PointClickCare®

White Paper

The Future of Care Coordination at the Hospital–SNF Intersection:

How Health Systems are Solving for Throughput, Readmissions, and Revenue Risk

Executive Summary

Care coordination has become a strategic lever for health systems. The greatest friction—and the greatest opportunity—sits at the transition between hospitals and skilled nursing facilities (SNFs). Hospitals and accountable care organizations (ACOs) that fail to modernize care coordination at the intersection of care with SNFs will see throughput bottlenecks, rising costs, and lost revenue—while competitors leveraging intelligent workflows will have an advantage in the market.

At the same time, value-based models and capacity pressure require faster, safer transitions supported by reliable visibility into post-acute care. New executive research highlights a consistent theme: leaders are looking beyond the electronic health record (EHR) for workflow efficiency and data they can act on.

This white paper summarizes what hospital leaders report, where coordination breaks down, how AI is beginning to help, and what "intelligent workflows" look like in practice. It also outlines how PointClickCare's PAC Management IQ equips hospitals to unify post-acute signals, reduce manual coordination, and align with SNFs on performance—so clinical teams can move patients sooner, intervene earlier, and protect quality and financial outcomes.

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Key Findings

69%

of **health system leaders** cite financial sustainability as a top challenge.

Redesigning Care Coordination for 2026 and Beyond

69% of health system leaders cite financial sustainability as a top challenge. ACOs and health systems are being moved more quickly into contracts where they can lose money for poor outcomes, not just share in savings. Changes to the Medicare Share Savings Program (MSSP) and the beginning of TEAM (Transforming Episode Accountability Model) are accelerating the shift to two-sided risk.

The value-based care glide path is shortening. Penalties and repayments are coming faster in existing models. New models will likely see more of the same.

60%

of C-suite leaders rank EMR optimization as a **top technology initiative**.

17%

yet only **17% strongly agree their EMR meets future needs**.

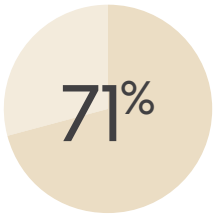
Leaders are pushing on core systems—but see gaps.

60% of C suite leaders rank EHR optimization as a top technology initiative, yet only **17%** strongly agree their EHR meets future needs. Future shifts include regulatory changes: every Medicare patient will be in a value-based care (VBC) model by 2030; the Transforming Episode Accountability Model (TEAM) becomes mandatory for surgical episodes in 2026.

CMS is signaling that mandatory VBC will become the norm – not just with TEAM. For the first time, there is no opt-out. Hospitals must prepare now or risk being left behind.

Workflow efficiency outperforms add ons

Executives report looking outside the EHR when current tools don't improve workflows or are cost prohibitive to extend.

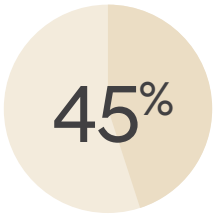


71% say post-acute poses a signficant challenge in accessing patient data, with **56%** citing data gaps at dicharge

Front and back ends of the stay are most fragile

Coordination pain concentrates at admission in the emergency department (ED) and at discharge to SNFs and community organizations. Post-acute transitions represent an area of significant challenge in gathering and accessing critical patient data, according to **71%** of respondents, with **56%** citing data gaps at discharge planning.

