



# Shifting Into High Gear: Connecting Managed Care and Acute Case Management for Better Patient Outcomes

**CMSA Detroit Fall Conference 2026**

Thursday, October 15, 2026 · Troy, Michigan

**30 Years of Impact: Driving the Future of Case Management**

# OBJECTIVES

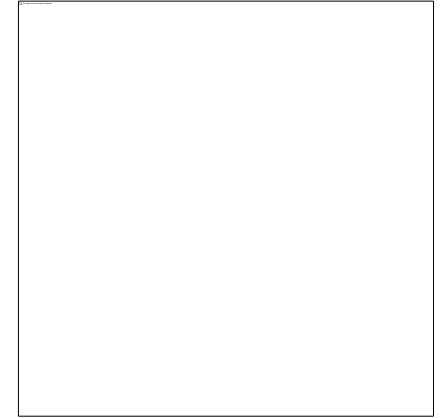
By the end of this session, participants will be able to:

- Explain the key differences and complementary roles of acute care and managed care case managers, including how each contributes to patient-centered care, regulatory compliance, and care transitions.
- Identify common barriers to collaboration across settings and describe strategies to overcome these challenges using standardized communication tools, shared documentation practices, and interdisciplinary alignment.
- Apply evidence-informed best practices to foster effective collaboration, such as warm handoffs, transition planning protocols, and mutual engagement in value-based care goals, including reduced readmissions and improved care continuity.



# DISCLOSURES

- There are no potential conflicts of interest contained in the information provided in this presentation. All material is the opinion of the presenters or cited to source and/or authority.
- Any products referred to during this presentation are for the sole purpose of example and should not be taken as product recommendation or endorsement.





# Why Collaboration Matters

*Better together. Better outcomes. Better experience.*



## TRANSITIONS ARE VULNERABLE MOMENTS—

Poor coordination leads to **readmissions, delays, and frustration.**



**HIGHER  
READMISSIONS**



**DELAYS IN CARE  
AND DISCHARGE**



**PATIENT & FAMILY  
FRUSTRATION**



## WHAT MAKES COLLABORATION ESSENTIAL



### SHARED GOALS

Aligned teams working toward the same outcomes.



### SEAMLESS COMMUNICATION

Timely information exchange reduces gaps and errors.



### BETTER COORDINATION

Clear roles and processes create smoother transitions.



### PATIENT-CENTERED CARE

The right care, in the right place, at the right time.



### IMPROVED OUTCOMES

Fewer readmissions.  
Better quality.  
Higher satisfaction.



### VALUE & COST EFFICIENCY

Lower avoidable costs and better use of resources.



**COLLABORATION IS NO LONGER  
SIMPLY A BEST PRACTICE—**

**IT HAS BECOME AN OPERATIONAL  
REQUIREMENT** for success in value-based care.





# CONCERNS

*Why we must work together.*

**FRAGMENTATION = DELAYS, DUPLICATION, AVOIDABLE HARM & COST**



**DELAYS**  
in care and  
transitions



**DUPLICATION**  
of tests, services  
and effort



**AVOIDABLE HARM**  
from gaps and  
miscommunication



**HIGHER COSTS**  
from inefficiency  
and readmissions



**FRUSTRATION**  
for patients,  
families & staff



**PATIENTS  
EXPERIENCE  
ONE JOURNEY;  
OUR SYSTEMS  
SHOULD, TOO.**

**HOSPITAL  
ADMISSION**



One patient.

**DISCHARGE  
PLANNING**



One plan.

**TRANSITION  
TO HOME/  
COMMUNITY**



One care team.

**FOLLOW-UP  
CARE**



One experience.

**ONGOING  
SUPPORT**



One goal:  
better outcomes.



**COLLABORATION  
ACCELERATES**



**THROUGHPUT**  
Faster movement.  
Fewer delays.



**SAFETY**  
Fewer gaps.  
Safer care.



**EXPERIENCE**  
Better communication.  
More satisfied patients  
and families.



**VALUE**  
Better outcomes.  
Lower costs.  
Stronger performance.



# Overview of the Continuum



Patients



Pre-Primary  
Care



Primary  
Care



Ambulatory  
Surgery Centers



Hospitals



Specialists



Inpatient Outpatient  
Rehabilitation



Skilled Nursing  
Facility



Home  
Care



Hospice

Insurance Partners



Community



Acute Care



Post-Acute Care

# ACUTE CARE ROLE

— Driving Efficiency, Quality & Value Across the Hospital Stay —

## CURRENT METRICS THAT MATTER

1



### LOS (LENGTH OF STAY)

Measures the average time patients spend in the hospital.

2



### AVOIDABLE DAYS

Tracks days patients remain in the hospital that could have been avoided.

3



### DISCHARGE READINESS

Assesses how prepared patients are for a safe and timely discharge.

4



### DENIALS

Monitors and reduces payer denials to protect revenue and support compliance.

5



### HOSPITAL THROUGHPUT

Measures the efficiency of moving patients through the hospital system.

6



### OBSERVATION OPTIMIZATION

Ensures appropriate use of observation status and minimizes unnecessary conversions.

7



### APPROPRIATE STATUS MANAGEMENT

Promotes accurate patient classification to ensure compliance and reduce risk.

8



### PATIENT FLOW OPTIMIZATION

Improves alignment of patients, people, and resources to enhance care and reduce delays.



OUR GOAL:

Right Patient. Right Place. Right Time. Every Time.



Quality Outcomes



Patient Experience



Financial Stewardship



# MANAGED CARE ROLE

*Supporting Members Across the Continuum for Better Health and Lower Costs*



## FOCUS LONGITUDINAL

Focuses on the whole person over time—managing benefits, closing gaps in care, and supporting chronic condition management.



### KEY ACTIVITIES



#### AUTHORIZATIONS

Review and approve services to ensure medical necessity and cost-effectiveness.



#### NETWORK NAVIGATION

Connect members to in-network providers and appropriate care settings.



#### SDOH RESOURCES

Link members to community resources to address social drivers of health.



#### ADHERENCE SUPPORT

Promote medication adherence and care plan compliance to improve outcomes.

### KEY METRICS



#### READMISSIONS

Reduce preventable readmissions through care coordination.



#### ED USE

Lower avoidable emergency department utilization.



#### HEDIS / GAPS

Close quality gaps and improve HEDIS performance.



#### TOTAL COST OF CARE

Manage total cost of care while delivering high-quality outcomes.

### STRATEGIC PRIORITIES



#### PREDICTIVE RISK IDENTIFICATION

Use data and analytics to identify members at risk and intervene early.



#### REMOTE PATIENT MONITORING

Leverage RPM to monitor health status and trigger timely outreach.



#### DIGITAL ENGAGEMENT

Use digital tools and messaging to engage members and improve outcomes.



#### COMMUNITY RESOURCE INTEGRATION

Partner with community organizations to address member needs.

### ADVANCED CAPABILITIES



#### POPULATION HEALTH ANALYTICS

Analyze data to identify trends, opportunities, and measure impact.



#### HIGH-COST MEMBER MANAGEMENT

Provide intensive care management for high-risk and high-cost members.



#### CARE COORDINATION

Coordinate services across providers and settings for seamless care.



#### QUALITY & COMPLIANCE

Ensure regulatory compliance and quality standards are met across the member journey.



### OUR GOAL

Better health outcomes.  
Exceptional member experience.  
Sustainable value.



