



**PointClickCare®**

eBook

---

## **Beyond the Handoff:**

How Real-Time Intelligence is Reshaping  
Post-Acute Care

## Executive Summary

For decades, post-acute care has operated in the shadows—largely invisible to acute providers who discharge patients and payers who cover recovery costs. This visibility gap has driven fragmentation, fueled preventable readmissions, and left high-risk patients and members vulnerable during critical care transitions.

**Recent research reveals a fundamental shift: payers and providers are converging around recognition that post-acute care—particularly the transition from post-acute settings to home—represents the single greatest opportunity to improve outcomes and reduce avoidable costs.** Reactive, claims-based oversight is no longer sufficient in an environment defined by value-based arrangements, quality accountability, and capacity constraints.

### The imperative is clear

Organizations must move from after-the-fact analysis to **predictive, real-time intelligence** that enables intervention before deterioration occurs.

Survey data shows overwhelming momentum

**65.6%**

of healthcare organizations  
planning to implement  
predictive analytics in 2026

**64%**

actively building or refining  
preferred post-acute  
provider networks

## Table of Contents

The Visibility Gap That Defined an Era .....	4
A Shared Inflection Point: Why Both Sides Can No Longer Wait .....	5
The Post-Acute Transition No One Was Watching .....	6
From Claims-Based Lag to Predictive Foresight .....	7
Preferred Networks: From Aspiration to Operation (For Hospitals and ACOs) .....	9
The Tools That Make Alignment Possible .....	10
What Leading Organizations Are Doing Differently .....	11
The Strategic Questions Leaders Are Asking .....	12
The Imperative to Collaborate with Post-Acute Care .....	13
The Path Forward: From Shared Vision to Shared Action .....	14
Survey Insights: Key Findings-at-a-Glance .....	15
Conclusion: A New Era for Post-Acute Care.....	16

# 1

## The Visibility Gap That Defined an Era

Post-acute care outcomes have been undermined by a lack of visibility, leaving stakeholders unable to monitor individual progress, identify risk early, or intervene during critical transitions of care. When patients transition from hospital to skilled nursing, home health, or rehabilitation, acute teams lose visibility almost immediately.

**Payers** often assess post-acute performance through claims data that arrives weeks or months after episodes conclude—well after the opportunity to intervene has passed.

**Providers**, meanwhile, may see admissions and discharges in near real time, but without clinical context or ongoing insight into patient progress, limiting their ability to anticipate deterioration or prevent avoidable readmissions.

This fragmentation produces real consequences:

- **Preventable readmissions**
- **Delayed interventions** allowing manageable conditions to escalate
- **Suboptimal discharge planning** mismatching patients to settings
- **Undetected variation in post-acute performance.**



## 2

# A Shared Inflection Point: Why Both Sides Can No Longer Wait

## What's Driving the Shift

Payers and providers are reaching the same conclusion. Post-acute care is now too critical to manage without better visibility and coordination.

### Provider Pressure

Value-based arrangements make providers accountable for post-discharge outcomes, where avoidable readmissions disrupt recovery and expose patients to unnecessary risk—while also driving cost and capacity strain.

### For Providers:

Hospitals participating in bundled payments and the **2026 TEAM model** are increasingly accountable for what happens after discharge, while facing mounting capacity and workforce constraints that make **post-acute throughput** a strategic bottleneck. At the same time, **ACOs**—often operating as distinct entities—**carry end-to-end cost and quality accountability**, intensifying the need for reliable post-acute performance. Across both models, reducing readmissions and improving coordination with post-acute partners are top priorities for 2026.

### Payer Evolution

Medicare Advantage, value-based contracts, and Star Ratings shift risk to payers for total cost of care, making early identification of high-risk members during transitions imperative.

### For Payers:

Claims-based analytics are no longer sufficient for managing post-acute performance. Today's quality and financial exposure is driven by measures that demand timely intervention, not retrospective review. With **Plan All-Cause Readmissions (PCR) now triple-weighted for Medicare Advantage, and Transitions of Care (TRC) measures directly tied to post-discharge execution**, delays in insight translate directly into avoidable cost and rating risk.