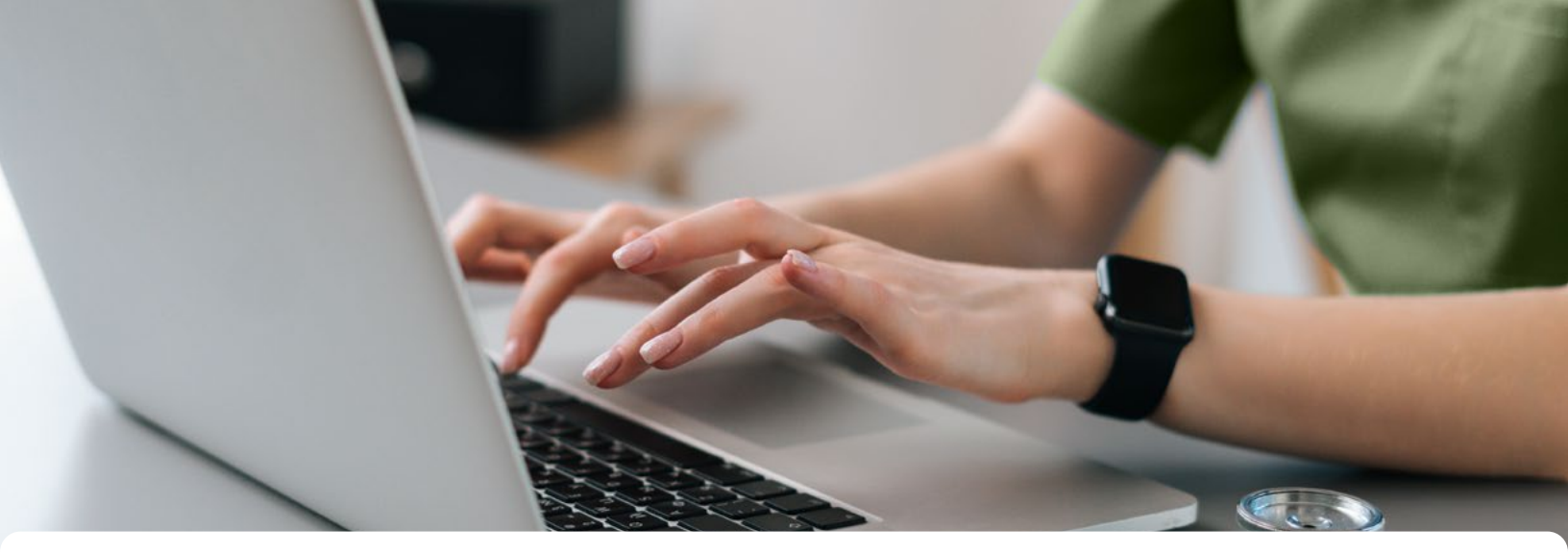
The inability to gather and unify patient information for effective care coordination results in increased length of stay and delayed discharges, which leads to longer wait times for patients and blocks inpatient bed availability for scheduling higher-margin procedures.



45% say integrating AI has improved data quality

AI benefits are emerging

AI is poised to help solve for inefficiencies and burdensome manual workflows. **45%** say integrating AI has improved data quality and accessibility; **37%** report improved data privacy and security; **20%** note evolving legal/regulatory considerations.

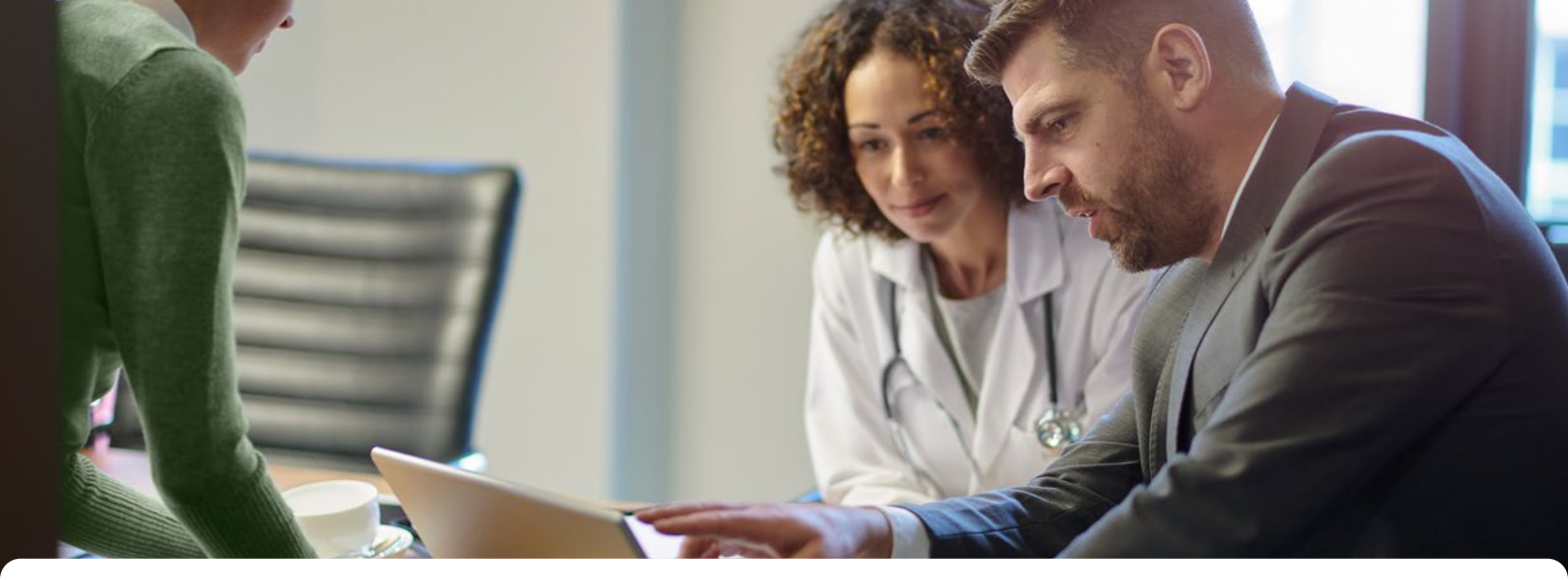


From Manual Workarounds to Intelligent Workflows: Redesigning Care Coordination for 2026 and Beyond