### RIGHT MEMBER



### RIGHT CARE



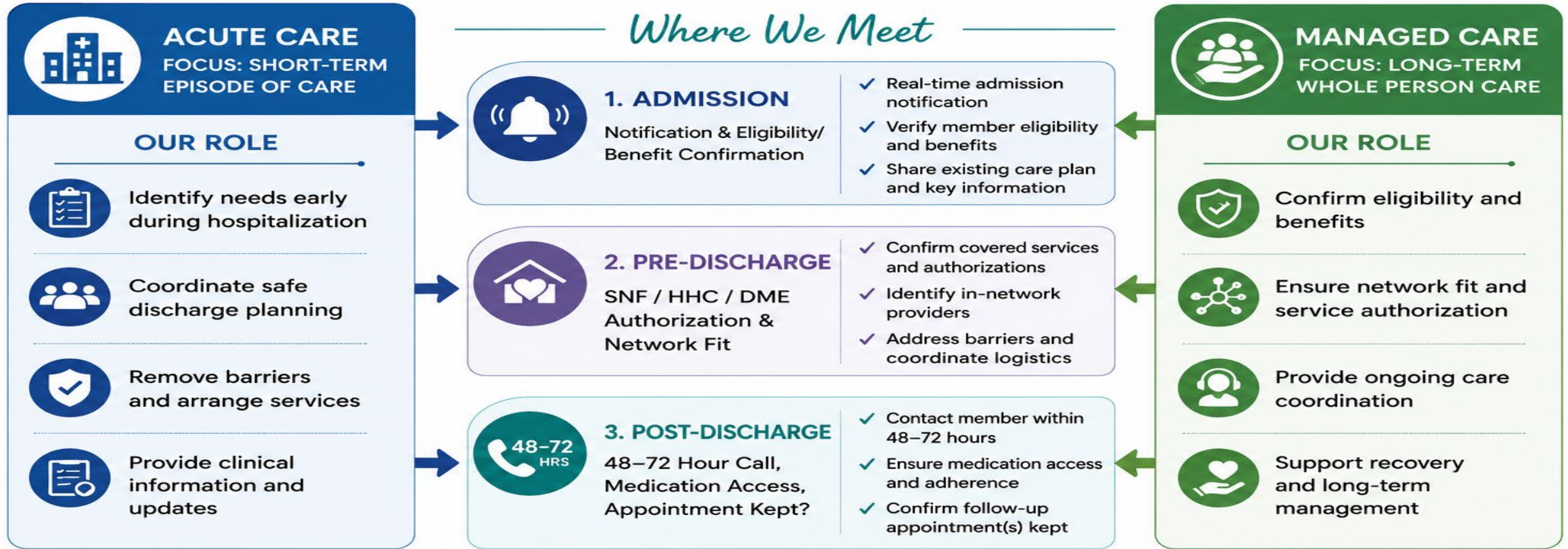
### RIGHT TIME



### RIGHT COST

# THE INTERSECTION POINT

Collaborating at Key Moments to Improve Outcomes Across the Continuum

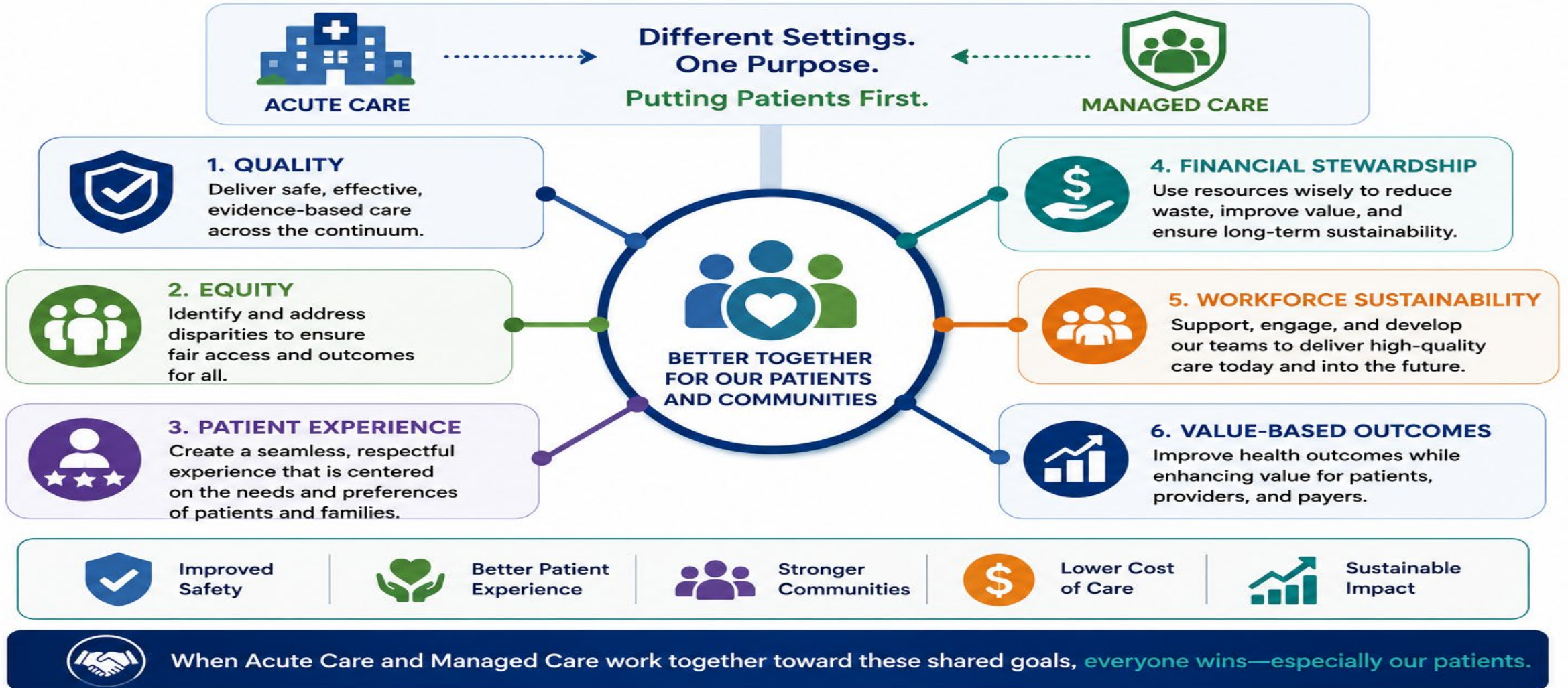


ONE PATIENT. ONE JOURNEY. ONE TEAM.

Consistent communication at these key moments improves outcomes, experience, and value.

# OUR SHARED GOALS

*Aligned Priorities. Better Outcomes. Stronger Together.*



1

# PRE-ADMISSION & EARLY IDENTIFICATION

Identify early. Align early. Act early for better outcomes.



## ACUTE CARE CM



Verify payer



Identify high-risk patients



Identify previous admissions



Screen for discharge barriers



Assess SDOH

## MANAGED CARE CM



Notify hospital of active case management



Share existing care plans



Identify existing community resources



Share historical utilization patterns



Provide member-specific information

## COLLABORATION OPPORTUNITIES



Real-time admission notification



Share existing care plan



High-risk patient flagging



Exchange contact information on Day 1



Early benefit verification



### OUR COLLABORATIVE GOAL:

Identify needs early and align resources to support a successful discharge.



### BETTER START. BETTER PLAN. BETTER OUTCOMES.

Improved patient experience, reduced costs, and fewer readmissions.

# DURING HOSPITALIZATION

*Instead of working independently, we work better together.*



## ACUTE CARE



Coordinates daily discharge planning



Removes barriers



Coordinates consultants



Leads MDR  
(Multidisciplinary Rounds)

## MANAGED CARE



Provides authorization support



Identifies covered services



Locates in-network providers



Helps solve benefit issues

## COLLABORATION OPPORTUNITIES



Participate in multidisciplinary rounds virtually



Weekly payer-provider case conferences



Joint review of complex patients



Shared escalation process



Concurrent discharge planning



### STRONGER TOGETHER

Shared communication and aligned efforts lead to smoother transitions and better outcomes.

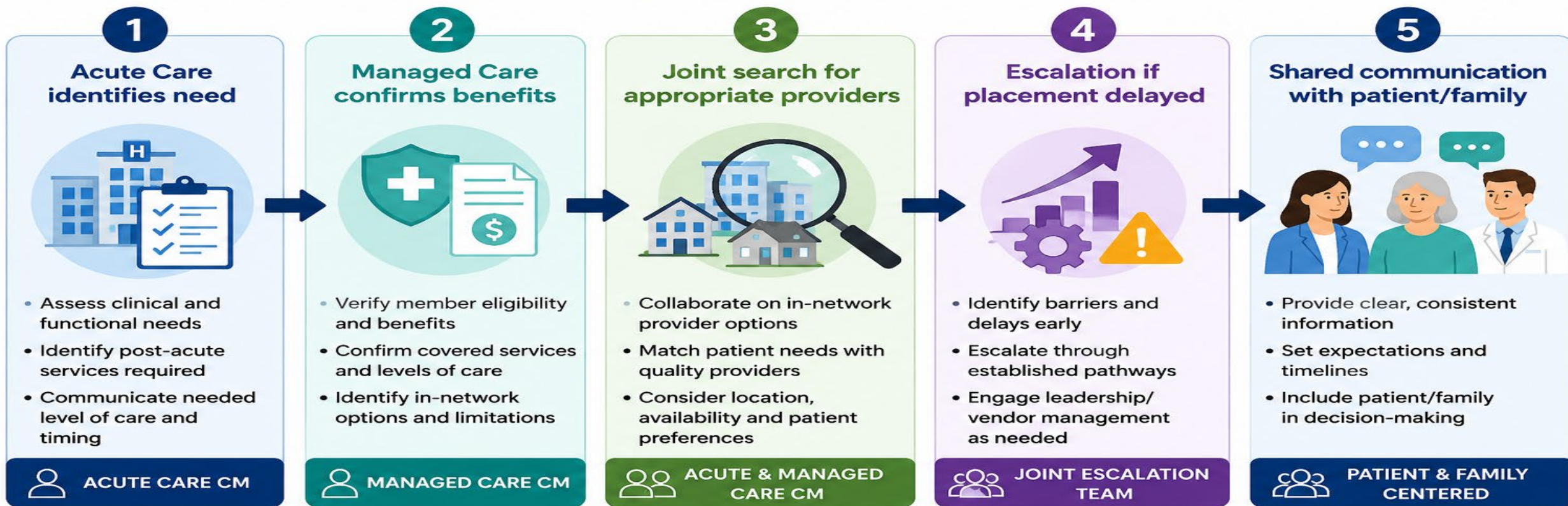


### OUR SHARED GOAL

The right care, in the right setting,  
at the right time.  
Better experience. Lower cost. Better outcomes.

# COMPLEX DISCHARGE PLANNING

Working Together for the Best Outcome



**One Team. One Plan. One Goal:** A safe, timely discharge to the right place, at the right time.



Collaboration



Quality



Patient Experience



Optimal Outcomes



Value & Efficiency



# PRIOR AUTHORIZATION COLLABORATION

Partnering early. Submitting smart. Approving faster.



## CURRENT CHALLENGES



### Late requests

Requests submitted too close to discharge delay approvals and discharge.



### Missing clinical documentation

Incomplete or missing information leads to denials and delays.



### Multiple reviewers

Requests routed to multiple reviewers extend turnaround time.



### Weekend delays

Requests submitted late in the week often wait until Monday for review.



## BEST PRACTICES



### Begin authorization at least 24–48 hours before anticipated discharge

Allows time for review and resolution of any issues.



### Shared clinical documentation checklist

Ensures all required information is included the first time.



### Dedicated escalation contacts

Direct access to the right people to quickly resolve issues.



### Electronic submission

Faster, more accurate, and easier to track.



### Daily status updates

Proactive communication keeps everyone aligned and prevents surprises.



**OUR SHARED GOAL:**  
**TIMELY DISCHARGES.**  
**HAPPIER PATIENTS.**  
**BETTER OUTCOMES.**



### Faster approvals

Reduce delays and denials.



### Better communication

Stronger partnerships lead to smoother transitions.



### Improved patient experience

Get the right care, in the right setting, sooner.



### Lower costs

Avoid unnecessary days and administrative waste.



# MEDICATION ACCESS

*A small step that prevents a big setback.  
The right medication. The right time. The right way.*



## ACUTE CARE



### New medications

Ensure new prescriptions are ordered, reviewed, and ready.



### Specialty medications

Identify needs early and coordinate timely access.



### Prior authorizations

Initiate early to prevent delays in filling prescriptions.



### Medication education

Provide clear instructions to support adherence and safety.

## MANAGED CARE



### Formulary review

Confirm coverage and identify preferred alternatives.



### Copay assistance

Help connect members with savings and assistance programs.



### Pharmacy coordination

Coordinate with in-network pharmacies for smooth transitions.



