

Public Health Care System and Local Health Plan Collaboration: Partnering to Improve Hospital Discharge and Follow-up

November 5, 2025
Oakland Marriott City Center
Grand Ballroom E-H, First Floor

AGENDA

Participants will...

- ✓ Examine system and plan roles and responsibilities in the discharge process and identify effective staffing models for coordinating transitions across care settings
- ✓ Learn how systems and plans implement clinical workflows and data exchange processes to support safe transitions home or to lower levels of care (e.g., skilled nursing facilities, recuperative care, assisted living, etc.)
- ✓ Identify promising strategies to discharge patients with complex health and social needs, such as homelessness and dementia
- ✓ Understand how systems and plans are partnering to meet new requirements under CalAIM's Population Health Management [Transitional Care Services](#)
- ✓ Strengthen relationships with system and plan partners through joint planning efforts

8:00am **Networking Breakfast**

9:30 **Welcome and Level-setting**

Amanda Clarke, Vice President of Programs, Safety Net Institute (SNI)

Amber Wade, Executive Director, Local Health Plans of California (LHPC) Institute

- SNI and LHPC will outline the agenda and goals for the day and discuss opportunities for public healthcare systems (PHSs) and Medi-Cal managed care plans (MCPs) to work together to improve hospital discharge and follow-up.

9:50 **Understanding System and Plan Priorities**

Ash Amarnath, MD, Chief Health Officer, SNI

Bradley Gilbert, MD, Local Health Plans of California

- SNI and LHPC will explain the policy and financial drivers that shape system and plan efforts to improve the hospital discharge process, such as efforts to reduce long lengths of stay and to meet new requirements under CalAIM's Population Health Management Transitional Care Services.

- 10:05 **Peer Share: Effective Models of System-Plan Coordination at Discharge**
Heidi Edmunds, Clinical Director of Care Management, Arrowhead Regional Medical Center
Mary Bridge, Manager, Integrated Transitional Care, Inland Empire Health Plan
Cathena Campbell, Director of Resource Management, San Mateo Medical Center
Melissa Robbins, Inpatient Review Supervisor, Health Plan of San Mateo
- System and plan leaders will explain how they organize staff roles, operational workflows, and data exchange throughout hospital discharge and follow-up, highlighting two effective models: virtual coordination and co-located health plan staff at the hospital.
- 10:50 **Team Time #1: Identifying Assets and Gaps in the Discharge Process**
- Using a framework of people, processes, and technology, system and plan dyads will walk through the discharge process together and map existing assets and areas for improvement during the transition.
- 11:30 **Peer Share: Safely Discharging Patients with Complex Health and Social Needs**
Nick Iverson, MD, Medical Director of Patient Flow & Complex Care, Zuckerberg San Francisco General Hospital
Shauntessa Aguon-Clark, Manager, Enhanced Care Management/Community Supports, San Francisco Health Plan
Nancy Pedersen, Senior Director of Care Management Programs, Institute on Aging
- This session will highlight a successful partnership between a system, a plan, and a community-based organization, working together to safely discharge patients who face challenges such as homelessness and severe mental illness.
- 12:00 **Lunch**
- 12:45 **Spreading What Works: Complex Discharge Gallery Walk**
- System and plan dyads will document how they have successfully addressed barriers to discharge for patients with complex health and social needs, as well as areas for improvement. Results will be posted around the room and available for viewing throughout the day.
- 1:10 **Roundtable Discussions: Opportunities for Improvement**
- Participants will join mixed groups of system and plan leaders and share strategies to improve hospital discharge and follow-up. Table topics include:
 - ◆ Care Manager Assignment and Role
 - ◆ Follow-up Appointments for Assigned and Unassigned Patients
 - ◆ Increasing Access to Skilled Nursing Facilities
 - ◆ Navigating Post-Discharge Placement for Complex Cases
 - ◆ Data Exchange to Support Hospital Discharge and Follow Up

1:55 **Team Time #2: Takeaways and Next Steps**

- Dyads will reconvene and share what they learned during the Roundtables and throughout the day, discussing implications for their work together. Teams will identify 2-3 next steps they will take to improve hospital discharge and follow-up.

2:20 **Wrap-up**

- SNI and LHPC will summarize takeaways from the day and announce upcoming learning opportunities to further strengthen system and plan collaboration.

2:30 **Adjourn**