As a result, **payers now rank predictive analytics as their highest technology priority**, driven by the need for real-time visibility into post-acute transitions and earlier intervention to prevent readmissions.

### Unprecedented Alignment

Both groups now share common understanding that the post-acute transition, especially discharge to home—represents the highest risk, highest impact moment in the care continuum.

### 3

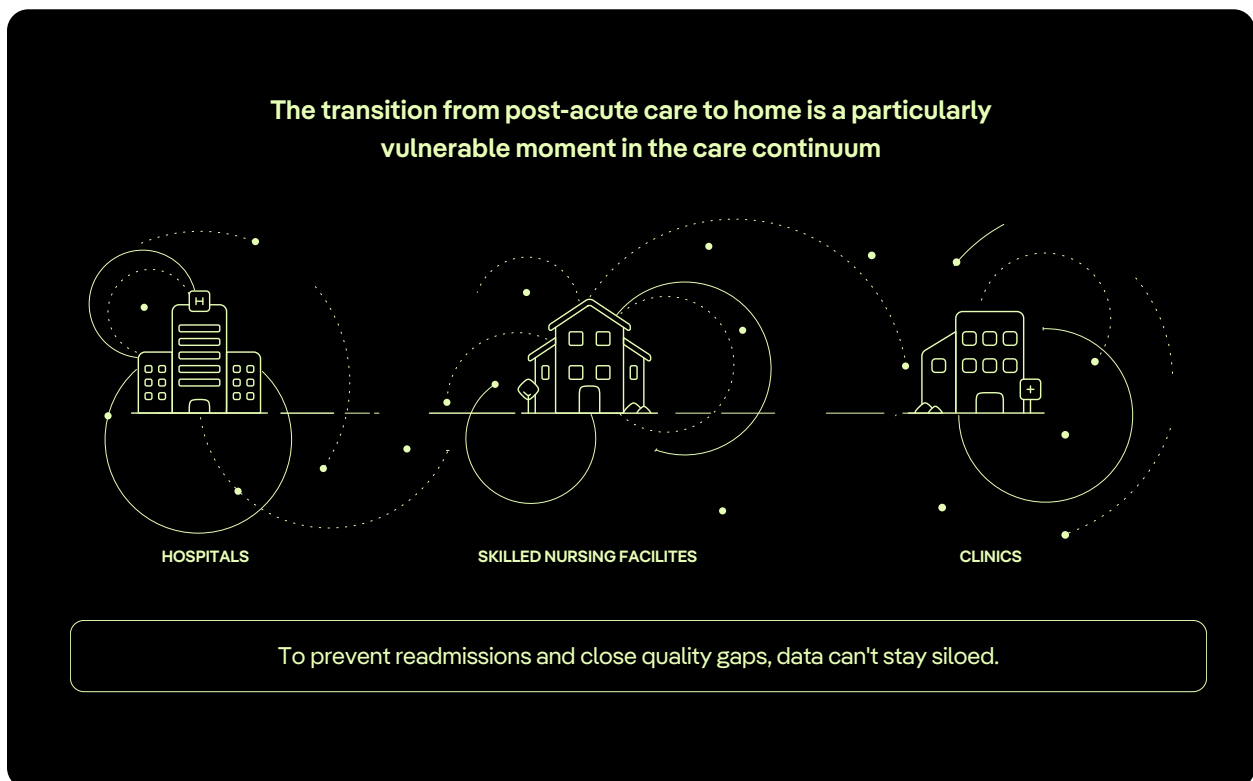
## The Post-Acute Transition No One Was Watching

### Why This Transition Matters Most

**The transition from post-acute care to home is a particularly vulnerable moment in the care continuum—not because of what happens days later, but because of what is (or isn't) in place at discharge.**

Clinical oversight often ends abruptly, leaving high risk individuals exposed to medication gaps, missing services, or inadequate support at home. When transitions are not intentionally designed for success—ensuring access to long-term services and supports, durable medical equipment, and medications—early warning signs may go unnoticed until conditions escalate into emergency department visits.

