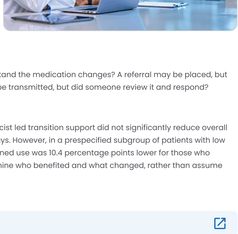
Edition - Nov 2026

Care in Motion



Completing the Play Is Not the Same as Improving the Outcome



Healthcare organizations track visits, outreach, referrals, care plans, and follow ups. Each completed activity represents an important play in a patient's care journey.

But completion alone does not answer the most important question:

Did it improve the outcome?

A discharge call may be documented, but did the patient understand the medication changes? A referral may be placed, but did the patient see the specialist? Remote monitoring data may be transmitted, but did someone review it and respond?

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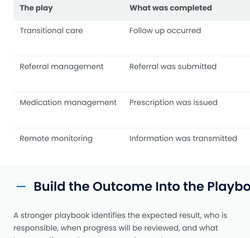
The activity matters. The result matters more.

A 2026 randomized clinical trial illustrates the distinction. Pharmacist led transition support did not significantly reduce overall unplanned hospital and emergency department use within 30 days. However, in a prespecified subgroup of patients with low medication adherence and health literacy, same hospital unplanned use was 10.4 percentage points lower for those who received the intervention. This finding reinforces the need to examine who benefited and what changed, rather than assume that a completed intervention improved outcomes.

Read the trial on pharmacist led discharge care.

jamanetwork.com

CMS Is Emphasizing Care Beyond the Visit



CMS programs offer examples of how care management is extending beyond the traditional visit. Advanced Primary Care Management includes comprehensive care management, care plans, referrals, and care transitions. For practices billing APCM, CMS includes follow up communication within seven days after discharge when clinically indicated.

Review CMS guidance on APCM services. **www.cms.gov**

The voluntary ACCESS Model is another example. CMS is testing technology supported chronic care with payment tied to measurable health outcomes, rather than simply the volume of activities delivered.

Learn about the ACCESS Model. **www.cms.gov**

Remote patient monitoring shows why follow through matters. A 2025 review of 40 randomized trials involving people with noncommunicable diseases found that monitoring may modestly reduce the proportion of patients in hospitalized and shorten hospital stays. The certainty of this evidence was low. Teams should evaluate monitoring in context and ask whether information was reviewed and led to an appropriate response.

Read the review of remote monitoring and health care use. **mhealth.jmir.org**

Read the Result, Not Just the Play

The play	What was completed	What still needs to be known
Transitional care	Follow up occurred	Were medication changes understood? Were follow up needs resolved?
Referral management	Referral was submitted	Did the patient complete the visit? Did the findings return to the care team?
Medication management	Prescription was issued	Did the patient obtain and continue the medication? Is the treatment working as expected?
Remote monitoring	Information was transmitted	Was it reviewed? Did it lead to appropriate action?

Build the Outcome Into the Playbook



A stronger playbook identifies the expected result, who is responsible, when progress will be reviewed, and what happens if care does not move forward.

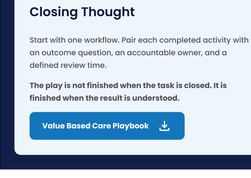
For each important need, define:

- **The Result:** What should be different for the patient?
- **The Owner:** Who is responsible for the next step?
- **The Timeframe:** When should the team check progress?
- **The Response:** What happens if the result is not achieved?

For example, a discharge call should do more than document contact. It should help confirm that the patient understands medication changes, identify barriers, and clarify the next step in care.

Old Play But Good Play

Confirm What Happened



Clinical, claims, utilization, quality, medication, and operational information each show part of the care journey. Connected information can help teams see whether care occurred, whether a need remains unresolved, and whether the plan should change.

A 2026 study of health-related social needs referrals found that fewer than 3% were documented as fulfilled. The researchers cautioned that documentation and workflow limitations affected what organizations could observe. A missing result did not necessarily mean a service had not occurred. It did reveal a visibility gap.

Read the study on referral tracking and documentation. **pubmed.ncbi.nlm.nih.gov**

Evaluate the Incomplete Play

A play can be called correctly and still fails to move the team downfield. When that happens, the team studies where execution breaks down and decides what should change.

Healthcare organizations need the same discipline.

Was transportation a barrier? Did information fail to reach the next provider? Was responsibility unclear? Did an alert arrive without a defined response?

Unanswered outreach, incomplete referrals, medication barriers, and missed follow ups should return to the care team for evaluation. The goal is not to assign blame. It is to understand the breakdown and adjust to the next play.

See More of the Field

AaNeel's connected healthcare ecosystem can help organizations connect care activities with what happened next.

AaNeelCare® supports care management, analytics, quality, utilization, and value-based care workflows. **AaNeel Connect®** supports interoperable information exchange. The Health Access Card® enables patients to securely share relevant health information with providers through a permission-based, patient authorized model.

Together, these solutions can support a clearer operational sequence:

Define the result. Assign the owner. Set the timeframe. Confirm what happened. Evaluate what remains unresolved.

What We're Thankful For

Our clients and partners.

We are grateful for the trust you place in AaNeel and for the opportunity to work alongside you. Your insights and collaboration help us create solutions that support your teams and the people you serve.

Our AaNeel family.

To our team, thank you for your commitment, creativity, and care for one another and our clients. The work you do each day helps bring our purpose to life.

The providers & care teams who serve patients.

Thank you for the compassion and dedication you bring to your work. Every patient is someone's loved one: a parent, child, spouse, sibling, or friend. Many of us have family members who rely on providers and care teams like you, and we know how much your care means.

Grateful for the People Behind Care

This season, we want to share our gratitude for the people who make a difference in healthcare every day.

From all of us at AaNeel, thank you for being part of our journey. We wish you and your families a ***Happy Thanksgiving.***

Closing Thought

Start with one workflow. Pair each completed activity with an outcome question, an accountable owner, and a defined review time.

The play is not finished when the task is closed. It is finished when the result is understood.

Value Based Care Playbook



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