

PointClickCare®

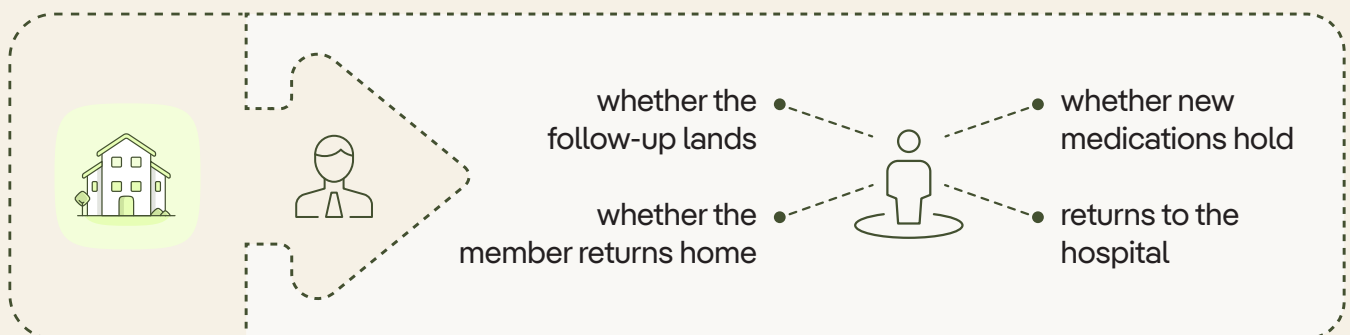
The Discharge Plan Was Always There. Care Teams Just Couldn't See It.

What happens when the discharge plan surfaces itself,
in the words of the people doing the work.

The Setting

The most important days of a post-acute stay are the last ones.

For members in skilled nursing and long-term care facilities,
the transition out decides what happens next:



**Coordinating that transition is the care manager's job,
and doing it well depends on something they rarely have:**
a current view of the discharge plan taking shape inside the facility.

THE CHASE

That plan exists.

It takes shape in the facility's notes, days before the member leaves for home or back to the community. Most care teams reconstruct it afterward, by **phone**, **fax**, and **follow-up emails**.

👂 It keeps us from having to bother the post-acute facilities and say, hey, send me this... sometimes we'll send them emails or call them two or three times trying to get this information.

Case manager, risk-bearing entity

WHAT CHANGED

AI reads the notes. Care managers read the plan.

Using AI-powered discharge planning, **PAC Management IQ** reads SNF progress notes and surfaces the discharge picture while the stay is still in progress.

Before



Notes sit inside the facility.
The plan is invisible
until it is over.

With PAC Management IQ



Primary care
provider



Home health
referrals



DME
needs



Follow-up
appointments



Patient
instructions



Discharge
disposition



Estimated
discharge date

Seeing the plan as it forms means
coordination starts before the stay ends, not after the member is home.

THE TIME IT RETURNS

“ It probably is cutting the time in half... we can use our resources more efficiently.

Clinical quality manager, risk-bearing entity

The time at stake is measurable.

One Medi-Cal plan, San Francisco Health Plan (190,000 members), tracked what live SNF visibility alone returned:



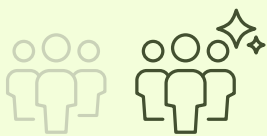
100-200
minutes back

per care manager, per week

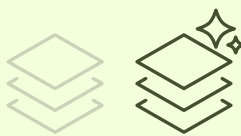


87-173
hours a year

per care manager
roughly two to four working weeks, based
on 52 weeks of the reported weekly savings



Same team



Same caseload



Time Savings

Time redirected from retrieving information
to member outreach and interventions.

WHAT GETTING AHEAD ENABLES

The hours come back earlier in the episode, while the discharge can still be shaped

An arrangement made while the member is still in the facility is
a problem that never happens at home.

Admission

Stay in Progress

Discharge Day

Home



Discharge plan surfaced during the stay

Cordination starts here—home health, DME, transport, appointments

Reconstructed after
through phone, fax, email



The transition that holds

Home health, equipment,
and transportation
arranged before
discharge day, so the
return home doesn't
undo the stay.



Barriers solved before they become readmissions

- Who's home with you?
 - Can you afford the new prescriptions?
 - How will you get to Thursday's appointment?
- Asked while there's still
time to fix the answer.



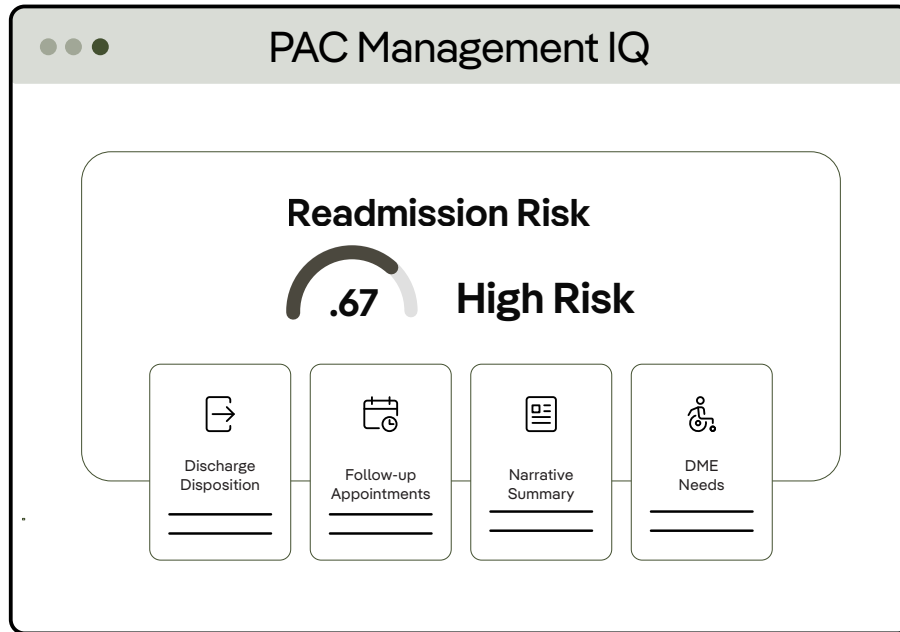
Follow-up already on the calendar

The clock on
post-discharge windows
starts at discharge.
Getting ahead means the
appointment exists before
the clock does.

**Less time chasing charts.
More time planning the next safe transition.**

Time back is a quality strategy, not just an efficiency project.

See how PAC Management IQ helps health plans act sooner



PAC Management IQ gives health plan and delegated care management teams real-time visibility into skilled nursing and long-term care stays, with the discharge plan surfaced as it forms and readmission risk scored with the clinical reason beside it.

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

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