eBook

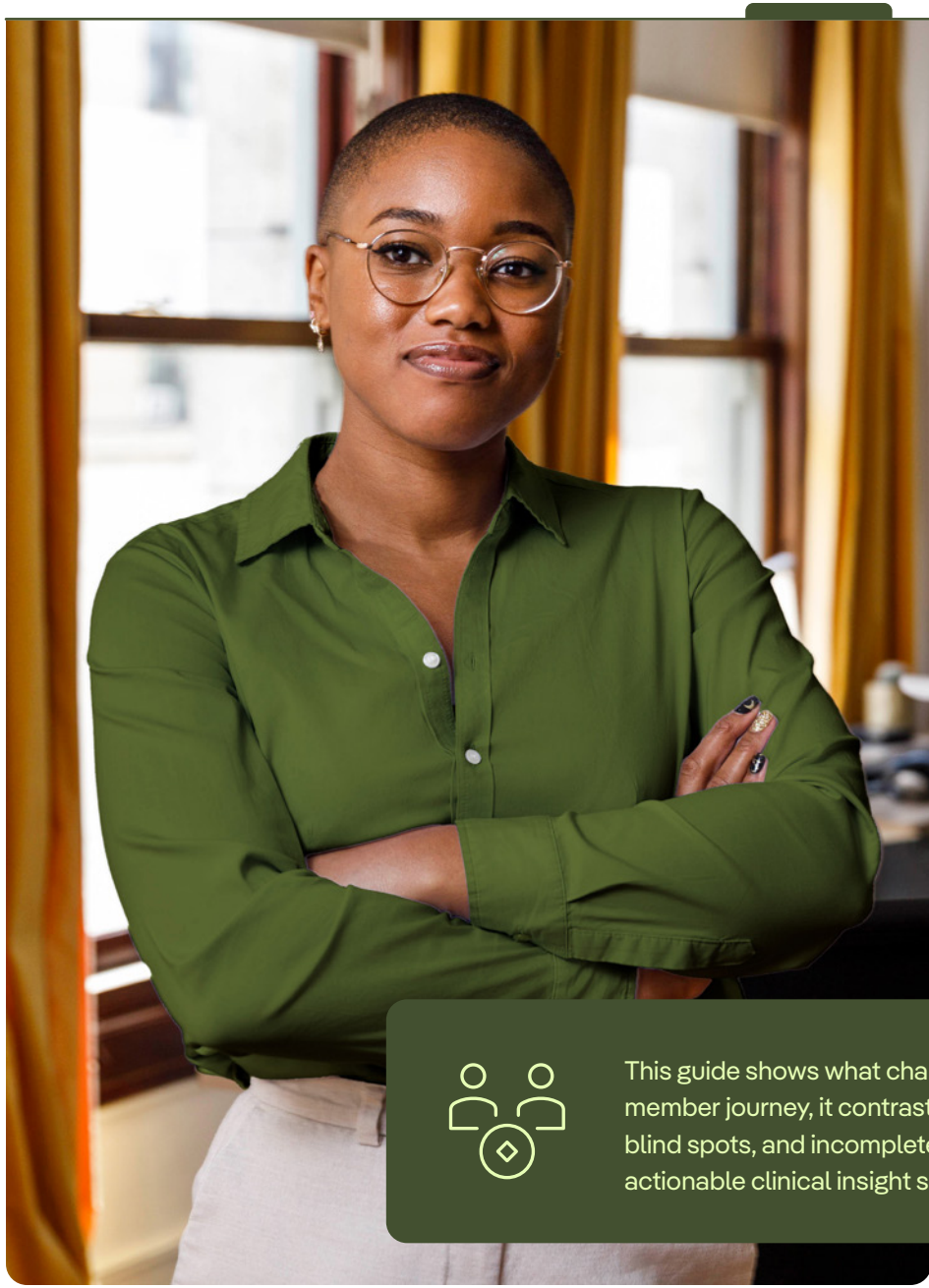
From Blind Spots to Better Transitions

A Practical Guide for Health Plans Managing High-Risk Transitions

Get Started

PointClickCare®

Table of Contents



For health plan leaders, the pressure to control cost is not letting up, but some of the levers plans have long relied on are getting harder to use in the same way.

Prior authorization and utilization management are under growing scrutiny. CMS-0057 is tightening turnaround requirements, and denial overturn trends continue to raise questions about how much these mechanisms can realistically do to shape outcomes on their own.

That matters because authorization decisions were never designed to determine whether a transition actually succeeds. An approved post-acute stay can still end in readmission. A member discharged to home health can still return to the ED if follow-up does not happen, medications are not reconciled, or barriers are left unaddressed. Increasingly, the real cost lever is not just controlling access to care. It is making the transition work.