At the same time, payers often lose real-time visibility during this period, limiting their ability to intervene before avoidable readmissions occur.



# 4

## From Claims-Based Lag to Predictive Foresight

### The Old Model vs. The New Model

Claims-based analytics suffer from a fundamental limitation: **they describe the past, not the future.** By the time claims are adjudicated, episodes are over and intervention opportunities have passed.

Leading organizations have replaced claims-based lag with real-time, predictive intelligence that enables:

- **Early identification of high-risk members** based on clinical signals, not historical averages
- **Real-time monitoring of patient progress** during and after post-acute stays
- **Predictive risk scoring** flagging individuals likely to experience deterioration
- **Automated alerts and workflows** routing insights to the right care team member at the right time

#### Predictive Analytics



65.6%

Organizations planning implementation in 2026

#### Real-Time Data Exchange



65.6%

Planning major improvements across continuum

#### AI Enhancement



47.5%

Expect AI to enhance predictive analytics

### Taken together, these findings point to a deeper transformation underway.

Organizations are no longer focused on digitizing existing processes—they are re-architecting operations around intelligence.

Real-time data and predictive capabilities are no longer viewed as incremental IT upgrades, but as strategic imperatives required to manage risk, intervene earlier, and compete in value-based environments.

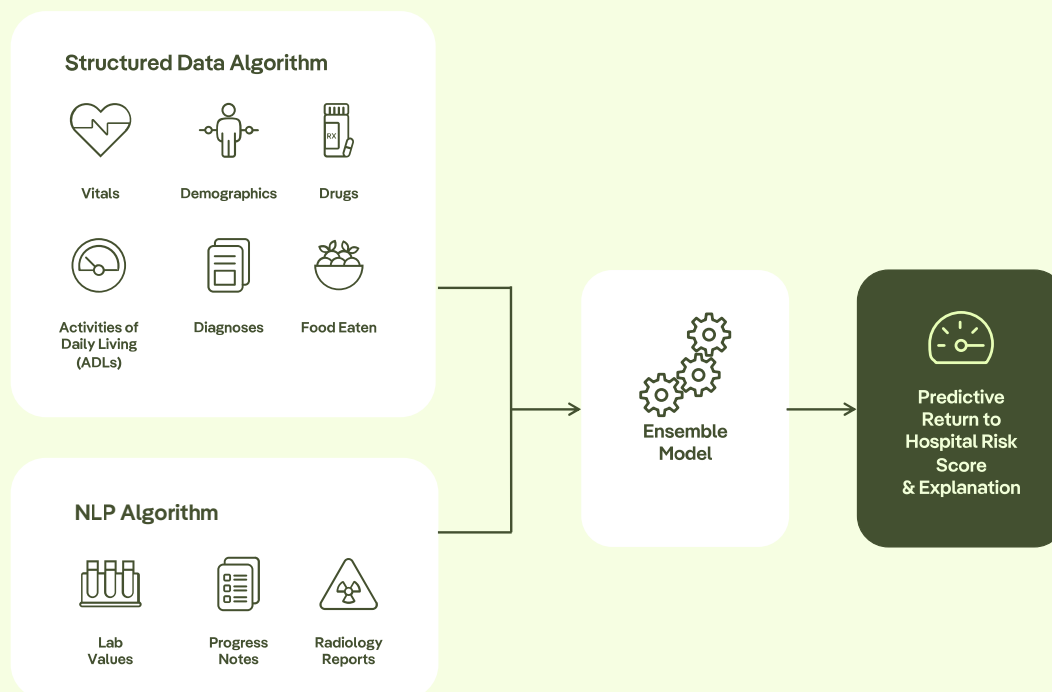
## What Makes Predictive Intelligence Different

**Predictive analytics** identifies patients who are high-risk for specific outcomes at specific moments—enabling targeted, timely interventions before deterioration occurs.

**For example**, payers can identify members likely to be readmitted within 72 hours of discharge to home, enabling outreach before patients leave facilities. The key distinction is timing—compressing the gap between signal and response.