What "Manual" Looks Like Today

Discovery by phone/fax Critical updates arrive late or not at all. Seamless care transitions were described as valuable by **54%** of respondents.	**54%**
Fragmented records Data sits in disconnected systems and formats—gathering and unifying all critical patient information for a comprehensive view of the patient is a top challenge for **58%** of leaders.	**58%**
Double documentation Teams re enter the same data to keep stakeholders informed, and workflow efficiency is a priority for **67%** of leaders.	**67%**
Unclear accountability Hospital and SNF teams work from different views of the patient and plan—with **64%** of respondents stating they use manual workarounds for post-acute discharge coordination.	**64%**

Consequences: Delayed discharges, avoidable inpatient days, inconsistent handoffs, elevated readmission risk, and staff burnout. To counteract these, improving quality metrics and hospital throughput are both ranked in the top three strategic priorities for leaders surveyed.



What "Intelligent" Looks Like

Unified post-acute visibility from day one

Real time, EHR level signals from SNFs—including those outside preferred networks—so discharge planners, case managers, and chief nursing officers (CNOs) can assess readiness and barriers early.

Interoperable, automation first workflows

Routine updates flow automatically; referral status and key milestones update in near real time. Duplicate data entry is minimized.

Risk aware prioritization

Rising risk patients surface to the top of the worklist with context (clinical changes, functional progress, social determinants) to guide timely intervention.

Shared performance views

Hospitals and SNFs align on metrics like LOS, readmissions, discharge readiness, and post-acute throughput—building high performing networks over time.

The CNO's Role

CNOs sit at the intersection of throughput, quality, and workforce burden. With reliable post-acute visibility and automated coordination, they can:

- **Reduce avoidable days and expedite discharge before noon,**
- **Standardize handoffs to improve safety, and**
- **Return time to nursing teams by eliminating manual chasing.**

This is not a technology story for its own sake—it's an operating model that enables clinical leaders to meet today's access and quality demands without adding to staff workload.

What Acute Care Leaders Reveal About the Future of Care Coordination

Where Coordination Breaks

Leaders consistently point to breakdowns at the handoffs into and out of inpatient care. Discharge coordination into SNFs and community based organizations, attribution in value-based arrangements, and incomplete or delayed data are recurring themes. Manual calls, faxes, and spreadsheets carry the process, resulting in inconsistent status updates, double documentation, and late discovery of barriers that should have been visible earlier.

These challenges result in higher cost of care, increased length of stay (LOS), delayed discharges, and increased readmissions, as well as decreased patient satisfaction, greater medical errors, and reduced quality of care.

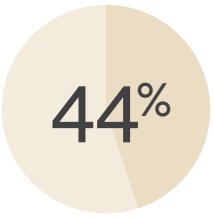
Strategic Priorities Behind the Pain

As access and capacity pressures mount, workflow efficiency has overtaken “experience add ons” as a practical priority. The focus is on tools that:

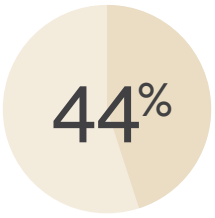
- **Integrate external post-acute data into daily workflows,**
- **Reduce duplicate documentation and manual chasing, and**
- **Provide timely, reliable signals at the point of coordination.**

Why Leaders Look Beyond the EHR

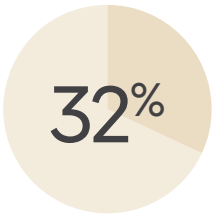
Surveyed executives report a clear rationale for augmenting core systems:



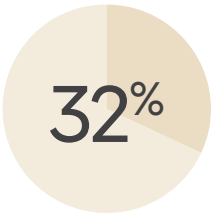
Our current EHR isn't improving workflows



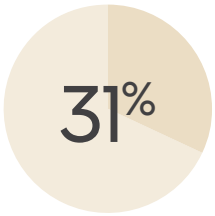
Patient safety



An outside solution promises better quality



Our EHR updates/add ons are too expensive



An outside solution promises better ROI

The Takeaway

The core record is essential, but it rarely provides real time visibility into **external** post-acute settings—precisely where discharge readiness, LOS, and readmission risk are determined.