### Specialty pharmacy referral

Refer to in-network specialty pharmacies for ongoing needs.

## JOINT WORKFLOW



1

### Identify early

Review medication needs and barriers as soon as possible.



2

### Plan together

Confirm coverage, authorizations, and pharmacy plan.



3

### Coordinate access

Secure approvals, arrange delivery, and resolve cost or coverage issues.



4

### Ready at discharge

Ensure medications are in hand before the patient leaves.



5

### Follow up

Confirm medications are filled and being taken as prescribed.



## AVOID PATIENTS LEAVING WITHOUT MEDICATIONS.

*Seamless medication access supports safer transitions and better outcomes.*



### IMPROVED SAFETY

Reduces gaps in therapy and medication errors.



### BETTER ADHERENCE

Patients have what they need to stay on track.



### LOWER COSTS

Fewer complications, readmissions, and avoidance of ED visits.



### BETTER OUTCOMES

Healthier patients. Stronger value. Shared success.



**TOGETHER**, we make medication access simple for our patients. | **RIGHT MEDICATION. RIGHT TIME. RIGHT PLACE.**



# SOCIAL DRIVERS OF HEALTH

*Addressing underlying needs. Improving outcomes. Together.*



## ACUTE CARE IDENTIFIES



### Food insecurity

Limited or uncertain access to enough nutritious food.



### Housing instability

Challenges with safe, stable housing.



### Transportation

Difficulty getting to appointments or pharmacy.



### Financial concerns

Cost of care, medications, and basic needs.

## MANAGED CARE PROVIDES



### Community programs

Connections to local resources that meet member needs.



### Care coordinators

Ongoing support and follow-up to navigate services.



### Transportation benefits

Access to rides for medical visits and pharmacy.



### Meal delivery

Nutritious meals delivered to the home.



### Utility assistance

Help with utilities to promote health and stability.



### Housing resources

Referrals and support for housing stability and security.

## JOINT PLANNING PREVENTS READMISSIONS



### SHARE INFORMATION

Share SDOH findings and resources early in the stay.



### CREATE A PLAN

Develop a personalized plan that addresses social needs.



### LINK & CONNECT

Connect members to the right resources before discharge.



### FOLLOW UP

Ensure continuity of support after discharge.



### IMPROVE OUTCOMES

Better adherence, fewer complications, fewer readmissions, lower costs.



**TOGETHER,  
WE CAN ADDRESS  
THE WHOLE PERSON.**



### Better patient experience

Members feel heard, supported, and cared for.



### Improved health outcomes

Stable social needs support recovery and well-being.



### Fewer readmissions

Addressing root causes reduces re-hospitalizations.



### Lower costs

Prevent avoidable utilization and improve value.



### Stronger partnership

Collaboration drives better results for our members.



We don't just treat conditions. **We improve lives.** | TOGETHER, WE BUILD HEALTHIER COMMUNITIES.



# CAREGIVER SUPPORT

## *Often forgotten.*

Family caregivers are essential partners in care and recovery.



When we support caregivers, we support better outcomes.



**PARTNERS  
IN CARE.  
BETTER  
TOGETHER.**



## COLLABORATE ON



### CAREGIVER READINESS

- Assess caregiver capacity, confidence, and needs
- Identify potential challenges before discharge
- Build a plan for a safe transition home



### EDUCATION

- Provide clear teaching and written materials
- Review medications, warning signs, and follow-up care
- Reinforce skills and answer questions



### RESPIRE SERVICES

- Connect with respite options
- Reduce caregiver stress and burnout
- Support rest and recharge



### HOME SUPPORTS

- Link to home health and personal care
- Ensure access to equipment and supplies
- Coordinate services for a smooth transition



### COMMUNITY ORGANIZATIONS

- Connect to local programs and resources
- Address social needs and practical supports
- Strengthen the caregiver support network



### SUPPORTING CAREGIVERS STRENGTHENS CARE.

When caregivers thrive, patients thrive.



#### Better caregiver confidence

Leads to safer, more effective care.



#### Fewer complications and readmissions

Supported caregivers improve outcomes.



#### Improved patient experience

Care that is coordinated, compassionate, and person-centered.



#### Lower costs

Preventable issues decrease when caregivers have the right support.



WE SEE THE PATIENT. WE SUPPORT THE CAREGIVER. WE IMPROVE OUTCOMES—TOGETHER.



# READMISSION REVIEW

*Better together. Better insights. Better outcomes.*



## INSTEAD OF ONLY REVIEWING READMISSIONS INTERNALLY...

We bring together perspectives, data, and expertise across the continuum of care.



## JOINTLY REVIEW TO FIND ROOT CAUSES

Shared data. Honest conversations. Stronger solutions.



When we learn together, we improve together.

## JOINTLY REVIEW



### AVOIDABLE READMISSIONS

Identify readmissions that could have been prevented with earlier intervention or better transitions.



### DELAYED AUTHORIZATIONS

Examine delays in approvals that postponed care, services, or discharge.



### MISSED FOLLOW-UP

Identify gaps in scheduling, communication, and appointment completion.



### MEDICATION BARRIERS

Review cost, access, understanding, and adherence challenges.



### SDOH BARRIERS

Address factors like housing, food, transportation, and financial insecurity.



### COMMUNICATION FAILURES

Uncover breakdowns in handoffs, discharge instructions, and follow-through.



## THEN JOINTLY REDESIGN PROCESSES.

Co-create solutions that reduce readmissions and improve the patient journey.



### Streamline workflows

Eliminate delays and duplication.



### Strengthen partnerships

Build trust and shared accountability.



### Implement solutions

Standardize best practices.



### Measure results

Track outcomes and impact.



### Continuously improve

Adapt, learn, and evolve together.



ONE GOAL.

ONE TEAM.

BETTER TRANSITIONS.

FEWER READMISSIONS.

BETTER OUTCOMES.

Together, we make every transition count.





# SHARED QUALITY IMPROVEMENT

*Better together. Measurable impact. Stronger patients.*

Hospitals and health plans often measure different things.  
Instead, create a shared scorecard.



## WHY A SHARED SCORECARD?



**Aligned goals.**  
Focus on what matters most to patients.



**Better collaboration.**  
Shared data drives shared solutions.



**Stronger outcomes.**  
Improve quality, reduce costs, and enhance experience.



**Accountability for all.**  
Joint ownership leads to sustainable change.



**Better for patients.**  
Smoother transitions.  
Better care. Better lives.

## SHARED SCORECARD

| SHARED METRIC                                                                                              | HOSPITAL | HEALTH PLAN |
|------------------------------------------------------------------------------------------------------------|----------|-------------|
|  Readmissions             | ✓        | ✓           |
|  ED Revisits              | ✓        | ✓           |
|  Medication Access        | ✓        | ✓           |
|  PCP Follow-up            | ✓        | ✓           |
|  Home Health Start        | ✓        | ✓           |
|  DME Delivery             | ✓        | ✓           |
|  Patient Experience       | ✓        | ✓           |
|  Avoidable Days           | ✓        | ✓           |
|  Authorization Turnaround | ✓        | ✓           |



**TOGETHER,  
WE CAN:**



**Focus on what matters.**  
Prioritize outcomes that improve lives.



**Collaborate with purpose.**  
Share insights. Solve problems.



**Drive continuous improvement.**  
Test, learn, and implement together.



**Achieve measurable results.**  
Better quality. Lower costs.



**Deliver a better experience.**  
For patients, families, and communities.



**ONE PARTNERSHIP. ONE SCORECARD. BETTER CARE. BETTER OUTCOMES.**



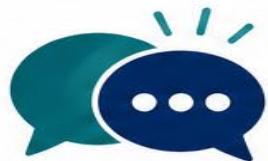
*Better together.*



# COMMON BARRIERS TO COLLABORATION



*Understanding the challenges  
so we can build better solutions together.*



# COMMUNICATION GAPS

*When communication breaks down, care and outcomes are at risk.*



## 1. NO SINGLE "FRONT DOOR"



No single "front door" to reach the right counterpart on the other side.



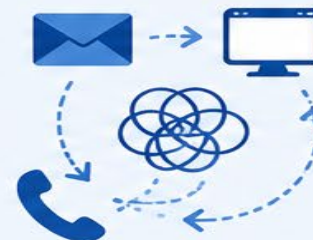
## 2. INFORMATION ARRIVES INCOMPLETE



- ✗ No payer CM contact
- ✗ Missing discharge plan
- ✗ Critical details left out



## 3. MULTIPLE CHANNELS = LOST IN TRANSLATION



Multiple channels (fax/portal/phone) = information gets fragmented, delayed, or lost.



Clear, consistent communication is the bridge between settings.

### WHAT WE NEED:

- ✓ Direct contacts
- ✓ Shared platforms
- ✓ Standardized handoffs



# MISALIGNED WORKFLOWS

*Good intentions. Disconnected steps. Delayed outcomes.*

1

## MEDICAL READINESS → AUTHORIZATION DELAYS



Patient  
medically ready



Authorization  
requested



Delayed  
authorization

### THE GAP:



Slow turnaround, incomplete information, or back-and-forth communication delays discharge and increases avoidable days.

2

## SERVICE ARRANGED → BENEFIT/NETWORK MISMATCH



Service  
arranged



Benefit or  
network issue  
identified



New search  
& rework  
required

### THE GAP:



Out-of-network, benefit limits, or prior auth requirements identified late cause rework and frustration for patients and teams.

3

## PCP/SPECIALIST FOLLOW-UP SCHEDULED → TRANSPORTATION ISSUES



Follow-up  
scheduled



Transportation  
needed



Ride fails  
or never  
arrives

### THE GAP:



Transportation barriers lead to missed appointments, poor outcomes, and higher risk of readmission.

## THE IMPACT



Longer LOS



Higher costs



Poor patient  
experience



Increased  
readmissions



Strain on  
staff and  
resources



ALIGNING WORKFLOWS. CLOSING GAPS. IMPROVING OUTCOMES.



Shared processes



Early collaboration



Clear communication



# REGULATORY & ORGANIZATIONAL CHALLENGES

*Complex rules. Different systems. Shared patients.*

1



## HIPAA CONFUSION BLOCKS HELPFUL DISCLOSURES

Uncertainty about what can be shared, with whom, and when leads to over-caution and delayed communication.



