Report

The Cost of Starting from Zero: Clinical Intelligence Changes Everything After Discharge

How Clinical Intelligence Equips Care Managers to Win the Critical 24-Hour Window Post-Discharge

Get Started

PointClickCare®

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Introduction: Why the First 24 Hours Matter Most

A care manager picks up the phone. A member was discharged yesterday—heart failure exacerbation, new medications, a follow up visit needed within a week. But the care manager doesn't know any of that yet.

So the call starts the way it always does:

> "Can you tell me what happened?"

On the other end of the line, the member is still exhausted and overwhelmed. They're expected to recount the details of their hospital stay to a health plan they assume already knows. The care manager toggles between systems, searching for clues and piecing together the story one question at a time.

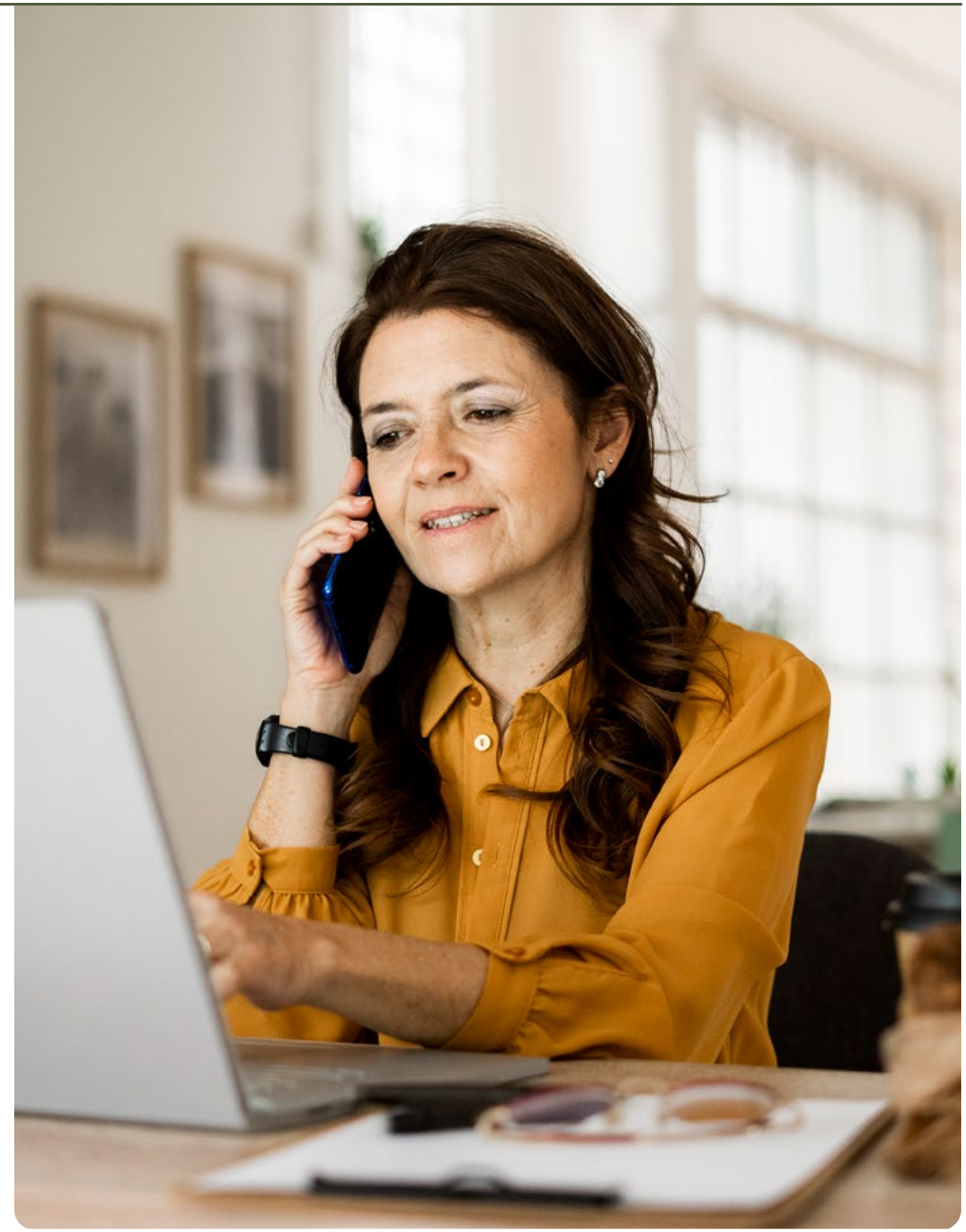
By the time the full picture comes into focus, the moment to guide instead of investigate has slipped away—and the time critical post discharge window continues to close.

This is the cost of starting from zero.