The Intersection That Matters: Hospital ↔ SNF

Performance in post-acute care increasingly influences hospital metrics. Without line of sight into SNF status and care plans, hospitals face:

- **Delayed or suboptimal placement,**
- **Avoidable inpatient days,**
- **Missed opportunities to intervene on rising risk, and**
- **Unnecessary utilization that erodes quality and margin.**

Value-based models raise the stakes further by aligning financial accountability with outcomes that occur beyond the hospital's four walls. In this context, reliable post-acute visibility and aligned network performance are no longer "nice to have," they are a "must-have." Health systems state that SNFs are the data source that is most critical, and also the one they have the least access to. Not having this access is a strategic risk to health systems.

AI in Care Coordination: Early Insights and Evolving Use Cases

AI adoption is still early, but leaders report operational and clinical benefits in care coordination contexts.

What leaders are seeing now

45%

Data quality and access: 45% report improvements when AI supports ingestion, normalization, and routing of relevant data

37%

Privacy and security: 37% cite improvements as AI enabled tools mature.

71%

Governance considerations: 71% say it's too early to confirm hard cost savings; **20%** acknowledge evolving legal and regulatory questions.

Practical use cases for coordination:

Signal extraction: Turning disparate SNF updates into usable status signals (e.g., functional progress, discharge readiness).

Risk surfacing: Earlier identification of rising risk patients to prioritize outreach and intervention.

Administrative automation: Drafting routine handoff notes, harmonizing documents, and minimizing duplicate entry—without replacing clinical judgment.

The guiding principle: apply AI to reduce manual burden and increase timeliness and reliability of data—so clinicians can act sooner with more confidence. Status quo solutions and workflows fail to solve for these challenges in comparison to the advanced abilities of AI tools.

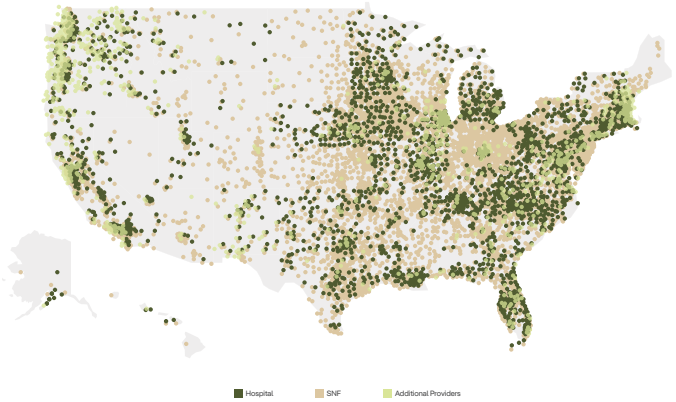
Get Your Data Visibility Report

How do your transitions compare?

In a 20 minute consultation, we'll benchmark your care coordination performance against national and state peers and identify high leverage opportunities to:

- **Reduce readmissions and avoidable inpatient days,**
- **Improve discharge timeliness and SNF acceptance speed, and**
- **Limit revenue leakage tied to post-acute blind spots.**

Request your personalized Data Visibility Report to benchmark your performance now or risk falling behind peers on key metrics like readmissions and LOS.



