

Payer Care Management Leaders: Are Your Teams Equipped to Intervene in the First 24 Hours?

What 150+ Health Plan Leaders Revealed
About the Post-Discharge Visibility Gap



New research¹ highlights a persistent challenge: **Clinical visibility breaks down at the most critical moment: when members are most reachable, risks are most catchable, and care gaps are still preventable.**

75%

of health plans say care managers act as information gatherers — not trusted advisors.

Not because they lack skill. Because they lack the right tools.

Care managers are doing everything they can. But without timely clinical intelligence, they're forced into detective work instead of care. Chart chasing. System hopping. Provider follow-ups. Reconstructing medication changes and discharge instructions that should already be visible.



1 in 5 health plans have complete discharge summaries.

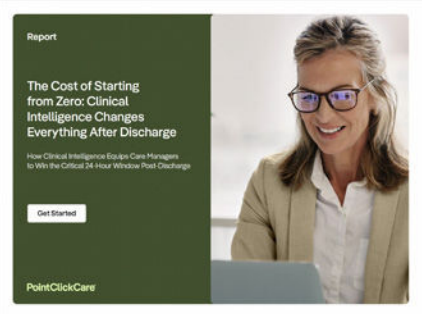
Four out of five care managers make the first call without a complete clinical picture. Medication changes go unreconciled, discharge instructions and follow-ups stay hidden, and high risk signals aren't visible to the person engaging the member.

Fewer than half of health plans can effectively engage members within the first 72 hours after discharge — missing the window when members are most vulnerable and most open to support.

Why This Matters Now: The Consequences of Acting Without Clinical Context


Traditional cost controls are no longer keeping pace with rising performance pressure. Readmissions now carry triple weight in Star ratings, Medicare Advantage margins are tightening under V28, and quality thresholds continue to rise. When a single readmission costs \$15,000–\$17,500, catching risk early versus missing it has a direct and compounding impact on both cost and quality performance. These critical gaps are clinical, not operational. Without timely context, early risks become readmissions, care gaps become quality misses, and the critical post-discharge window for intervention is lost.

Before Discharge Intel	After Discharge Intel
<p>✗ Care manager starts with limited or incomplete clinical context.</p>	<p>✓ Care manager receives AI-powered clinical insights within 24 hours of inpatient or ED discharge.</p>
<p>✗ Call begins with questions: “I see you were in the hospital, can you tell me what happened?”</p>	<p>✓ Call begins with answers: “I see you were discharged after a CHF exacerbation. Let’s make sure you have what you need.”</p>
<p>✗ Member feels confused and overwhelmed.</p>	<p>✓ Member feels supported and guided.</p>
<p>✗ Time is spent gathering information.</p>	<p>✓ Time is spent solving problems.</p>
<p>✗ Medication issues go unnoticed.</p>	<p>✓ Medication changes are flagged and reconciled.</p>
<p>✗ Follow-up appointments are missed.</p>	<p>✓ Follow-up needs are surfaced and scheduled.</p>
<p>✗ Readmissions happen.</p>	<p>✓ Readmissions are prevented.</p>



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

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The Post-Discharge Blind Spot: Why Visibility Across Care Transitions Is the New Imperative for Health Plans

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1 Research conducted by Sage Growth Partners, commissioned by PointClickCare. Based on surveys of 150+ health plan leaders across Medicare Advantage, Medicaid, commercial, and dual-eligible lines of business. December 2025.

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