### RESULTS:

Delays in care coordination and preventable information gaps.

2



## CONTRACT RULES, PRIOR AUTH CRITERIA, NETWORK RESTRICTIONS

Varying payer policies, network limitations, and clinical criteria create barriers to timely approvals and service access.



### RESULTS:

Delays, denials, and increased rework for patients and teams.

3



## URAC/NCQA REQUIREMENTS

Different accreditation standards drive documentation, reporting, and process requirements that don't always align.



### RESULTS:

Duplicative work and misalignment across organizations.

4



## AUTHORIZATION RULES/ TIMELINES DEPENDENT ON WHERE COMING FROM

Rules, timelines, and requirements vary by referral source, setting, payer, and line of business.



### RESULTS:

Confusion, inconsistent processes, and missed deadlines.

5



## DOCUMENTATION LIVES IN DIFFERENT SYSTEMS

Information is fragmented across EHRs, portals, faxes, and payer systems with limited interoperability.



### RESULTS:

Information gaps, duplicate data entry, and errors in handoffs.

## THE IMPACT



Delays in care



Increased denials



Higher costs



Poorer patient experience



Strain on staff and resources



Challenges meeting quality and compliance



## WHAT HELPS



Clear communication guidelines



Aligned policies and standards



Integrated technology



Consistent processes and timelines



Ongoing education and collaboration



# BEST PRACTICES & STRATEGIES

*Proven approaches. Practical solutions. Better outcomes—together.*



## COMMUNICATE CLEARLY

Share the right information  
at the right time through  
the right channels.



## ALIGN PROCESSES

Standardize workflows  
to reduce variability  
and delays.



## BUILD STRONG RELATIONSHIPS

Foster trust, collaboration,  
and mutual understanding  
across teams.



## USE DATA STRATEGICALLY

Leverage insights to  
drive decisions and  
improve outcomes.



## FOCUS ON COMPLIANCE

Understand regulations  
and requirements to  
ensure quality and safety.



## CONTINUOUSLY IMPROVE

Evaluate, learn, and  
adapt to meet evolving  
needs.



Great outcomes happen when we work better—together.





# STANDARDIZED HANDOFF PROTOCOLS

Right information. Right time. Right partner. Right outcome.



**SEND BEFORE  
DISCHARGE**  
Target Time  
by 11:00 AM

## USE SBAR+

**S**

### SITUATION

What is happening now?  
Why is the patient  
discharging?



**B**

### BACKGROUND

Relevant history, hospital  
course, key events.



**A**

### ASSESSMENT

Current status, risks,  
barriers, SDOH factors.



**R+**

### RESOURCES / BENEFITS

What's arranged, what's needed,  
and available resources/benefits.



## INCLUDE THESE KEY ELEMENTS



Payer Case Manager name / phone / email



LOA / Prior Authorization status and number



Network needs (facility/providers in network)



DME specifics (items, delivery, vendor, ETA)



Medication access issues  
(new meds, cost, prior auth, delivery)



Follow-up appointments  
(date/time, provider, location)



Caregiver readiness & teach-back  
(who, education provided, confidence level)



Additional notes / special considerations  
(SDOH, transportation, interpreter, etc.)



## HANDOFF TIMELINE



Complete  
Handoff



Send to Payer CM  
& Care Team



Confirm  
Receipt



Patient Discharged  
with Plan in Place



**BEST PRACTICE:** Send by target time to allow payer  
and care teams time to act and resolve any issues  
before the patient leaves.

## HOW TO SEND



Secure  
Messaging  
(Preferred)



Payer  
Portal  
(Case Notes)



Fax  
(If required)



Phone  
(Follow-up  
confirmation)



**CLEAR HANDOFFS  
LEAD TO:**



Safer transitions  
of care



Fewer delays  
and denials



Better patient  
experience



Lower readmissions  
and costs



Stronger partnerships  
across the continuum



**PRO TIP:**

Standardize the template.  
Train the team.



Use the same fields.  
Every time.



Confirm receipt and  
close the loop.



Measure and improve  
handoff quality.



# SHARED CARE PLANNING & DOCUMENTATION

— One plan. One view. Better coordination. Better outcomes. —

## 1 ONE SHARED PLAN

Goals, risks, actions, owners, dates



### Goals

What we are working toward



### Risks

What could get in the way



### Actions

What we will do



### Owners

Who is responsible



### Dates

By when / next review

## 2 WHERE IT LIVES

EHR care plan + payer portal notes (mirror content)

### EHR CARE PLAN



### PAYER PORTAL NOTES



Mirror content. Same plan. Same team. Always up to date.

## 3 INTEROP LITE

ADT alerts, secure messaging, shared task list



### ADT ALERTS

Timely notifications of admissions, discharges, and transfers



### SECURE MESSAGING

Direct, encrypted communication between care teams



### SHARED TASK LIST

Track tasks, due dates, and ownership in real time

## THE RESULT



Everyone works from the same plan



Fewer gaps and duplication



Faster decisions and follow-through



Better experience for patients



Better outcomes at lower cost



## ENABLING CONNECTED CARE



### FHIR-ENABLED COMMUNICATION

Standardized data exchange across systems and settings



### INTEROPERABILITY

Seamless data flow across EHRs, payer platforms, and partners



### SHARED DASHBOARDS

Real-time view of metrics, tasks, and member status



### SECURE MESSAGING

HIPAA-compliant communication that accelerates action



### AI-GENERATED SUMMARIES

Condensed insights that save time and improve clarity



Better together.  
Stronger outcomes.



Improved  
Care Coordination



Reduced Readmissions  
& ED Visits



Higher Quality  
(HEDIS & Star Ratings)



Lower Total Cost  
of Care



# WARM HANDOVERS

— A warm handoff today. A smoother recovery tomorrow. —



## THE GOAL

Seamless transitions.  
Stronger connections. Better outcomes.



### 1 WARM CALL: CONNECT & CONFER

Acute CM ↔ Plan CM  
with patient/caregiver present



ACUTE CM



PLAN CM



PATIENT/  
CAREGIVER

- ✓ Real-time information exchange
- ✓ Builds rapport and trust
- ✓ Aligns on plan, roles, and next steps
- ✓ Patient/caregiver voice is included



**TIP:** Schedule the warm call before discharge and document in the care plan.

### 2 48-72H FOLLOW-UP: STAY CONNECTED

Proactive follow-up within 48-72 hours to close gaps and prevent readmissions.



Reconcile medications



Confirm access & transportation



Identify & address red flags early



Reinforce plan & answer questions



Escalate needs & connect resources



Early touch. Early fixes.  
Better outcomes.

### 3 VIRTUAL INTRODUCTIONS

Introduce key team members to the patient and caregiver before discharge.



- ✓ Meet the plan CM
- ✓ Meet the PCP
- ✓ Meet the pharmacist
- ✓ Meet the community support team



Faces to names. Familiarity.  
Confidence in the plan.

### • EXTEND THE CONNECTION •



#### TELEHEALTH FOLLOW-UP

Virtual visits for timely check-ins, education, and support.



#### TEXT REMINDERS

Appointment reminders, medication prompts, and care tips.



#### AUTOMATED OUTREACH

Automated calls/texts to check in, share resources, and flag concerns.



#### COMMUNITY HEALTH WORKER INVOLVEMENT

Bridging gaps, addressing social needs, and providing ongoing support.



**STRONGER HANDOVERS.  
BETTER OUTCOMES.**



Fewer readmissions



Improved patient experience



Better adherence & outcomes



Stronger relationships across teams



Lower total cost of care



# MANAGED CARE INTERACTION IN ACUTE CARE SETTING

— Stronger partnerships. Seamless communication. Better outcomes. —



## WEEKLY VIRTUAL MEETINGS

Consistent, structured touchpoints keep everyone aligned and proactive.



- ✓ Review census & high-risk patients
- ✓ Discuss barriers, auths & discharges
- ✓ Share updates on policies, criteria & resources
- ✓ Align on priorities and next steps



### GOAL:

Identify issues early, reduce delays, and improve care transitions.



## BRIDGE NURSE OR NAVIGATOR

Dedicated liaison who bridges the hospital and the health plan.



### GOAL:

Improve communication, reduce rework, and enhance patient experience.



## CO-LOCATED OR EMBEDDED CM

Case managers embedded in the hospital team for real-time collaboration.

- Real-time access to plan resources and decision-makers
- Quicker problem solving and auth turnaround
- Stronger alignment on care plans and discharge needs
- Builds trust and shared accountability



### GOAL:

Streamline workflows, shorten length of stay, and improve outcomes.

## OUR PARTNERSHIP IN ACTION



**SHARED VISIBILITY**  
Real-time information and transparency.



**PROACTIVE SOLUTIONS**  
Address barriers before they impact discharge.



**BETTER ALIGNMENT**  
Unified goals, criteria, and expectations.



**FASTER TRANSITIONS**  
Timely authorizations and smooth handoffs.



**BETTER OUTCOMES**  
Healthier patients. Lower costs.



**WORKING TOGETHER  
AT THE BEDSIDE  
AND BEYOND.**



One team.  
One plan.



One patient  
at a time.



Better today.  
Stronger tomorrow.



# BEST PRACTICE: WEEKLY VIRTUAL MEETINGS

Working together. Aligning care. Delivering value.



STRONGER  
PARTNERSHIPS  
BETTER OUTCOMES

## 1 PURPOSE



Improve outcomes, streamline discharges, reduce costs



Align care quality with value-based models



Foster collaboration and drive continuous improvement

## 2 KEY PARTICIPANTS



### HOSPITAL

- Case managers
- Discharge planners
- Social workers
- Administrators



### MCO

- Case managers
- Medical directors
- Utilization reviewers



### OTHERS (AS NEEDED)

- PCPs
- Specialists
- Home health staff

## 3 AGENDA HIGHLIGHTS



### CASE REVIEWS

- High-utilization/complex patients
- Discharge readiness
- Transition of care
- Post-acute utilization
- Coverage/benefits updates



### SYSTEM DISCUSSIONS

- Metrics (LOS, readmissions, satisfaction)
- Resource coordination (SDOH)
- Process improvement
- Documentation quality



**FREQUENCY: WEEKLY**  
60 minutes • Virtual

## 4 BENEFITS



Better patient outcomes & smoother transitions



Cost reduction via efficient utilization



Stronger hospital-MCO communication



Improved operational efficiency



**TOGETHER,  
WE ACHIEVE:**



Seamless  
care transitions



Higher quality  
of care



Better experience  
for patients



Healthier  
populations



Sustainable  
cost savings



**SUCCESS STARTS WITH CONNECTION.** A weekly commitment today leads to better outcomes tomorrow.





**BEST PRACTICE:**

# BRIDGE NURSE OR NAVIGATOR

*Bridging the gap. Connecting people to better health.*



ONE POINT OF CONTACT.  
CONTINUITY OF CARE.  
BETTER OUTCOMES.