Health plans are under mounting pressure: shrinking margins, heightened regulatory scrutiny, and increasingly demanding quality benchmarks. Traditional cost control levers—utilization management, prior authorization—are losing ground. But the real untapped lever isn't another denial or policy change.

It's what happens in the first 24 hours after discharge.

This is when members are most vulnerable, most reachable, and most in need of support. The organizations that win in this window are the ones that equip their care managers with clinical intelligence before the first call—transforming conversations from investigative to actionable, and from reactive to truly proactive.



Chapter 1: Beyond the Old Playbook

Today's health plans operate in a landscape of relentless complexity and pressure. Financial headwinds—Medicaid cuts, rising medical costs, and the unyielding climb of Star ratings—squeeze margins and raise the stakes for every decision. In this environment, maintaining the status quo is not an option; standing still means losing ground.

Defensive Strategies Under Pressure

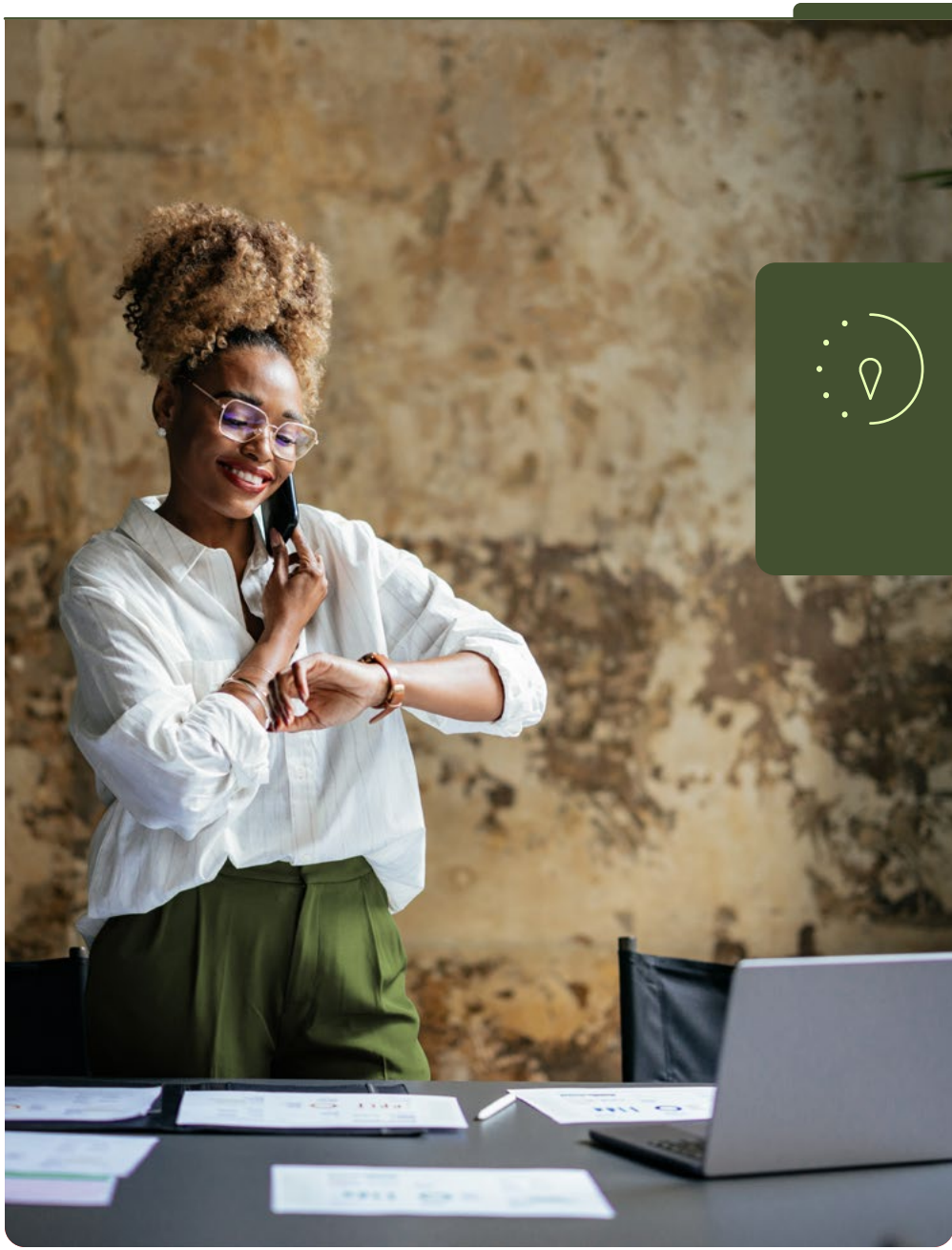
For years, strategies like utilization management and prior authorization formed the backbone of cost control and care appropriateness. Now, these approaches are increasingly seen as blunt instruments—and they're under growing regulatory scrutiny. Gold-card laws in several states exempt high-performing providers from prior authorization. Meanwhile, the Office of Inspector General intensifies audits, and new federal rules raise the compliance bar. New federal rules demand faster decisions and greater transparency. The result: a more complex compliance environment, higher administrative burden, and shrinking leverage from the tools plans have relied on for decades. None of this means utilization management and prior authorization are going away. But it does mean they're no longer enough.