That is where care management becomes more than a support function. When plans can identify members earlier, reach out with the right context, and stay connected through post-acute care, they are in a stronger position to reduce avoidable utilization while also protecting the member experience. Those same moments shape whether a member picks up the phone, stays engaged, follows through on the care plan, and builds trust in the plan over time, with implications for both outcomes and CAHPS performance.

This guide shows what changes when that journey becomes more connected. Through a side-by-side member journey, it contrasts two realities: one where care managers and providers are working with delays, blind spots, and incomplete information, and another where earlier visibility, timely notifications, and actionable clinical insight support faster intervention and stronger coordination across the continuum.

Introduction: What Changes When You Can Act Earlier

The promise of better transitions is straightforward: if your team can identify members earlier, reach out with the right context, and stay connected through post-acute care, you are in a stronger position to prevent readmissions, reduce avoidable costs, improve care coordination, and make care management resources go further.

The opportunity is measurable across health plans.

50% reduction in readmissions in the first year (CareOregon).

3+ hours saved daily identifying and gathering patient information (CareOregon).

100–200 minutes saved per care manager per week with real-time access to post-acute clinical notes (San Francisco Health Plan).

CareOregon shows what that can look like at scale.

Serving 543,000 Medicare Advantage and Medicaid members, the plan once relied on faxed hospital census reports to track transitions, which slowed post-discharge visibility and limited the team's ability to intervene before members returned to the hospital. After moving to real-time data from PointClickCare, CareOregon cut readmissions in half in the first year.

> "With PointClickCare, we have access to real-time member data as soon as they are discharged. This empowers our nurses to engage in direct care coordination promptly, affording them additional time to connect with our members swiftly after discharge."

Summer Sweet, Triage and Data Integration Manager, CareOregon

For health plans, the implication is bigger than one successful intervention. When care managers can engage earlier, work from better context, and stay involved across the episode, care management becomes a stronger lever for reducing avoidable utilization, improving quality performance, and delivering a member experience that builds trust over time.

How Better Transitions Work, Step by Step

If your team is still piecing together the episode from claims, faxed records, manual outreach, and scattered provider follow-up, this journey will feel familiar. The contrast below shows what changes when health plans can see the member sooner, prioritize the right cases, and coordinate the episode with more confidence.

Stage 1: Spot the Transition Early So You Can Prioritize the Right Members

Why it matters: You cannot prioritize what you cannot see. If the plan learns about the admission, discharge, or SNF transfer too late, care management starts behind and high-risk members are harder to reach before problems escalate.

Without Connected Visibility	With Connected Visibility
The plan learns about the event too late, often through claims that arrive weeks or months later. By then, the member may already have returned to the ED multiple times.	The plan gets real-time visibility into admissions, discharges, and transfers, so members enter the workflow while there is still time to act.
Teams are flooded with data but still lack clear, actionable insight. As a result, high-risk members are harder to prioritize quickly.	Risk signals help direct care management time where it can have the most impact, so high-priority members rise to the top sooner.
Once the member moves into post-acute care, visibility drops and coordination breaks down.	The plan has real-time visibility throughout the post-acute stay, making it easier to spot opportunities to intervene and reduce length of stay.

Stage 2: Equip Care Managers Before the First Outreach

Why it matters: The first outreach call is often your best chance to keep risks from escalating, close gaps in care, and address barriers before the member returns to a higher-cost setting. That call works very differently when care managers have clinical context before they pick up the phone.

Without Connected Visibility	With Connected Visibility
The first call starts with guesswork. The member has to explain what happened, and time is spent gathering facts instead of helping.	Before outreach, the care manager receives an AI-powered clinical summary within 24 hours of discharge that distills the discharge documentation into the focused view they can act on quickly.
Care managers become record-chasers. Medication issues and follow-up needs are harder to catch in time.	The summary surfaces what is most actionable, including medication changes, time-sensitive follow-up instructions, and barriers that could derail the transition, so the call starts with intervention instead of investigation.
The outreach feels generic, so engagement suffers when members need support most.	Because the most important context is already in front of them, outreach feels informed and relevant, and the care manager can guide the member through the next best step with more confidence.

> "Real-time data helps us coordinate care directly and engage members faster after discharge, when timing matters most."

Summer Sweet, CareOregon

Stage 3: Stay Involved During the Post-Acute Stay

Why it matters: For many plans, the post-acute stay is where cost, readmission risk, and discharge complexity build fastest, yet visibility is weakest. If your team cannot see what is happening in the SNF, it is difficult to manage the stay before it turns into a longer, more expensive episode.

