitschka. "If leaders over-index on short-term savings, they risk a more frail population down the road that is more costly to manage. Plans must embrace technology that enables individual-level precision and population-based analytics."

In the U.S., it's a simple fact that healthcare use and costs rise as members get older. That will only continue to ring more true as the overall population ages and needs care for ever-more complex conditions.

"Aging populations bring rising complexity and cost," says Selbitschka. "The opportunity lies in driving more value, not by cutting corners, but by removing inefficiencies." With the right solutions, payers can lower costs and deliver value, and the benefits will extend to all.

Are you ready to improve financial and clinical outcomes through real-time visibility and collaboration with post-acute care providers?

Connect with PointClickCare and request a demo today.

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PointClickCare®

PointClickCare is a leading health tech company with one simple mission: to help providers deliver exceptional care. With the largest long-term and post-acute care dataset, we power AI-driven healthcare to deliver intelligent transitions, insightful interventions and improved financial performance. Enhanced by our Marketplace of 400+ integrated partners and trusted by over 30,000 provider organizations and every major U.S. health plan, we're redefining healthcare so it doesn't just survive — it thrives.

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