### How PointClickCare's Predictive Intelligence is Different

PointClickCare's predictive intelligence is driven by its AI powered **predictive return to hospital (pRTH)** algorithm. Purpose built for post acute care, pRTH is trained on years of longitudinal post acute clinical data and evaluates both clinical and non clinical signals, including patient progress and care team documentation, to identify elevated readmission risk—and the “why” behind it—while intervention is still possible .



## 5

## Preferred Networks: From Aspiration to Operation (For Hospitals and ACOs)

The rapid adoption of **preferred post-acute provider networks** reflects recognition that **not all post-acute providers perform equally**. Steering patients to high-performing partners is one of the most effective levers for reducing readmissions and managing episode costs.

### What High-Performing Networks Require

Organizations cite the same enabling capabilities:



**Performance Benchmarks** allowing objective comparison



**Real-time Patient Transition Insights** providing visibility



**Quality and Outcomes Tracking Tools** beyond claims metrics



**Seamless Data Sharing Capabilities**

### Why Networks Are Accelerating Now

Timing reflects convergence of several forces:



**Value-based Care Models** making partner performance a direct financial driver



**Quality Measure Accountability** tying reimbursement to post-acute performance



**Technology Maturity** enabling real-time data exchange



**Shared Recognition** that post-acute partnerships are the most impactful improvement lever

Preferred networks are now a **strategic necessity** for organizations competing on value, quality, and member experience.





## 6

## The Tools That Make Alignment Possible

Alignment between payers and providers has always been appealing. What's different now: **the tools to operationalize alignment finally exist.**

### The Technology Stack for Alignment

Organizations achieving meaningful alignment share a common technology foundation:

Technology	Purpose
 <b>Real-Time Patient Transition Dashboards</b>	Unified view of patient status across settings, replacing fragmented communication with continuous updates
 <b>AI-Driven Readmission Risk Scoring</b>	Identifies highest-risk patients, enabling prioritized interventions and efficient resource allocation
 <b>Automated Referral and Intake Workflows</b>	Streamlines discharge planning, reducing delays and ensuring appropriate placements
 <b>Shared Preferred-Network Analytics (Hospitals &amp; ACOs)</b>	Provides transparent performance metrics enabling objective evaluation

These tools **create a shared operating picture** where all stakeholders see the same patient journey, risk indicators, and performance outcomes.

# 7

## What Leading Organizations Are Doing Differently

High-performing organizations share defining characteristic



### **They Ensure a Successful Transition to Home**

Ensure discharge readiness by proactively aligning services, equipment, medications, and follow up so patients can succeed at home and avoid preventable readmissions.



### **They Replace Claims Lag with Real-Time Clinical Signals**

Use real-time clinical data from post-acute settings to inform care management



### **They Design Workflows for Real Humans**

Eliminate manual workarounds ensuring predictive insights translate seamlessly into action



### **They Build Trusted Partnerships with Post-Acute Providers:**

Strengthen collaboration with SNFs through shared, real time data insights that create transparency, reduce after the fact follow up, and replace manual phone calls with a shared understanding of patient progress.



### **They Use Predictive Foresight, Not Historical Averages**

Deploy AI-driven risk stratification for targeted interventions

Organizations embracing these practices report significantly better outcomes:



**Fewer Preventable  
Readmissions**



**Faster  
Throughput**



**Lower Episode  
Costs**



**Stronger Quality  
Performance**

## 8

## The Strategic Questions Leaders Are Asking

Critical questions have emerged:

**Do we have early visibility into our highest-risk patients and members?**

Organizations can no longer wait for claims data—they need real-time clinical signals from post-acute settings.

**Do our teams share the same definition of success?**

Alignment requires shared metrics, workflows, and accountability spanning acute, post-acute, and payer domains.

**Are we still managing with manual workarounds?**

Phone calls and faxed summaries signal outdated models; leaders have replaced these with intelligent automation.

**Do we know which partners truly perform?**

For hospitals and ACOs, effective preferred networks require objective, comparable benchmarks beyond anecdote.