## WHO THEY ARE

Bridge Nurses or Navigators are dedicated care partners who ensure seamless transitions from the hospital to home and beyond.



## IMPACT



Bridge Nurses/Navigators close care gaps, reduce readmissions, improve patient experience, and lower costs.

## KEY ROLES & RESPONSIBILITIES



### POST-ACUTE CARE COORDINATION

Ensuring the patient understands and can follow through with discharge instructions, including medication, follow-up appointments, and other therapies.



### PATIENT AND FAMILY EDUCATION

Acting as an advocate and educator to help patients and caregivers understand the diagnosis, treatment plan, and self-care requirements.



### COMMUNICATION LIAISON

Serving as the central point of contact for the patient, their family, and the various healthcare providers involved in their care.



### RESOURCE CONNECTION

Helping patients access necessary community resources, such as social services, transportation, and long-term care options.



### PROBLEM-SOLVING

Addressing barriers to care, which can range from lack of financial resources to social isolation.



### MANAGED CARE PLAN ALIGNMENT

Communicating with the patient's managed care plan to ensure alignment on the care plan, manage costs, and coordinate transitions.

## SPECIALTY CARE EXPERTISE



### ONCOLOGY

Supporting patients through complex treatment journeys.



### HIV

Ensuring continuity of care, medication adherence, and support services.



### NICU

Partnering with families for education, resources, and smooth transitions home.



### HIGH RISK POPULATIONS

Focused support for patients with complex medical, social, or behavioral needs.

## KEY OUTCOMES



Fewer readmissions and ED visits



Improved patient experience and satisfaction



Lower total cost of care



Better adherence to treatment and follow-up



Stronger care coordination and communication





## BEST PRACTICE:

# CO-LOCATED/EMBEDDED MANAGED CARE CM

*Integrated. Onsite. Aligned.*



WORKING TOGETHER  
AT THE BEDSIDE  
FOR BETTER OUTCOMES

### WHAT IS IT?

A managed care case manager is physically present in the hospital, working side-by-side with the care team to support patients, improve transitions, and align care across the continuum.



#### THE GOAL

Seamless care coordination, better patient experience, and lower total cost of care.

### PERSONAL EXPERIENCE: A PROVEN MODEL IN ACTION



#### 2006–2012

BCBSIL embeds in several large Chicago hospitals.



#### 2022–CURRENT

CountyCare, Aetna liaisons rounding at Chicago hospitals to educate patients and assist in care coordination.



#### 2025

Meridian Health Plan embeds CM RN at UI Health.



#### 2026

BCBSIL Community embedded 2–3 days/week at UI Health.



#### 2026

CountyCare to start with care coordinator visiting members in hospital identified through weekly meetings.

### VALUE TO PATIENTS, PROVIDERS & PLANS



#### Better Patient Experience

Personal support, education, and resources at the bedside.



#### Improved Care Coordination

Real-time collaboration with hospital teams and faster issue resolution.



#### Reduced Readmissions & ED Visits

Stronger follow-up and smoother transitions of care.



#### Lower Total Cost of Care

Appropriate utilization, fewer denials, and avoidance of unnecessary services.



#### Stronger Plan Alignment

Shared goals, better communication, and data-informed decision-making.

### WHY CO-LOCATION WORKS



Builds relationships and trust



Speeds up decision-making



Improves clarity and reduces barriers



Aligns clinical and plan priorities



Puts the right support at the right time



**CO-LOCATION IS MORE THAN PRESENCE—IT'S PARTNERSHIP.** Together, we deliver better care, better outcomes, and a better experience.





# BEST PRACTICE: GOVERNANCE & AGREEMENTS

Clear processes. Shared accountability. Better outcomes.

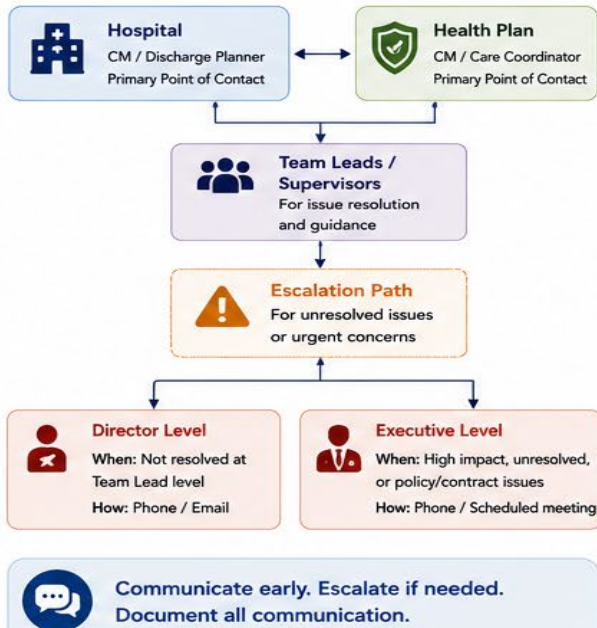


STRONG PARTNERSHIPS.  
CLEAR EXPECTATIONS.  
BETTER PATIENT CARE.



## 1. CONTACT TREE & ESCALATION PATH (WHO, WHEN, HOW)

### CONTACT TREE (EXAMPLE)



## 2. SERVICE LEVEL AGREEMENTS (SLA)

Clear expectations drive performance.  
We agree on:

| SERVICE                                                                                                                             | STANDARD TURNAROUND TIME | NOTES                                                |
|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------|
|  AUTHORIZATIONS                                    | 24–48 HOURS              | Routine requests during business days                |
|  DURABLE MEDICAL EQUIPMENT (DME)                   | 24–48 HOURS              | From order receipt to approval/delivery coordination |
|  TRANSPORTATION                                    | 24 HOURS                 | Routine transportation arrangements                  |
|  SUB-ACUTE REFERRAL (SAR) FOR DIFFICULT PLACEMENTS | 48–72 HOURS              | Includes outreach, updates and options               |
|  STATUS UPDATES                                    | WITHIN 24 HOURS          | Return calls/messages and status updates             |



### SLA PRINCIPLES

- ✓ Measurable
- ✓ Time-bound
- ✓ Achievable
- ✓ Reviewed and updated regularly



## 3. REGULAR COLLABORATION

Stay aligned. Solve issues. Improve together.



### MONTHLY JOINT HUDDLES

- Review key metrics & trends
- Address barriers and opportunities
- Share updates & resources
- Reinforce process improvements



Frequency: Monthly  
Format: Virtual (30–60 minutes)  
Participants: Hospital & Health Plan teams



### QUARTERLY CASE CONFERENCES

- Deep-dive complex cases
- Evaluate outcomes & learnings
- Align on strategies & initiatives
- Drive system-level improvements



Frequency: Quarterly  
Format: Virtual or In-Person (60–90 minutes)  
Participants: Hospital, Health Plan, and key partners



### SHARED COMMITMENT

We are accountable to each other  
and to the patients we serve.



Stronger relationships  
and trust



Faster resolution  
of issues



Better outcomes  
and experience



Improved efficiency  
and cost savings





# BEST PRACTICE: MEASUREMENT & FEEDBACK

Measure what matters. Share what works. Improve together.



DATA-INFORMED.  
TRANSPARENT.  
BETTER OUTCOMES.

## 1. STARTER BUNDLE: KEY METRICS

Core outcomes to track together and drive results.



### AUTHORIZATION TURNAROUND TIME

Average time from request to decision

TARGET

≤ 24-48 hrs



### AVOIDABLE DAYS

Total avoidable inpatient days

TARGET

Reduce  
month over month



### 7/30-DAY RETURNS

All-cause returns within  
7 and 30 days of discharge

TARGET

7-Day: ≤ 8%  
30-Day: ≤ 15%



### APPOINTMENTS KEPT

% of post-discharge appointments  
kept (7 and 30 days)

TARGET

≥ 85%



### TIME-TO-DME IN HOME

Average time from order to DME  
in the patient's home

TARGET

≤ 3 Days

## 2. RAPID-CYCLE QI: PLAN-DO-STUDY-ACT

Test changes quickly. Learn fast. Sustain what works.



### PLAN

Identify the  
problem and  
set aim.

### DO



Implement  
change on  
a small scale.



### ACT

Adopt, adapt,  
or abandon.  
Spread success.

### STUDY

Analyze data.  
What worked?  
What didn't?

### EXAMPLES OF QI FOCUS AREAS

- ✓ Reduce authorization turnaround time
- ✓ Decrease avoidable days
- ✓ Improve post-discharge follow-up
- ✓ Speed DME delivery
- ✓ Lower 7/30-day returns

## 3. SHARED & PUBLIC DASHBOARDS

Real-time visibility drives accountability and action.