The Shift to Proactive Strategies

Today's regulatory and financial pressures make it increasingly difficult for health plans to rely solely on traditional, defensive cost control tactics. Leading organizations understand that meaningful impact now depends on acting earlier—specifically during the immediate post discharge period, when members are most vulnerable and key outcomes are determined.

By equipping care managers with the clinical context needed to act within this time critical window—especially the first 72 hours, when the risk of complications and confusion is highest—plans can show up proactively and with a clear plan that supports smoother care transitions and positively shapes members' outcomes and utilization.

This shift transforms outreach from reactive to intentional. Instead of starting from zero, care managers begin informed and ready to address barriers, reinforce follow up care, and guide members through the transition. The result is better engagement, fewer avoidable readmissions, and stronger quality and cost performance.



The Underleveraged Opportunity

While defensive cost controls face rising headwinds, one lever remains undertapped: clinically informed care management in the post discharge window.

The first 24 hours after a member leaves the hospital are pivotal. This is when medication issues surface and follow up appointments are scheduled—or missed. It's also when time critical quality measures like Transitions of Care (TRC) and triple-weighted CMS Star measures such as Plan All Cause Readmissions (PCR) are won or lost.

The problem isn't effort. Care managers are working hard. What they lack is the clinical intelligence needed to act in that window. Too often, they're starting from zero—without the discharge summary, medication changes, or follow-up requirements that would give them actionable insight into the member's most recent encounter. By the time they've pieced together the picture, the moment of maximum impact has passed.

A New Standard for Success

The real opportunity lies in shifting from a defensive posture to a proactive one. Health plans that invest in technologies that unlock new value from existing care management teams—by operationalizing actionable intelligence within guided workflows that prioritize the members most in need—will be the ones that lead the market.

Chapter 2: The Hidden Cost of Starting from Zero

Unlocking the full value of care management depends on having the right tools at the right time. The real challenge isn't effort or expertise— it's starting from zero, without timely clinical intelligence from a member's most recent encounter.

A Typical Post-Discharge Call

When outreach begins without clinical context, the conversation can only start one way:

> "Hi, I'm calling from your health plan. I understand you were recently in the hospital. Can you tell me what happened?"

The member, still exhausted, tries to piece together the details. Which medications were new? What instructions mattered most? Who were they supposed to follow-up with? They aren't sure. They're tired. And now they're being asked to reconstruct their own clinical story for someone they assume already has it.

As the care manager asks more questions, frustration builds. What should be a supportive touchpoint instead feels like an interrogation. By the time the full picture comes into focus, care teams may have already missed the chance to intervene when their actions would have had the greatest effect.

This isn't a failure of effort or empathy. It's a failure of information.

The Cost Is Real—Across Every Dimension

The consequences of starting from zero ripple across everything health plans are trying to achieve.

Cost. Medication issues are one of the leading drivers of preventable readmissions. When care managers don't know what changed at discharge, they can't catch problems before they escalate—a missed dose, a dangerous interaction, a prescription that was never filled. The result is avoidable ED use or even readmission. Each event costs thousands of dollars, multiplied across a population.

Quality. Time-critical HEDIS measures like TRC, FUM, FUH, FUA, and many more, operate within narrow windows. When the first outreach call is spent gathering basic information instead of addressing barriers, gaps remain open past the measurement deadline. The chance to close them—and secure the associated quality revenue—is lost.

Trust. Members notice when their health plan seems unaware of their situation. That first post discharge call sets the tone for the entire relationship. If it begins with questions instead of answers, members disengage. They stop picking up the phone. They don't follow through on care plans. And the cycle of avoidable utilization continues.

Ultimately, this is an information problem—one that can be solved. By equipping care managers with timely, clinical insights, outreach shifts from asking questions to offering answers, improving outcomes for both members and plans.

Chapter 3: The ROI of Showing Up Informed

The case for clinical intelligence isn't theoretical. It's measurable.

Health plans have long understood that post discharge outreach matters — and the data overwhelmingly confirms it. When care managers connect with members quickly and with the right clinical context, the impact is immediate, significant, and financially material.

The Readmission Reduction Case

A CDC sponsored meta analysis of U.S. studies found that timely post discharge follow up is associated with a 21% reduction in 30 day all-cause readmissions for patients with heart failure, COPD, and stroke.[1] That's not a marginal lift — it's a meaningful reduction in one of healthcare's costliest and most disruptive events.