> "Plans have strong visibility into hospitals, but SNFs are fragmented and largely invisible. That's where patients, and opportunities, are getting overlooked." **SVP,** Regional Managed Care Organization. Sage Market Report

Without Connected Visibility	With Connected Visibility
The post-acute stay becomes a blind spot. records and not enough time coordinating care.	The plan has real-time visibility into what is happening during the SNF stay, so risk, progress, and changes in condition are easier to manage while the episode is still underway.
Discharge planning starts late, with limited insight into who is ready, who is at risk, and what support will be needed at home.	Risk and discharge readiness signals help the plan see who needs intervention while there is still time to change the outcome.
Care managers spend too much time chasing records and not enough time coordinating care.	Risk-based prioritization helps the team focus on the members most likely to readmit or need complex coordination, with less time lost to record-chasing.

What the member notices: When they're ready to go home, the transition is coordinated. Home health is scheduled, DME is arranged, follow-up is confirmed, and transportation is in place. For members with complex needs or limited support, that coordination is often the difference between a safe transition and a return to the hospital.

> "With my care management hat on, the biggest ask is to stop chasing charts. That is one of the most inefficient things between UM and CM that people have to do to coordinate care." **SVP,** Population Health & Care Management. San Francisco Health Plan

Stage 4: Strengthen the Transition Home Before Risk Turns Into Readmission

Why it matters: The transition home is where small gaps become expensive setbacks. If medications are not reconciled, follow-up is not confirmed, or services are not in place, the plan often ends up paying for a failure that could have been prevented with earlier coordination.

Without Connected Visibility	With Connected Visibility
The member goes home with gaps the plan could not see or influence in time.	Discharge planning starts early enough to surface needs such as home health, transportation, equipment, and community-based support before the member leaves the facility.
The PCP and care team are left to reconnect after the fact, when small issues are already becoming bigger ones.	Providers and care teams stay connected with the information they need, so the transition home is more coordinated and less likely to unravel after discharge.
The result is often a preventable readmission, higher cost, and a weaker member experience.	The result is a steadier transition home, lower readmission risk, and a care management investment that is more likely to pay off.

> "If we utilize the data in the right way, then we're going to move the needle. If it's sitting somewhere in some server or some database and not being pulled out, then there's nothing we can do."

Source: Director of Healthcare Management. Sage Market Report

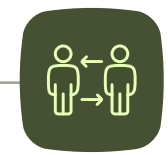
Why One Better Workflow Can Improve Multiple Outcomes

Care management outcomes rarely move one at a time. The same discharge event can trigger outreach, medication questions, provider coordination, post-acute monitoring, and readmission prevention.

When the team can see the member in real-time, understand the clinical picture quickly, and stay connected through post-acute care, one workflow starts doing the work of many. Outreach becomes more relevant. Coordination starts sooner. Small gaps are less likely to turn into expensive ones.

That is the shift from reactive care management to connected care management: fewer blind spots, fewer handoff failures, and more moments where the plan can actually change the outcome.

Member Journey Summary: Disconnected vs. Connected Care

	Admission / Discharge	First 24–72 Hours	SNF / Post-Acute Stay	Transition Home
				
Without Connected Visibility	Discharge invisible for days or weeks; flat caseloads; SNF transfer unseen	No clinical context; call starts from zero; medication issues undetected	Zero visibility; readmission risk unknown; discharge planning invisible to plan	Fragmented handoff; meds unreconciled; PCP not notified; home health not arranged
With Connected Visibility	Real-time transition alerts; risk-stratified caseloads; provider engagement in parallel	Timely clinical summary; informed outreach; medication changes easier to identify	Live post-acute visibility; risk signals; discharge readiness insight; proactive coordination	Coordinated discharge; medications clarified; providers informed; service needs arranged before transition
Business Impact	Care team mobilizes during the episode	Readmissions prevented; member engagement improved	28% reduction in avoidable readmissions; shorter LOS	Readmission prevented; costs controlled; member retained

What Leading Health Plans Are Doing Differently

If you are trying to reduce avoidable utilization, improve handoffs, and get more value from your care management resources, this is the operating model to pay attention to.

Leading plans tend to organize around a few practical priorities:

Speed to intervention measured in hours, not days, during the post-discharge window when action changes outcomes

Clinical context before outreach so care managers solve problems instead of gathering them

Provider activation in parallel, with the PCP notified and equipped instead of chasing faxes