### PARTNER PERFORMANCE DASHBOARD

Last Updated: 5/12/2025

#### AUTH TURNAROUND

(hrs)

26

▼ 12%

#### AVOIDABLE DAYS

per 1,000 Discharges

8.7

▼ 15%

#### 7-DAY RETURNS

(%)

6.1%

▼ 18%

#### 30-DAY RETURNS

(%)

12.3%

▼ 10%

#### APPTS KEPT

(7/30 Days)

88%

▲ 6%

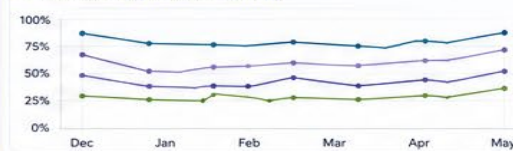
#### TIME-TO-DME

IN HOME (Days)

2.6

▼ 20%

### PERFORMANCE OVER TIME (TREND)



### COMPARE & FILTER

Facility: All  
Payer: All  
Service Line: All  
Time Period: Last 6 Months



Real-time  
visibility



Peer  
comparison



Actionable  
insights



Transparent  
reporting

## 4. FEEDBACK LOOP: CLOSE THE GAP



### DATA REVIEW

Identify trends  
and gaps



### ROOT CAUSE ANALYSIS

Understand  
why issues occur



### ACTION PLANNING

Prioritize and assign  
owners



### IMPLEMENT & MONITOR

Track progress with  
real-time data



### SHARE & CELEBRATE

Share wins and  
standardize success



### SUSTAIN & IMPROVE

Continuous improvement  
is our culture



### OUR COMMITMENT

Together, we use data, collaborate relentlessly,  
and deliver better outcomes for every patient.



Better patient  
outcomes



Lower costs



Stronger  
partnerships



Healthier  
communities





# The Authorization Loop

*Better coordination. Fewer delays. Safer transitions.*



## SCENARIO



Patient ready for discharge with new oxygen/DME.



Auth not started; vendor out-of-network.



Discharge delayed.



## WHAT WE CHANGED



**Standard handoff sent at EDD-1**

With DME details & preferred in-network vendors.



**Plan CM joins discharge huddle virtually**

Vendor confirmed same day.



## LESSONS



**Advance notice + vendor directory = fewer delays**

Early coordination prevents avoidable barriers.



**Escalation tree prevents last-minute stalls**

Clear path to resolve issues before discharge.

## THE AUTHORIZATION LOOP

*Proactive steps break the cycle.*



**EDD IDENTIFIED**  
Discharge plan developed



**HANDOFF SENT AT EDD-1**  
DME details & preferred vendors included



**PLAN CM JOINS HUDDLE**  
Virtually reviews needs and barriers



**VENDOR CONFIRMED**  
In-network & available same day



**DISCHARGE ON TIME**  
Equipment in place; patient home safely



## ESCALATION TREE



**1. Case Manager**  
Resolve with vendor/plan



**2. Supervisor**  
If unresolved



**3. UM Leadership**  
Expedite decision



**4. Executive Escalation**  
Last resort



**Communication early. Partners together. Patients home.**





# High Risk COPD Readmission



## SCENARIO



Frequent ED use



Missed pulmonology follow-ups



Medication affordability issues



## WHAT WE CHANGED



### Warm handoff at bedside

Acute & Plan CM meet with patient before discharge



### 48-hour virtual visit

Follow-up to assess symptoms, review meds, answer questions



### \$0 copay inhaler option identified

Medication access ensured before discharge



### Transport scheduled for specialist visit

Reliable transportation arranged to pulmonology



## LESSONS



### Medication access + transportation are often the real problems

Addressing SDOH and cost barriers drives better outcomes.



### Co-managed follow-up reduces bounce-backs

Timely outreach and coordinated care keep patients stable at home.

## THE PATH TO FEWER READMISSIONS



Warm handoff at bedside



48-hour virtual visit



Med access secured



Transport to specialist



Stronger recovery. Fewer readmissions.



Coordinated care. Addressing real barriers. Better outcomes for our COPD patients.





# Sickle Cell Super User Collaboration

One Team. One Plan. Better Outcomes.



## SCENARIO



27-year-old patient with sickle cell disease presents to the ED with vaso-occlusive pain crisis.



9 ED visits and 4 hospital admissions in the past 12 months.



Missed hematology follow-ups due to transportation challenges, authorization delays, and difficulty coordinating appointments.



Acute Care CM activates Sickle Cell Super User process and convenes an interdisciplinary huddle with all key partners (including the patient).



Team creates a coordinated transition plan before discharge addressing medical, social, and behavioral needs.



## WHAT WE CHANGED

### ACUTE CARE TEAM



Identified patient early through Super User criteria.



Convened interdisciplinary discharge planning.



Completed comprehensive assessment of barriers.



Scheduled hematology follow-up prior to discharge.



Initiated bedside medication delivery.



Provided individualized sickle cell education and crisis action plan.



Engaged while patient was still hospitalized.



Confirmed medication coverage and prior authorizations.



Coordinated transportation for appointments.



Arranged post-discharge case management outreach within 48 hours.



Connected patient with community resources and financial assistance.



Established ongoing care management to reduce avoidable utilization.



## LESSONS



Early collaboration improves continuity across the care continuum.



Identifying high-utilization patients early enables proactive intervention—not reactive crisis management.



Addressing social drivers of health alongside clinical needs reduces barriers to successful transitions.



Warm handoffs between inpatient and health plan case managers improve patient engagement after discharge.



Shared accountability leads to better outcomes: improved experience, fewer ED visits, reduced readmissions, and stronger partnerships.



A standardized Super User workflow creates consistency while allowing individualized, patient-centered care planning.

## SICKLE CELL SUPER USER WORKFLOW



1. Identify High Utilization (Super User Criteria)



2. Interdisciplinary Huddle (Including Patient)



3. Assess Barriers (Clinical, Social, Behavioral, Access)



4. Develop Coordinated Transition Plan



5. Confirm Access (Medications, Auths, Resources, Transport)



6. Follow-Up Within 48 Hours Post-Discharge



7. Ongoing Care Management & Monitoring



Coordinated care. Addressing barriers. Empowering patients. Reducing avoidable utilization.



Better outcomes. Stronger together.



# Medication Access Through Acute Care–Managed Care Collaboration

*Right medication. Right time. Right team.*



## SCENARIO



45-year-old patient with severe rheumatoid arthritis admitted for disease flare limiting mobility and daily activities.



Recently transitioned to a new Medicaid MCO after previous health plan exited the market.



Stable for 5+ years on a high-cost biologic after multiple failed trials of formulary-preferred therapies.



Medication not on new plan's formulary. Without intervention, patient will be discharged without access—high risk for decline, hospitalization, and complications.



Acute Care CM partners with Managed Care CM, specialty pharmacy, rheumatology, pharmacist, and UM team to develop a plan before discharge.



## WHAT WE CHANGED

### ACUTE CARE TEAM



Identified the formulary issue during admission medication reconciliation.



Alerted the Managed Care Case Manager immediately.



Collaborated with the prescribing specialist to compile documentation of prior medication failures and clinical response.



Coordinated specialty pharmacy involvement before discharge.



Delayed discharge only until a safe medication access plan was confirmed.



Educated the patient regarding temporary medication access and follow-up expectations.



### MANAGED CARE TEAM



Assigned an expedited case manager to oversee the transition.



Coordinated an urgent formulary exception and prior authorization review.



Worked with the health plan pharmacy department and medical director to review documented step-therapy failures.



Approved continuation of the non-formulary medication based on medical necessity and continuity of care.



Coordinated specialty pharmacy dispensing and home delivery immediately following discharge.

Established ongoing pharmacy case management to prevent future treatment interruptions.



## LESSONS



Insurance transitions can unintentionally disrupt access to medically necessary therapies, especially for specialty medications.



Early identification of formulary barriers during hospitalization prevents avoidable treatment interruptions after discharge.



Collaboration among acute care CM, managed care, pharmacy, specialty providers, and UM accelerates medication access.



Comprehensive documentation of prior treatment failures and clinical success supports timely medical necessity determinations.



Continuity of medication therapy improves outcomes, reduces exacerbations, ED visits, readmissions, and builds patient confidence during insurance transitions.



A standardized collaborative workflow transforms reactive appeals into proactive, patient-centered care coordination.

## MEDICATION ACCESS COLLABORATIVE WORKFLOW



1 Formulary issue identified during medication reconciliation



2 Alert Managed Care CM immediately



3 Gather documentation of prior failures & clinical response



4 Engage specialty pharmacy early



5 Expedited PA & formulary exception review



6 Approval for continuation of non-formulary medication



7 Dispense & deliver medication at discharge



8 Ongoing pharmacy case management for continuity



9 Patient stays on therapy. Better outcomes. Fewer avoidable visits.



Working together to remove barriers and ensure continuous access to the right medication.



Better access.  
Better outcomes. Better together.



# Power Mobility Through Acute Care–Managed Care Collaboration

*Right equipment. Right time. Right team. Empowering independence.*



## SCENARIO



22-year-old medical student with Ehlers-Danlos syndrome (EDS) admitted for worsening pain, recurrent joint instability, and declining mobility.



Previously denied a power wheelchair due to inadequate documentation of medical necessity.



Since the denial, condition has deteriorated—fatigue, frequent falls, severe pain after short distances. Difficulties walking across campus, attending clinical activities, and meeting academic requirements.



Acute Care CM partners with Managed Care CM, PT, OT, PM&R, treating physician, and DME provider to reassess needs and build a strong medical necessity case.



## WHAT WE CHANGED

### ACUTE CARE TEAM



Completed a comprehensive functional assessment documenting worsening endurance, pain, mobility limitations, and fall risk.



Coordinated PT and OT wheelchair evaluations, including objective mobility testing.



Obtained PM&R consultation to support long-term mobility recommendations.



Documented impact on ADLs, community participation, and medical school requirements.



Coordinated with DME vendor to ensure all documentation met payer requirements.



### MANAGED CARE TEAM

Reviewed previous denial and identified documentation gaps.



Assigned a complex case manager to facilitate expedited review.



Collaborated with medical director and DME utilization review team.



Considered updated functional assessments showing significant clinical decline.



Approved power wheelchair based on current medical necessity and functional impairment.



Coordinated timely authorization, equipment delivery, fitting, and follow-up services.



## LESSONS



A previous denial should not prevent reconsideration when a patient's medical condition has significantly changed.



Functional decline, pain, endurance limitations, and participation restrictions are critical components of medical necessity—not simply diagnosis alone.



Early collaboration between acute care, managed care, rehab specialists, PM&R, and DME providers strengthens clinical documentation and streamlines authorization.



Comprehensive functional assessments provide objective evidence that supports payer decision-making.



Appropriate mobility equipment promotes independence, safety, educational participation, and long-term health while reducing the risk of falls, injury, and avoidable utilization.



