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White Paper

What Care Managers Catch: Real Cross-Continuum Workflows That Keep Patients Safe

A look at the real workflows care-transitions and post-acute teams use to catch risk, close gaps, and keep patients safer across every stage of the journey. Drawn from real customer experiences.[1]

Executive Summary

Care managers and transitions teams carry some of the hardest work in healthcare: keeping patients from falling through the gaps between settings, finding problems before they become crises, and holding together a care plan that can unravel at any handoff.

This guide documents how teams actually do that work, stage by stage, across the post-acute continuum. It is not a product overview. It is an account of the workflows care managers run, the moments those workflows catch what would otherwise be missed, and what changes when teams have the information they need to act.

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At the Hospital: Inpatient Acute Care

What Breaks Here: The discharge clock starts the moment a patient is admitted, but the inpatient team is often working without two key pieces of information.

Gap 1

First, they have no visibility into whether the patient has recently used skilled days and how many remain on the benefit.

Gap 2

Second, when the patient does discharge to a SNF, the packet that travels with them is frequently incomplete: a transfer form missing wound-care orders, a medication list that doesn't match, an IV antibiotic ordered without a line to deliver it.

Teams were setting their SNF partners up to fail without knowing it.

What Care Managers Do Now: Validate Skilled Days, Orders, and Medications Before Transfer

1

Before placement decisions are made, a care manager looks up the patient's prior SNF stays and remaining skilled days directly in PointClickCare.

2

On the discharge side, two reviewers go through every discharge to a SNF within 24 hours. They pull the abstract, the medication list, and the transfer form and compare them against what the SNF has in its actual orders.

3

When a gap surfaces, whether a missing wound-care order, a medication that didn't transfer, or an IV antibiotic sent without a line, it routes to the education team the same day to course-correct with the case manager before the first dose is ever missed.

Some teams also use this workflow to validate single-case agreements: if a daily therapy rate is being paid and the patient is refusing sessions, the chart shows exactly which days to dispute.

The Difference It Made: Errors Are Caught Before the First Missed Dose

Within the first 30 days of running this workflow, one team identified a systemic missing wound-care-order problem across multiple discharges and corrected the pattern at the source through staff education rather than one patient at a time.

High-risk missing medications are now caught before the first dose.

One team traces its original decision to adopt the product to a medication-risk incident: a wrong Medication Administration Record (MAR) had been sent with a patient, resulting in incorrect medications at the facility. Having the chart to compare against made that kind of error visible before it could repeat.

> "Now we can go straight to the chart, see what's going on, and focus on what matters instead of sitting on hours of calls."

Getting to the SNF: The Transition

What breaks here: Every hour spent chasing updates is an hour the team does not have to confirm where the patient landed, identify what is missing, or prepare the next step in the transition.

The Handoff	Transition specialists were sitting on four-to-five-hour SNF utilization-management and rounding calls just to get a single patient snapshot, and the verbal handoff was still incomplete.
The ACO View	On the ACO side, teams had no real-time view of where a patient actually landed after discharge. Care was reactive and driven by claims data that arrived weeks or months late.
The Discharge	SNF partners, meanwhile, were often reluctant to share an estimated discharge date, treating the question as an intrusion rather than a coordination tool.

What Care Managers Do Now: Confirm Placement and Discharge Readiness in Real Time

1 Skip the marathon call.

Instead of joining the marathon utilization management call, the team pulls the SNF chart directly to validate the transition, then makes a single targeted call only when something is missing.

2 Review new admits in real time.

Each morning, a coordinator reviews new admits across partner facilities through the parsed admits/discharges view in real time, not from a claims lag.

3 Get ahead of the date.

Where a partner has entered an estimated discharge date, the team uses it to get ahead: lining up DME, home health, and ambulatory support so the patient is ready on day one.

4 Identify SNF for handoff.

ACO teams use this same daily view to identify SNF placements immediately and initiate warm handoffs before the relationship with the facility goes cold.

From Length of Stay to Care Continuity

When a partner is hesitant to share a date, the conversation that works is not about controlling length of stay; it is about being ready to support the patient when they leave.

The Difference It Made: Calls Shrink, Outreach Starts Earlier

Significant blocks of manual SNF follow-up time were eliminated.

Work that previously pulled multiple nurses into hours-long facility calls is now handled by a much smaller team pulling charts directly, and far more patients get reviewed than the old call-based process ever allowed.

On the ACO side, real-time identification of SNF placement replaced claims-lag visibility entirely, enabling immediate outreach and measurable reductions in average SNF length of stay.