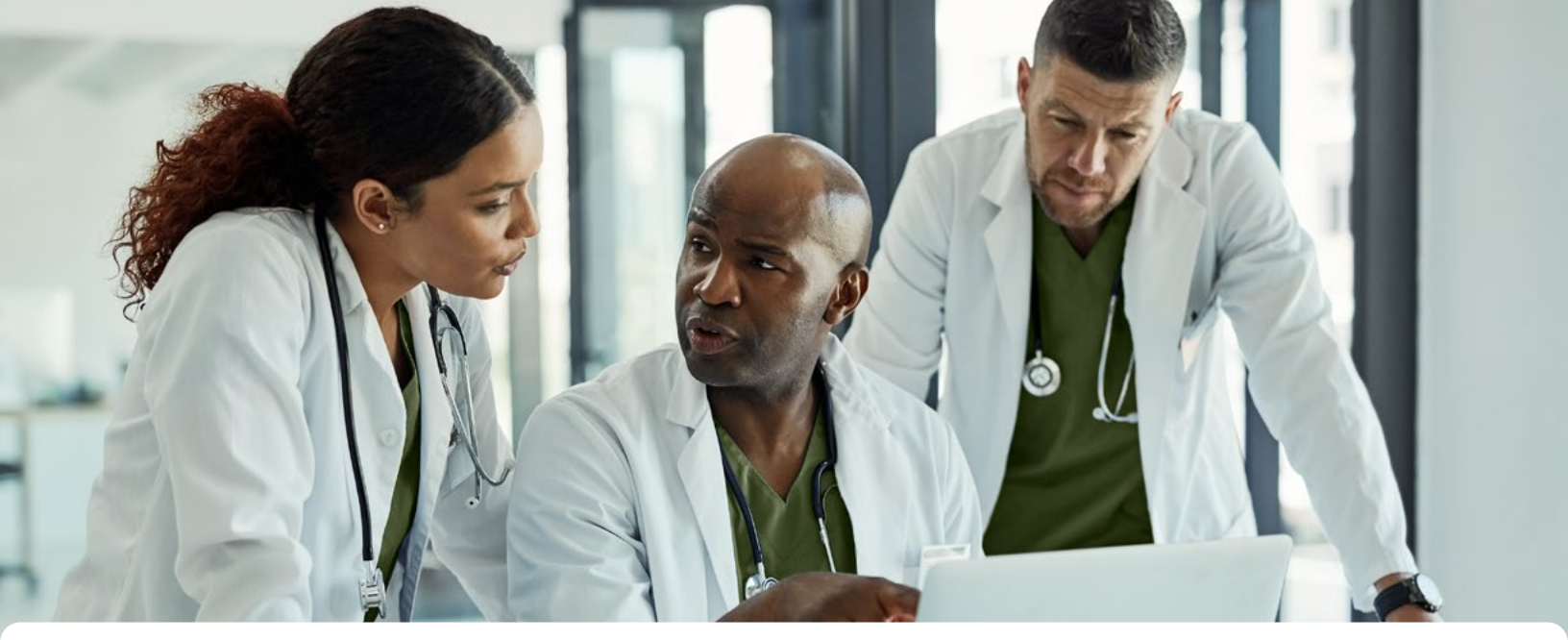
Top SNFs in Your PAC Network

Skilled Nursing Facility	PointClickCare EHR
SNF Name 1	NO
SNF Name 2	YES
SNF Name 3	YES
SNF Name 4	YES
SNF Name 5	YES
SNF Name 6	YES
SNF Name 7	YES
SNF Name 8	YES
SNF Name 9	YES
SNF Name 10	YES

ED Volume	Number of SNFs on PCC	All Cause Readmission Rate
52,700	38	15%

SNF Referrals	Readmission Costs	Readmission Avoidance
812	$1,827,000	20%

Potential Savings	$290,250
Estimated ROI	5.0x



About Our PAC Management IQ Solution

Only PointClickCare connects providers with actionable, cross-continuum intelligence that measurably impacts value-based performance and patient flow. **PAC Management IQ** gives hospitals and ACOs real time visibility into the post-acute journey—starting on day one of the inpatient stay.

What it enables

- **Day one visibility into SNFs:** See patient status, risks, and care plans—across preferred and non preferred facilities.
- **Earlier interventions:** Anticipate discharges, monitor LOS, and prioritize rising risk patients before they bounce back.
- **Automation over administration:** Eliminate manual updates and double documentation with interoperable, workflow integrated signals.
- **Aligned network performance:** Collaborate with SNFs using shared, comparable metrics to build a high performing network over time.

Why it fits the moment

- Leaders are seeking **workflow efficiency** and **external data** their EMR doesn't provide.
- Emerging **AI assisted capabilities** can improve data quality and timeliness without adding burden to clinical teams.
- Value-based models demand accountability for outcomes beyond discharge—requiring sustained visibility into post-acute care.

About the Study

PointClickCare commissioned Sage Growth Partners, a healthcare consultancy, to conduct a survey of 108 health system and hospital C-suite executives in 2023. Approximately 17% of respondents represented community hospitals, 54% represented health systems and integrated delivery networks and others included academic medical centers, small health systems, and privately owned hospital systems. The study explored strategic priorities, technology investments, and operational challenges facing healthcare organizations in 2024–2025.

Learn how PointClickCare's PAC Management IQ solution enables hospitals and health systems to strengthen collaboration across the continuum, streamline transitions of care, and improve patient outcomes through enhanced care coordination.

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

Discover more

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