# 9

## The Imperative to Collaborate with Post-Acute Care

**Both payers and providers now recognize they cannot succeed without deeper, more intelligent collaboration with post-acute partners.**

Post-acute care is now recognized as **the strategic lever** for achieving reduced readmissions, lower episode costs, better patient experiences, and stronger value-based performance. Organizations treating it as tactical miss the opportunity; those treating it as **strategic** are reshaping outcomes.

### What Effective Collaboration Requires

True collaboration demands:



**Shared Visibility**  
into patient status



**Real-Time Data Exchange**  
eliminating information gaps



**Transparent Performance Measurement** with  
objective benchmarks



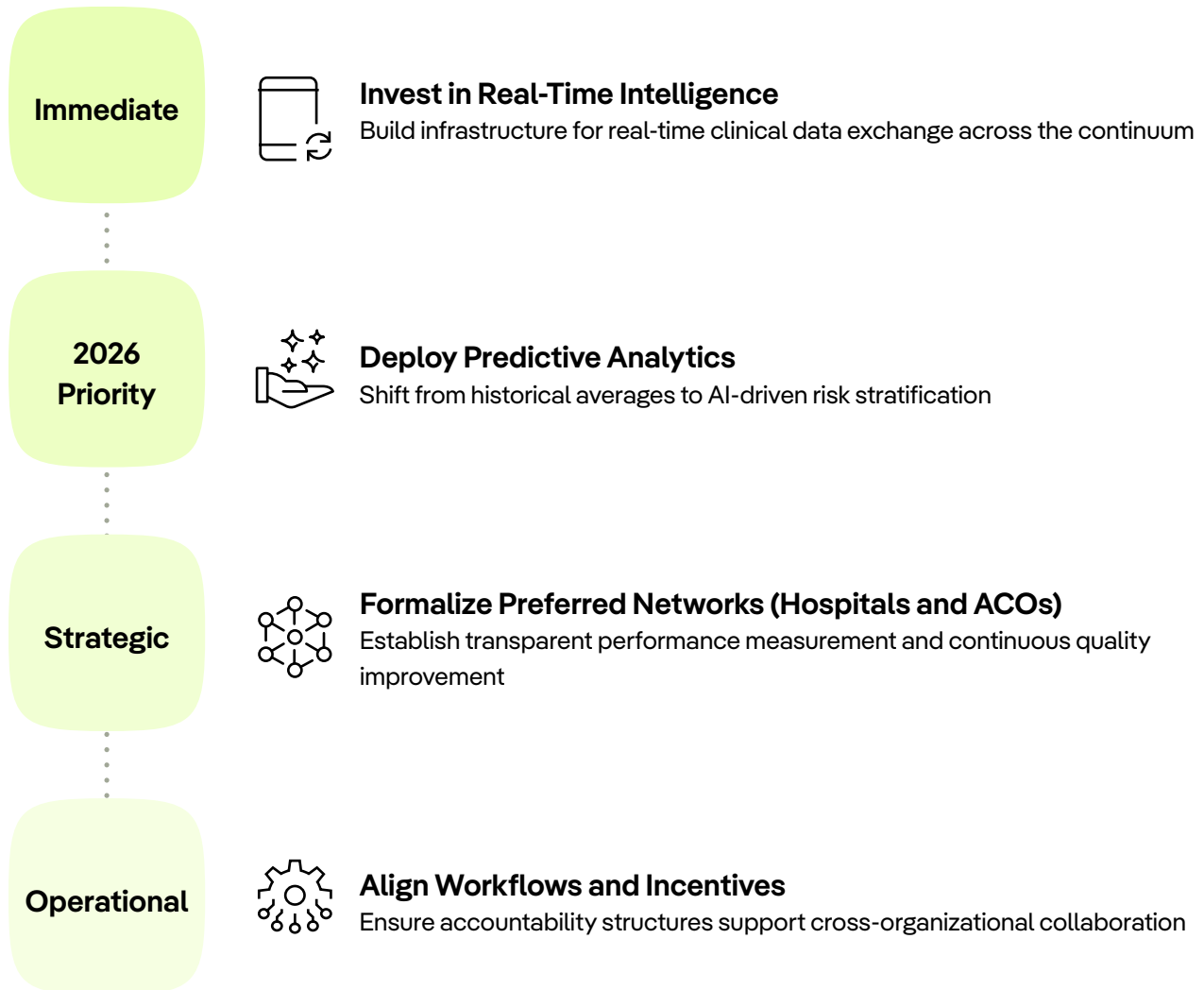
**Predictive Intelligence**  
identifying proactive  
intervention opportunities