> “They’d spend hours listening through all the reports just to pick out what they need. Now it just streamlines the process.”

Inside the SNF: Active Care Management

What breaks here: Once a patient is in a SNF, risk accumulates quietly. Important readmission drivers hide in free-text notes making them harder to read:

A congestive heart failure (CHF) patient whose weight is creeping up	A patient refusing a critical medication	Abnormal labs waiting on a fax

Length of stay defaults to a round number out of habit rather than clinical need. The physicians and nurse practitioners covering multiple buildings cannot dig through every chart. And the health-system side is calling to ask status questions that SNF staff are too busy to answer thoroughly.

What Care Managers Do Now: Review Risk Factors Before IDT and Escalate Specific Concerns

Coordinators review patient charts across their SNF partner network ahead of scheduled IDT meetings. They check each patient's readmission-risk score and the specific contributing factors, then act on what they find.

For a CHF Patient

For a CHF patient, that means confirming daily weights are being recorded and that the patient is taking their diuretic.

For a High-Risk Patient

For a high-risk patient, it means pulling the risk factors, adding their own clinical notes alongside them, and sending that directly to the covering physician and NP, who manage multiple buildings and cannot dig through charts between visits.

When something is wrong, the call that follows is specific: "I see he's refusing his Lasix, why?" rather than a general check-in.

The ACO Question

ACO teams use the same view to ask a question the old workflow never surfaced: does this patient actually need 30 days, or are we defaulting to it out of habit?

The Difference It Made: Earlier Interventions, Better Documentation, Shorter Stays

Weight gains and therapy non-participation that used to go unnoticed until a patient bounced back are now surfaced while there is still time to intervene.

Health systems using this workflow have seen meaningful, sustained reductions in both average SNF length of stay and readmission rates over multiple years, not a one-time dip, but a floor that held.

Teams have also observed a second-order effect: knowing that the health system is actively reviewing charts, SNF partners have become more diligent in their own documentation. Visibility changed behavior on both sides.

> "This window into the post-acute space has just been fantastic."

Back to Acute: When a SNF Patient Returns

What breaks here: When a SNF patient returns to the emergency department, staff historically had nothing.

No Information	A paper transfer sheet was supposed to arrive with the patient; in practice it showed up rarely. The ED team would start from scratch: no prior medication list, no facility history, no social notes.
Back to Square One	For the patient, care restarted at square one. For the team, it was a race against volume with no information to work from.
No Visibility for ACO	ACO nurse navigators faced the same problem from a different angle: they could see that patients were leaving, but not where they were going, and not until claims came in weeks later.

What Care Managers Do Now: Surface the Recent Post-Acute Record Before Care Restarts

1 Detect the event.

An ED SNF Summary, combined with HIE and ADT alerts, notifies the care team the moment a SNF patient discharges or returns to the hospital.

2 Review the record.

Before the patient is seen, the ED team pulls up the prior 7 to 14 days of medications, facility history, and social-work notes, surfaced directly on the ED track board.

3 Coordinate the next step.

For high-utilizer patients, a coordinator opens the post-acute record alongside the hospital chart, confirms whether the patient had a prior skilled stay, and reaches out to the prior SNF to ask if they will take the patient back. That answer goes to the inpatient care-management team, which matters most when the patient hasn't yet loaded into the ADT feed.

4 Prepare the care teams.

On the pharmacy side, this is where medication reconciliation pays off most visibly: the team can see which SNF the patient came from, what medications they were on, when each was last administered, and whether any were discontinued, without a single call.

The Difference It Made: ED and Pharmacy Teams Act With Context

ED physicians and the virtual pharmacy team say the information they need is there now, instead of depending on a paper transfer sheet that rarely arrived.

Teams report that prior SNFs are substantially more willing to readmit a returning patient when the receiving facility has a full clinical record to work from rather than a cold-call request.

For teams relying on claims data to identify post-acute transitions, real-time ADT feeds shortened the gap between a patient's discharge and first outreach from weeks to hours.

> "We don't have the pink sheet, we have this now."
>
> "The minute they go to the ER, they start over at square one. PointClickCare helps connect the dots across the continuum."

Heading Home: The Discharge Transition

What breaks here: Home is where continuity is easiest to lose.

No Plan

As a patient moves from hospital to SNF to home, teams need to make sure the discharge plan is actually ready to support them.

Multiple Handoffs

Care relationships restart at each handoff, sometimes even within the same health system.