At an average cost of $15,000+ per readmission, even preventing a small portion of avoidable returns creates a sizable financial impact. For a plan managing 100,000 members, reducing just a fraction of readmissions translates into millions in annual savings — all by ensuring care managers have the right information early enough to act.

The Total Cost of Care Impact

McKinsey estimates that payer led care management programs can reduce total cost of care by 2–3%, driven largely by improved coordination, reducing unnecessary utilization, and closing high value care gaps.[2]

The operative phrase is payer led. When health plans invest in proactive outreach powered by clinical intelligence, they shift from reacting to downstream events to getting ahead of them. Instead of waiting for issues like missed medications, unfilled prescriptions, or deteriorating symptoms to escalate, care managers can intervene early — before avoidable costs accrue.

Clinical intelligence compresses the information-gathering phase, giving care managers more runway to address barriers—transportation, medication access, follow-up scheduling—before the measurement window closes.

Chapter 4: How Discharge Intel Powers Informed Outreach

The journey from aspiration to action in care management hinges on delivering clinical intelligence exactly when it's needed most. PointClickCare's Discharge Intel is designed to do just that—turning the critical 24-hour window after discharge from a missed opportunity into a moment for meaningful action.

The challenge is clear: care managers need timely, actionable clinical intelligence to make a difference when it matters most. The question now is how to bridge that gap—how to move from recognizing what's missing to actually delivering on that need.

That's where Discharge Intel comes in.

Clinical intelligence delivered when it matters most. Within 24 hours of discharge, care managers receive the clinical context they need to engage members at their most pivotal moment—when they are most vulnerable, most attentive, and most open to support.

AI that turns dense discharge documents into insight. Lengthy discharge summaries become concise, actionable briefs. AI pinpoints the details that shape outcomes—diagnoses, medication shifts, follow ups, and barriers—so care managers start with answers, not questions.

Prioritization that aligns effort with risk. Discharge Intel automatically surfaces members whose conditions and discharge details indicate elevated readmission risk, ensuring outreach is focused, efficient, and clinically meaningful.

Information designed for real world workflows. Discharge Intel doesn't just present data—it organizes it in a way that accelerates action. Care managers see exactly what they need to guide the first conversation and intervene early.

Discharge Intel doesn't just deliver data—it organizes information around what care managers need to do, not just what happened. With these tools, care managers know the member's story before making the first call. High-risk members are surfaced for immediate attention, and every outreach begins with insight and a plan.

Without Discharge Intel	With Discharge Intel
The care manager picks up the phone with no clinical context. **The call starts with questions:** "I see you were just in the hospital, can you walk me through what happened?" "What medications did you receive?" "What discharge instructions did you receive?" **Time is spent piecing together the story. The member feels interrogated, not supported.**	The care manager reviews the AI-summarized clinical insights before the call. She sees the diagnosis, the three new medications, the cardiology follow-up needed within seven days. **The call starts differently:** "I see you were discharged yesterday after a CHF exacerbation. You're on a few new medications, and you need a follow-up soon. Let's make sure you have what you need." **The conversation focuses immediately on solutions, support, and preventing readmissions.**

This transformation—from asking questions to offering answers—is what sets leading organizations apart. **With clinical intelligence at their fingertips, care managers can act within the critical window, delivering timely, informed, and compassionate support.**

The Time to Elevate Care Management with Clinical Intelligence is Now

Care management has always held untapped potential. What's been missing isn't effort, it's information. Clinical intelligence changes the equation. When care managers have the diagnosis, the medications, and the follow-up needs before the first call, they stop working around the gaps and start closing them. Outreach becomes proactive. Conversations focus on support, not investigation. Members experience their health plan as a partner. This is what the future of care management looks like. Discharge Intel is how you get there.

The Future Starts Here with Discharge Intel

Scan or click to discover how you can deliver better outcomes for your members and your organization.

Get Started

Sources

1. A CDC sponsored meta analysis of US studies showed that timely post discharge outpatient follow up visits were associated with a 21% reduction in 30 day all cause readmissions for patients with heart failure, COPD, and stroke, highlighting the impact of early engagement after discharge. (Source: https://www.cdc.gov/pcd/issues/2024/24_0138.htm)

2. McKinsey estimates that payer led care management programs can reduce total cost of care by 2–3%, largely by improving care coordination, preventing avoidable utilization, and closing high value care gaps. This underscores that proactive, analytics enabled care management is not just clinically meaningful but also a material financial lever for health plans and at risk providers.

(Source: https://www.mckinsey.com/industries/healthcare/our-insights/reimagining-sustainable-healthcare-and-business-models.)

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

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