Coordinated advocacy across the continuum removes barriers and helps individuals achieve their personal, educational, and professional goals.

## POWER MOBILITY COLLABORATIVE WORKFLOW



1 Patient admitted with functional decline



2 Interdisciplinary team huddle initiated



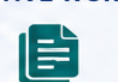
3 Comprehensive functional assessment



4 PT/OT wheelchair evaluation & testing



5 PM&R consult & recommendations



6 Documentation package completed (ADLs, school needs, clinical decline)



7 MC reviews prior denial & identifies gaps



8 Updated review & approval



9 Authorization, delivery, fitting & education



10 Improved mobility, safety & academic success



Working together to open doors to independence, education, and a brighter future.



Better access.  
Better outcomes. Better together.



# Moving Toward Value-Based Integration

*Stronger Together. Better Outcomes. Greater Value.*

## ACUTE CARE

Expertise.  
Coordination.  
Transitions.



## MANAGED CARE

Access.  
Support.  
Continuity.



### PATIENT CENTERED

Whole person.  
Whole journey.



### PROACTIVE CARE

Identify needs early.  
Prevent avoidable harm.



### BETTER OUTCOMES

Improved quality,  
fewer readmissions.



### SMARTER SPEND

Reduce waste.  
Maximize value.



### SHARED ACCOUNTABILITY

Aligned goals.  
Shared success.



### STRONGER TOGETHER

Integrated teams.  
Sustainable solutions.

**>> Integrating acute care and managed care today to build a healthier, more equitable tomorrow.**



# Integrated Health System



*Two Models. One Mission. Better Outcomes.*

| FEATURE                                                                                                             |  KAISER PERMANENTE |  UPMC                                           |
|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
|  <b>PAYER/PROVIDER RELATIONSHIP</b> | Fully integrated. The health plan and providers are part of the same organization.                  | Provider-led plan operates within a multi-payer market; has internal insurance division but also works with other insurers.        |
|  <b>CASE MANAGER ROLE</b>           | Standard part of the integrated care team, with incentives fully aligned.                           | A strategic position used to improve outcomes for specific populations, often its own health plan's members.                       |
|  <b>PATIENT DATA ACCESS</b>         | Complete access to a single, unified EHR system across all services and care settings.              | Access to internal UPMC patient data, but may need to navigate external systems for non-UPMC members.                              |
|  <b>COORDINATION</b>                | Seamless, built-in coordination across all of Kaiser's services and facilities.                     | Requires intentional collaboration between the embedded case manager and the clinical team.                                        |
|  <b>INCENTIVE ALIGNMENT</b>        | Financial incentives are fully aligned around population health and preventive care.                | Incentives for embedded CMs are aligned for targeted populations, but the broader system also engages with fee-for-service models. |



Different models. *Same goal.* | Better outcomes for the people we serve.





# JOINT EFFORTS: READMISSIONS & RISK STRATIFICATION

Identify early. Act together. Support always. Prevent readmissions.



RIGHT PATIENT.  
RIGHT CARE.  
RIGHT TIME.  
BETTER OUTCOMES.

## 1. SHARED REGISTRY OF HIGH-RISK MEMBERS ON ADMISSION

Real-time data sharing to identify risk and align care from day one.



### SHARED HIGH-RISK REGISTRY

- Claims & utilization data
- Clinical history & diagnoses
- Social determinants of health
- Recent admissions/ED visits
- Care gaps & adherence

### RISK STRATIFICATION TIERS

#### HIGH RISK (Top 5–10%)



- Multiple chronic conditions
- Recent admission or ED use
- Complex social needs

#### MODERATE RISK (Next 20–30%)



- Chronic conditions with some gaps
- History of utilization

#### LOWER RISK (Remaining Members)



- Stable conditions
- Lower utilization history



### JOINT DATA GOVERNANCE

Secure data sharing • Privacy compliant • Role-based access  
Regular data refresh • Outcome focused

## 2. TRIGGERED WORKFLOWS FROM FLAG TO FOLLOW-UP

Consistent actions at key moments to engage, educate, and connect.



### FLAG

High-risk member identified on admission  
Automated alert to care team & plan CM



### BEDSIDE EDUCATION

Nurse/CM provides personalized education on condition, medications, follow-up, and red flags using teach-back



### PLAN CM FOLLOW-UP

Plan CM contacts member (in-person or phone) prior to discharge or within 24–48 hrs  
Post-discharge support & care coordination



### CONTINUOUS SUPPORT

Address barriers, connect resources, reinforce care plan, and monitor progress

### ENABLERS



Role clarity



Timely alerts



Closed-loop communication



Shared accountability

## 3. TRACK BUNDLE: KEY DRIVERS OF SUCCESS

Monitor the essentials that impact readmissions.



### 7-DAY PCP VISIT

% of discharged members with PCP visit within 7 days

TARGET  
≥ 70%

### WHY IT MATTERS

Early follow-up prevents complications.



### MEDICATIONS FILLED

% of new or changed medications filled within 7 days

TARGET  
≥ 85%

### WHY IT MATTERS

Med adherence reduces readmissions.



### CARE-PLAN ADHERENCE

% adherence to care plan (self-care, meds, appts, lifestyle)

TARGET  
≥ 80%

### WHY IT MATTERS

Consistent adherence drives better outcomes.

### EXAMPLES OF HIGH-RISK POPULATIONS



Heart Failure



COPD



CKD



Diabetes



Behavioral Health

## 4. OUTCOMES WE DRIVE TOGETHER



Fewer 30-day readmissions



Higher quality of care



Improved patient experience



Lower total cost of care



Better health plan alignment



Stronger community impact

### MEASURE • ACT • IMPROVE

Together, we can reduce readmissions and improve lives.



SHARED GOAL. SHARED DATA. SHARED SUCCESS. Better coordination today leads to better outcomes tomorrow.



# FUTURE-FORWARD: CO-MANAGEMENT & TECH

Smarter together. Connected care. Better outcomes.



INNOVATE TODAY.  
INTEGRATE ALWAYS.  
TRANSFORM TOMORROW.

## 1. CO-MANAGED CLINICS

Better care for complex patients.

### CO-MANAGED CLINICS FOR COMPLEX COHORTS

Examples: CHF, COPD, Diabetes, CKD, High Utilizers



Joint care management by  
hospital & health plan teams



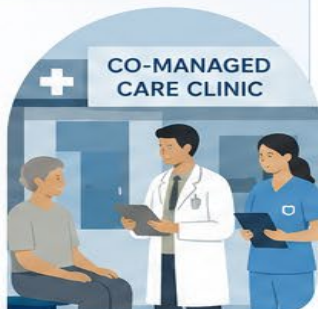
Standardized care plans  
& evidence-based protocols



Address medical, behavioral,  
and social needs



Proactive outreach &  
close follow-up



### KEY BENEFITS

- ✓ Improved quality of life
- ✓ Fewer hospitalizations & ED visits
- ✓ Better patient & caregiver experience
- ✓ Lower total cost of care

## 2. DATA & COMMUNICATION INTEGRATION

Right information. Right team. Right time.



### ADT EVENT NOTIFICATIONS

Real-time alerts to plan care managers  
for admissions, discharges, and  
transfers.



### PAYER-EHR MESSAGING (FHIR / DIRECT)

Secure, standards-based exchange  
of clinical & administrative  
information.

- Care summaries
- Authorizations & approvals
- Care plan updates
- Post-acute referrals & status



### INTEGRATED WORKFLOWS

- Closed-loop communication
- Reduced phone calls & faxes
- Faster decisions & smoother transitions
- Improved documentation & accuracy



### Secure. Compliant. Interoperable.

Built on national standards (FHIR, Direct, HL7).

## 3. DIGITAL SUPPORTS & PATIENT ENABLEMENT

Technology that extends care beyond the hospital.



### REMOTE MONITORING

Track vital signs, weight, oxygen, and symptoms.  
Early alerts trigger timely interventions.



### AUTOMATED REMINDERS

Appointment reminders, medication prompts,  
self-care tips, and symptom check-ins.



### RIDE SERVICES INTEGRATION

Seamless scheduling for medical transportation.  
Reduces no-shows and readmissions.



### MEDICATION DELIVERY

Home delivery of medications & supplies.  
Ensures access and adherence.



### PATIENT EMPOWERMENT

- ✓ Easy access to care and information
- ✓ Better self-management
- ✓ Greater engagement & satisfaction

## 4. STRONGER TOGETHER: A CONTINUUM OF CONNECTED CARE



### Admit

ADT alert to  
plan CM



### In-Hospital

Joint planning  
& coordination



### Discharge

Coordinated  
transition



### Post-Discharge

Digital supports &  
follow-up



### Better Outcomes

Healthier patients.  
Lower costs.  
Stronger system.



### COLLABORATE

Shared goals



### INTEGRATE

Connected data & workflows



### INNOVATE

Leverage technology



### IMPROVE

Better outcomes for all

## THE FUTURE IS CONNECTED

Co-management and technology integration  
create a seamless experience that delivers  
the right care, at the right time, in the  
right place—every time.





# FUTURE-FOCUSED APPROACHES

Smarter Insights. Proactive Actions. Better Outcomes.



INNOVATE TODAY.  
DELIVER TOMORROW.  
TRANSFORM TOGETHER.

## 1. AI ALERTS FOR HANDOFFS

Right information. Right time.

### AI ALERT EXAMPLE



#### High Risk Handoff Alert

**Patient:** John D.

**Risk:** Readmission (High)

**Reason:** 3+ prior admits, CHF, med non-adherence

**Action:** Ensure follow-up & meds to bed

🕒 Just now



### Benefits

- ✓ Real-time risk identification
- ✓ Improved handoff communication
- ✓ Fewer missed follow-ups
- ✓ Better continuity of care

## 2. PREDICTIVE CASE MANAGER PAIRING

Right CM. Right patient.

### MATCHING PATIENTS TO THE RIGHT CM



### Benefits

- ✓ Stronger patient-CM relationships
- ✓ Higher engagement & satisfaction
- ✓ More efficient case management

## 3. SDOH DASHBOARDS

See the whole picture. Act on what matters.