Missed Conversations

Patients who need hospice conversations don't always get them because the SNF never flags the decline.

Too Many Unknowns

Teams may not know whether the patient left with the right medications, referrals, caregiver support, and follow-up plan in place.

What Care Managers Do Now: Confirm the Plan Before the Patient Leaves the SNF

Review Admits/ Discharges	On a SNF discharge, a post-acute nurse reviews the admits/discharges list each morning, then opens each chart and works through the post-discharge plan: confirming the home-health referral is documented in the nursing discharge summary, that medications were sent to the pharmacy, and that caregiver hours and case-worker contact are in the social-services note.
The Transition Call	They review the risk score and contributing factors, the latest vitals trend, and the CCD, then make the transition-of-care call to the patient and follow up with the home-health partner to confirm a start-of-care date.
Partners Off-Platform	For patients with non-platform home-health agencies, connectivity tooling still surfaces relevant information.

When a patient is declining at the SNF and a prior hospice or palliative-care conversation is visible in the record, teams use that as a trigger to reach out to the SNF and offer a warm referral before the patient deteriorates to the point of an ED transfer.

The Difference It Made: The TOC Call Starts With Answers, Not Guesswork

Even in against-medical-advice discharges, care managers have been able to coordinate caregiver hours, medications, and home-health starts for patients who previously would have left with no plan.

Teams describe the transition-of-care call as a different conversation now: they already know what is and is not in place before they dial.

Health systems are also expanding access to affiliated home-health and hospice teams so those programs stop losing visibility at the SNF admission and can follow patients all the way home.

> “You just had to hope for the best, and hope the information passed along in that telephone game. This window into the post-acute space has just been fantastic.”

Once Home: The 30-Day Window

What breaks here: The 30-day readmission window doesn't close when the patient leaves the SNF, but oversight typically does.

Widening Gaps

Without coordinated post-discharge support, gaps can widen quickly: appointments don't get scheduled, home care doesn't show up, and barriers that could have been removed with one phone call go unaddressed until the patient returns to the ED.

What Care Managers Do Now: Set Up Follow-Up, Referrals, and Supports Before Day One at Home

1 Detect the event.

Post-acute nurses and care coordinators use the discharge plan to make sure key supports are arranged before the patient leaves: follow-up appointments, medication and pharmacy details, caregiver-hour documentation, case-worker contacts, and referrals to ambulatory care management, social work, or complex-care outpatient programs.

2 Review the record.

The coordinator and clinical lead maintain a running list of flagged discharges and review charts together weekly to identify patients who need extra planning before the handoff. The AI discharge plan helps ensure the right supports are identified and coordinated before the patient leaves the facility.

3 Coordinate the next step.

Specialty coordinators for stroke, coronary artery bypass grafting (CABG), and congestive heart failure (CHF) use the same process to help confirm post-discharge appointments are planned and that needed home-care referrals or supports are documented.

4 Prepare the care teams.

ACO teams use this window to complete transitional care management (TCM): the follow-up contact that supports care continuity and strengthens performance on quality programs.

The Difference It Made: The 30-Day Window Starts With a More Complete Plan

Teams describe being able to address barriers that used to go unnoticed until the patient returned, because the discharge plan makes gaps clearer before the handoff.

Patients are picked up faster as SNF stays shorten. TCM completion rates have improved.

The 30-day window starts with a more complete plan rather than a set of unanswered questions that only surface later in claims data

> “We’re making sure patients don’t fall through the cracks.”

The thread that runs through all of it

What looked like heroic work before, chasing charts, sitting on four-hour calls, piecing together a patient picture from faxes and voicemails, was never what care management was meant to be. Take the logistics out of the equation, and this is what's left: information, used the way it was always supposed to be.

Good care management has always depended on good information. This is what it looks like when the information is actually there.

Ready to see how your team could work?

Most care managers already know where the gaps are. PointClickCare helps them close those gaps before they become readmissions.

The workflows in this guide are not hypothetical. They are running today, at health systems and ACOs that gave their teams a real-time, connected view across the care continuum. If your team is still relying on phone calls, faxes, and claims data to manage post-acute transitions, there is a better way to work.

Talk to a PointClickCare specialist to explore the potential real-world impact you could see by implementing similar workflows

Request a demo >

Explore PAC Management IQ to see how care-transitions teams manage post-acute workflows in real time

Learn more >

References & Citations

1. All organizations referenced in this guide are anonymized. Workflows, quotes, and outcomes are drawn from real customer accounts; results reflect individual program experience and are not presented as benchmarks.

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