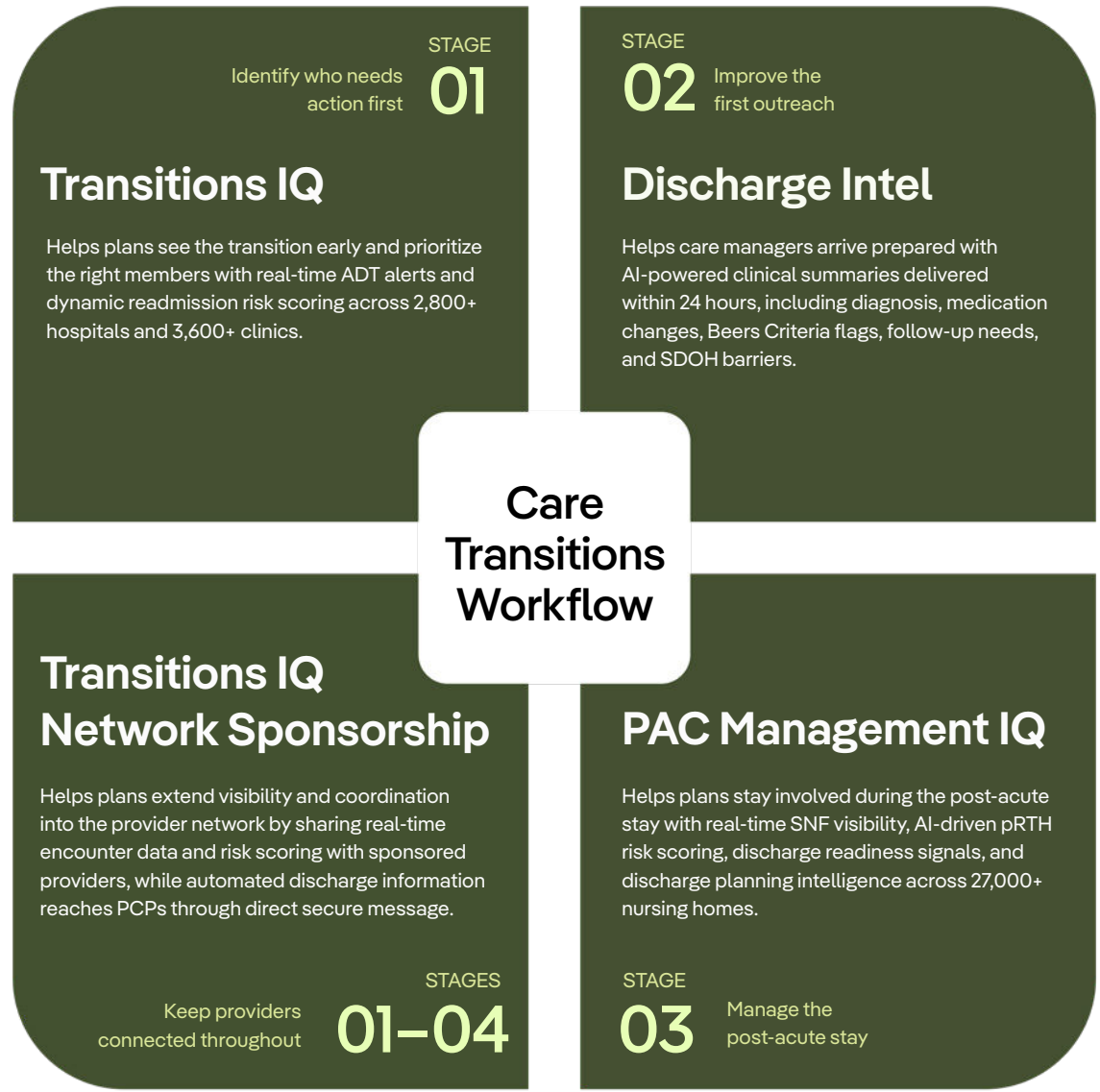
Post-acute visibility to manage the stay in real time, not react to readmissions after the fact

One connected workflow across the continuum, with less record-chasing and more time on members

When real-time alerts, discharge intelligence, post-acute visibility, and provider coordination work together, the member journey becomes easier to manage and easier to repeat at scale.

> "Post-acute care is where risk concentrates, and where visibility most often disappears. It's the highest-opportunity part of the continuum, and the part where most plans have historically had the least insight."

L.A. Care Health Plan



What Better Transitions Can Deliver

For health plan leaders responsible for care management performance, better transitions mean more than a smoother member experience. They create a clearer path to reducing avoidable utilization, improving coordination across settings, and making finite care management resources work harder where they matter most.

In practical terms, that means fewer missed handoffs, less time spent tracking down records, more informed outreach, and a stronger ability to manage post-acute stays before they turn into readmissions or higher-cost episodes.

PointClickCare helps make that possible by giving plans earlier visibility into care transitions, better insight into what happened during the stay, and stronger coordination across providers and post-acute settings. The result is a care management model that is easier to scale, easier to prioritize, and more likely to change outcomes that matter.

Ready to see how this approach could strengthen care management in your health plan?

Learn more at PointClickCare.com/caremanagement, or contact us to schedule a tailored walkthrough of how these solutions support your care management strategy.

Learn More **Schedule a Demo**

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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