**Aligned Incentives**  
rewarding quality  
and outcomes

# 10

## The Path Forward: From Shared Vision to Shared Action



### Organizations that lead will **turn shared visibility into shared action.**

This requires investment in real-time intelligence, commitment to predictive analytics, formalization of preferred networks, and alignment of workflows and incentives.

The market is moving rapidly. Organizations that delay risk falling behind competitors already capturing benefits of proactive post-acute management.

# Survey Insights: Key Findings-at-a-Glance

### Shared Strategic Priorities

Both payers and providers rank reducing readmissions as **#1 priority for 2026**

Why it Matters

**Signals unprecedented alignment around post-acute performance as strategic lever**

### Visibility Gaps

**38%** cite lack of integration  
**36%** report insufficient real-time data

Why it Matters

**Technology exists but intelligent integration remains the barrier**

### Predictive Analytics Momentum

**65.6%** plan implementation in 2026

Why it Matters

**Market-wide shift from retrospective analysis to proactive risk stratification**

### Real-Time Data Exchange

**65.6%** plan implementation in 2026

Why it Matters

**Organizations building infrastructure for continuous visibility**

### Preferred Network Development

**64%** have built or are building preferred networks

Why it Matters

**Strategic partnerships are operational, not aspirational**

### Partnership as Top Lever

**70.5%** say post-acute collaboration is most important coordination driver

Why it Matters

**Post-acute partnerships now recognized as mission-critical**

### AI and Machine Learning

**47.5%** expect AI to enhance predictive analytics

Why it Matters

**Confidence in AI as enabler of early intervention**

### Critical Transition Focus

Organizations prioritize visibility ahead of and during discharge to home

Why it Matters

**Highlights most vulnerable and most impactful continuum moment**

## Conclusion: A New Era for Post-Acute Care

Value based accountability, quality measurement, and predictive technology have aligned payers and providers around a shared priority: improving outcomes depends on stronger collaboration during the transition to home—when people are most vulnerable and visibility has historically been limited.

Leading organizations are moving from retrospective oversight to **getting transitions right from the start**. By replacing claims based lag with real time, predictive intelligence and

ensuring individuals leave post acute settings with the services, supports, equipment, and medications needed to succeed at home, they are reducing avoidable risk before it escalates.

As shared visibility replaces fragmented handoffs, a more connected operating model is emerging—one that enables earlier insight, better coordination, and shared accountability across the continuum. The opportunity is clear.

**The pace of action will define who leads.**

Post-acute performance doesn't improve by chance—it improves when organizations operationalize visibility, predictive intelligence, and collaboration.

Our **PAC Management solutions** provide the real-time data, risk insight, and workflow alignment that enable hospitals, ACOs, and health plans to turn shared priorities into measurable outcomes across the continuum.

### Hospitals & Health Systems

**PAC Management for Hospitals & Health Systems** helps hospitals gain real-time visibility into post-acute performance, reduce avoidable readmissions, and build high-performing preferred networks.

[Discover How >](#)

### ACOs

**PAC Management for ACOs** supports end-to-end cost and quality accountability by strengthening post-acute coordination, risk stratification, and partner performance.

[Discover How >](#)

### Health Plans

**PAC Management for Health Plans** enables health plans to move beyond claims-based oversight with predictive, real-time insight into post-acute transitions and member risk.

[Discover How >](#)

## About the Study

The PointClickCare Payer-Provider Study was conducted with the Alliance for Smart Healthcare Excellence and Healthcare IT Today.

The study surveyed 61 healthcare leaders—51% from provider organizations and 49% from payer organizations—representing care management, network management, clinical leadership, informatics, and administrative roles.

PointClickCare is a leading health tech company with one simple mission:  
**to help every provider deliver exceptional care.**