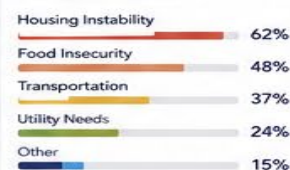
### SDOH RISK OVERVIEW

#### SDOH RISK SCORE



↑ 15 pts from last admit

#### TOP SDOH NEEDS



### AT-RISK POPULATION (This Week)

**124**  
High Risk  
Members

**36**  
Needs  
Intervention

**18**  
Resolved  
This Week



### Benefits

- ✓ Identify needs earlier
- ✓ Target resources effectively
- ✓ Improve outcomes & equity

## AI-ENABLED SOLUTIONS FOR CARE TRANSFORMATION



### AI-ASSISTED DISCHARGE PLANNING

Recommends optimal discharge plans, services, and timing.



### PREDICTIVE LOS

Estimates length of stay to support planning and resource allocation.



### PREDICTIVE READMISSION

Identifies risk early to enable proactive interventions and reduce avoidable readmissions.



### DIGITAL TWINS

Simulate patient scenarios to predict outcomes and personalize care strategies.



### VIRTUAL NURSE NAVIGATORS

Provide 24/7 patient support, education, and guidance.



### CLOSED-LOOP REFERRALS

Ensure referrals are received, scheduled, and completed.



### INTELLIGENT AUTHORIZATION WORKFLOWS

Automate decisions, reduce delays, and improve accuracy.



### AUTOMATED DOCUMENTATION

Extracts & drafts clinical notes to save time and reduce burden.



### AMBIENT AI

Listens, understands, and documents naturally—so clinicians can focus on patients.

## POWERED BY DATA & AI – DRIVING PROACTIVE, PERSON-CENTERED CARE



**DATA INTEGRATION**  
EHR, Claims, ADT,  
SDOH, Pharmacy,  
Devices & more



**AI & ANALYTICS**  
Machine learning  
models identify  
patterns & risks



**ACTIONABLE INSIGHTS**  
Real-time alerts  
and recommendations  
for care teams



**PROACTIVE ACTIONS**  
Intervene early,  
coordinate care,  
close gaps



**BETTER OUTCOMES**  
Healthier patients,  
lower costs,  
higher satisfaction

THE FUTURE  
WE BUILD  
TOGETHER



**Patient-Centered**  
Putting patients at  
the center of every  
decision.



**Data-Informed**  
Using data and AI  
to drive smarter  
decisions.



**Seamlessly Connected**  
Integrated systems  
and communication  
that work together.



**Equitable & Inclusive**  
Addressing social needs  
and closing gaps in  
care.



**Efficient & Sustainable**  
Improving outcomes  
while controlling  
costs.



Together, we can anticipate needs,  
remove barriers, and deliver the right  
care at the right time—every time.  
Better for patients. Better for providers.  
Better for all.



# EMERGING TECHNOLOGIES SUPPORTING COLLABORATION

Technology connects. Collaboration transforms.



Better information.  
Stronger partnerships.  
Better outcomes.

## 1 ARTIFICIAL INTELLIGENCE (AI)



AI systems analyze large amounts of data to support clinical and operational decision-making.

### EXAMPLES

- Risk scoring
- Natural language processing
- Intelligent workflows
- Care gap identification

### HOW IT SUPPORTS COLLABORATION



- Delivers real-time insights to all care team members
- Prioritizes patients needing attention
- Reduces administrative burden

## 2 PREDICTIVE ANALYTICS



Uses historical and real-time data to predict outcomes and guide proactive care.

### EXAMPLES

- Predict readmission risk
- Predict length of stay
- Identify patients at risk for decline

### HOW IT SUPPORTS COLLABORATION



- Enables proactive planning across disciplines
- Targets resources where needed most
- Improves transitions and outcomes

## 3 AMBIENT DOCUMENTATION



AI listens during patient interactions and generates accurate clinical documentation.

### EXAMPLES

- Real-time note generation
- Auto coding
- Summarization

### HOW IT SUPPORTS COLLABORATION



- Frees up time for patient and team interaction
- Ensures consistent, high-quality documentation
- Keeps all providers informed

## 4 GENERATIVE AI



Creates content, summaries, and recommendations based on data and clinical context.

### EXAMPLES

- Discharge instructions
- Patient education materials
- Care plan summaries
- Email drafts and updates

### HOW IT SUPPORTS COLLABORATION



- Standardizes communication
- Improves patient understanding
- Saves time on non-clinical tasks

## 5 DIGITAL CARE NAVIGATION



Digital tools and apps guide patients through their care journey.

### EXAMPLES

- Patient portals
- Appointment scheduling
- Care plan tracking
- Secure messaging

### HOW IT SUPPORTS COLLABORATION



- Keeps patients engaged and informed
- Enables two-way communication
- Aligns patients, families, and care teams

## 6 REMOTE MONITORING



Devices collect patient data at home and transmit it to care teams.

### EXAMPLES

- Wearables
- RPM devices (BP, glucose, weight)
- Home sensors

### HOW IT SUPPORTS COLLABORATION



- Enables earlier intervention
- Improves chronic disease management
- Shares data across the care continuum

## 7 SHARED CARE PLATFORMS



Integrated platforms that centralize information and enable care team coordination.

### EXAMPLES

- Interoperable EHRs
- Care collaboration platforms
- HIEs (Health Information Exchanges)

### HOW IT SUPPORTS COLLABORATION



- Provides a single source of truth
- Improves visibility and coordination
- Enhances care continuity

### TECHNOLOGY ENABLERS



Data Security & Privacy



Interoperability (FHIR, APIs)



Cloud Infrastructure



User-Centered Design



Change Management & Training

### TOGETHER, WE CAN:



Improve patient outcomes



Reduce costs and waste



Strengthen team collaboration



Make data-driven decisions



Deliver the right care at the right time, every time



CONNECTED TEAMS.  
BETTER CARE.  
BRIGHTER FUTURE.

# STRONGER TOGETHER.

## Better Outcomes.



Two care teams.  
One shared purpose.



One patient.  
Whole-person care.

Collaborating across the continuum  
for every patient, every time.



### ACUTE CARE CM *In the Hospital*



Coordinates care during hospitalization



Leads discharge planning



Identifies & removes discharge barriers



Engages providers, patients & families



Plans for a safe transition



### MANAGED CARE CM *In the Community*



Provides benefit & authorization support



Connects to in-network providers & services



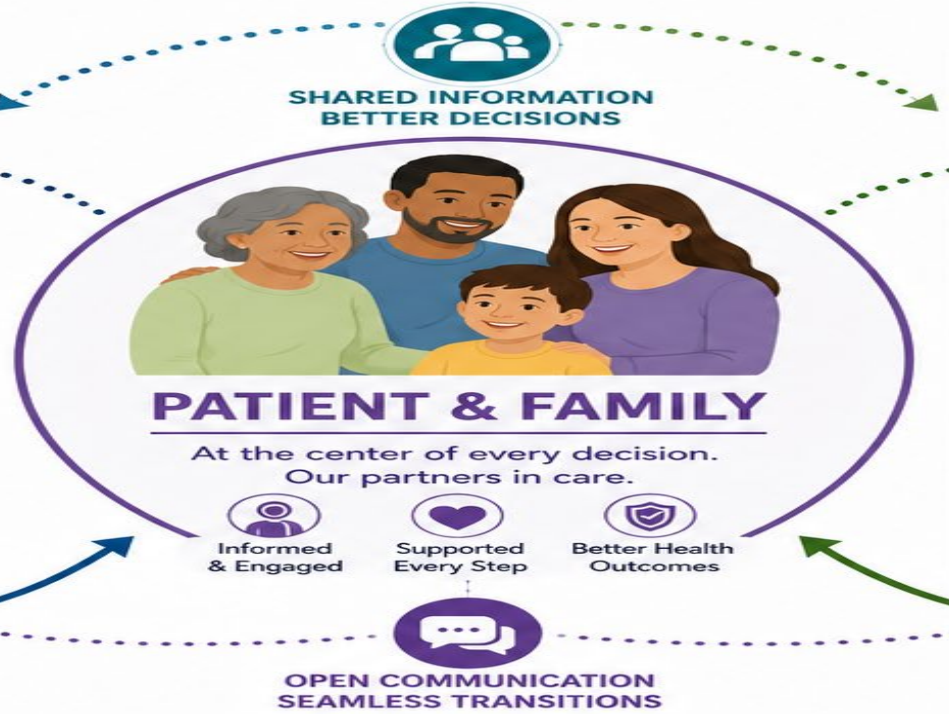
Addresses social needs & community resources



Monitors progress & closes care gaps



Supports ongoing recovery at home



### OUR SHARED GOALS



Improve Patient Experience



Improve Quality of Care



Reduce Avoidable Readmissions



Lower Total Cost of Care



Improve Health Outcomes



WHEN WE WORK TOGETHER, PATIENTS THRIVE.

ONE PATIENT. ONE TEAM. BETTER TOGETHER.

# • Key Takeaways •

*Stronger Together. Better Outcomes. Greater Value.*



1

## **Collaboration drives outcomes.**

Seamless coordination between acute and managed care case managers reduces readmissions, shortens length of stay, and improves patient satisfaction.



2

## **Know your counterpart.**

Understanding each role's scope, timelines, and regulatory constraints creates mutual respect and smoother transitions.



3

## **Communication is the bridge.**

Use standardized tools (SBAR+, shared care plans, warm handoffs) to ensure complete and timely information flow.



4

## **Align on the “why.”**

Shared goals—quality, safety, value, and patient-centered care—unite both sides of the continuum.



5

## **Start small, scale success.**

Begin with one shared form, one patient, or one weekly meeting—demonstrate quick wins and build momentum.



6

## **Data fuels collaboration.**

Track outcomes together—readmissions, LOS, patient experience—to guide continuous improvement.



7

## **Trust + transparency = transformation.**

Sustainable partnerships require openness, consistent follow-through, and shared accountability.



When we work together across the continuum, patients win.

*Stronger Partnerships. Better Care. Greater Impact.*



**The future is not acute care versus managed care  
it is acute care and managed care functioning together**

**Patients do not experience separate healthcare systems**

**The greatest opportunity lies in building intentional partnerships  
to improve outcomes, enhance the patient experience**

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# THANK YOU!

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