eBook

Navigating TEAM: A Playbook for Hospitals and Health Systems in Post-Acute Care Coordination

Preparing for Success in the Transforming Episode Accountability Model

Get Started

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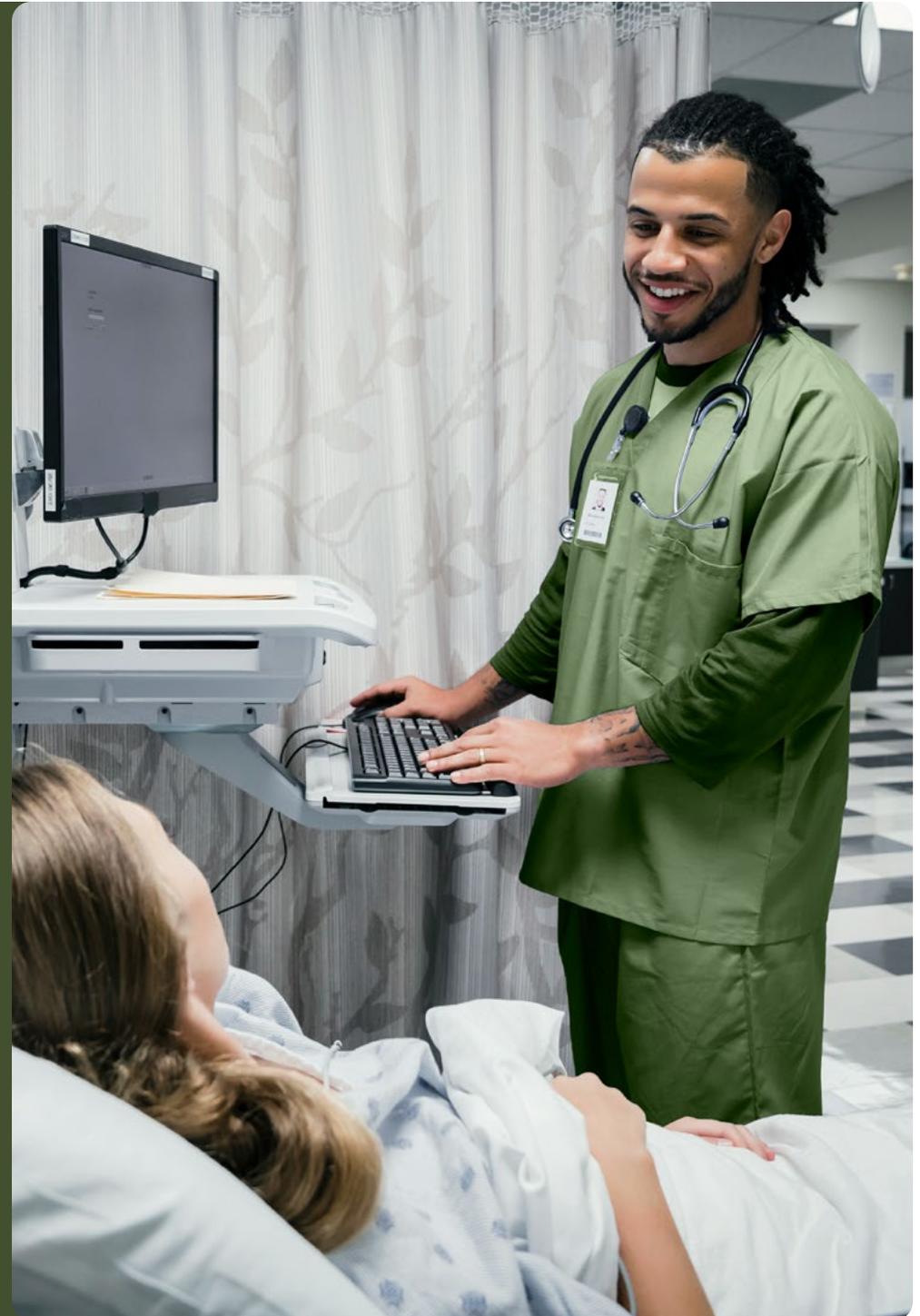
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Introduction

The Centers for Medicare & Medicaid Services (CMS) is set to launch the mandatory Transforming Episode Accountability Model (TEAM) in 2026, impacting over 700 selected hospitals. This model holds these hospitals accountable for the costs and outcomes of Medicare fee-for-service patients for a 30-day period following discharge. This shift necessitates a proactive strategy focused on care coordination, effective discharge planning, and seamless transitions to post-acute care providers.

For the first time, hospitals are mandated to bear risk for the full 30-day episode, making it critical to focus not only on transitions to post-acute care but also on the post-acute care itself. Under the TEAM model, hospitals will be held accountable for not only inpatient care but also for the costs and outcomes related to post-acute care services, making collaboration with skilled nursing facilities (SNFs) and other post-acute providers critical to success.

CMS is increasingly focused on saving money by leveraging accountable care models. With the introduction of the TEAM mandate, CMS is accelerating the shift to value-based care, compelling hospitals — especially those in high-cost regions that serve large Medicare fee-forservice populations — to adapt quickly.

While CMS positions the model as a broad initiative, the areas selected reflect a clear push to drive efficiency and curb escalating costs where they're most needed. The TEAM model is one of the primary levers in this broader cost-containment strategy.

Karen Joswick, CEO of Benovelence Health and value-based care thought leader, shares, "The number one question I get asked about is 'What's going on with value-based care?' It's not just payment reform; there's a lot of industry movement that's happening to address the conflicting challenges when delivering care...and the goal behind all these changes is to pull healthcare into the value-based care space."

This playbook provides hospital and health system leaders with a comprehensive guide to understanding and preparing for the TEAM model, specifically addressing post-acute care coordination. It unpacks the critical elements required today for getting ahead of the new rules and pressures to improve clinical and financial performance beyond the four walls of the hospital.

> By 2026, over **$10 billion is expected to be allocated** for performance-based incentive payments through the TEAM model, with hospitals that excel earning up to 2% bonuses for reducing costs and improving patient outcomes.

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Understanding TEAM

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Understanding TEAM

The **Transforming Episode Accountability Model (TEAM)** represents a significant step towards accountable care, shifting the focus from volume to value. Under this model, selected hospitals will be responsible for managing the total cost of care for Medicare patients undergoing specific procedures, not only during their inpatient stay, but for a full 30 days after discharge.

The greatest opportunity for reducing losses and increasing savings lies in managing readmissions. Hospitals must address the costs associated with readmission, along with post-acute services and other related healthcare expenses as these are the key drivers of financial risk under this model.
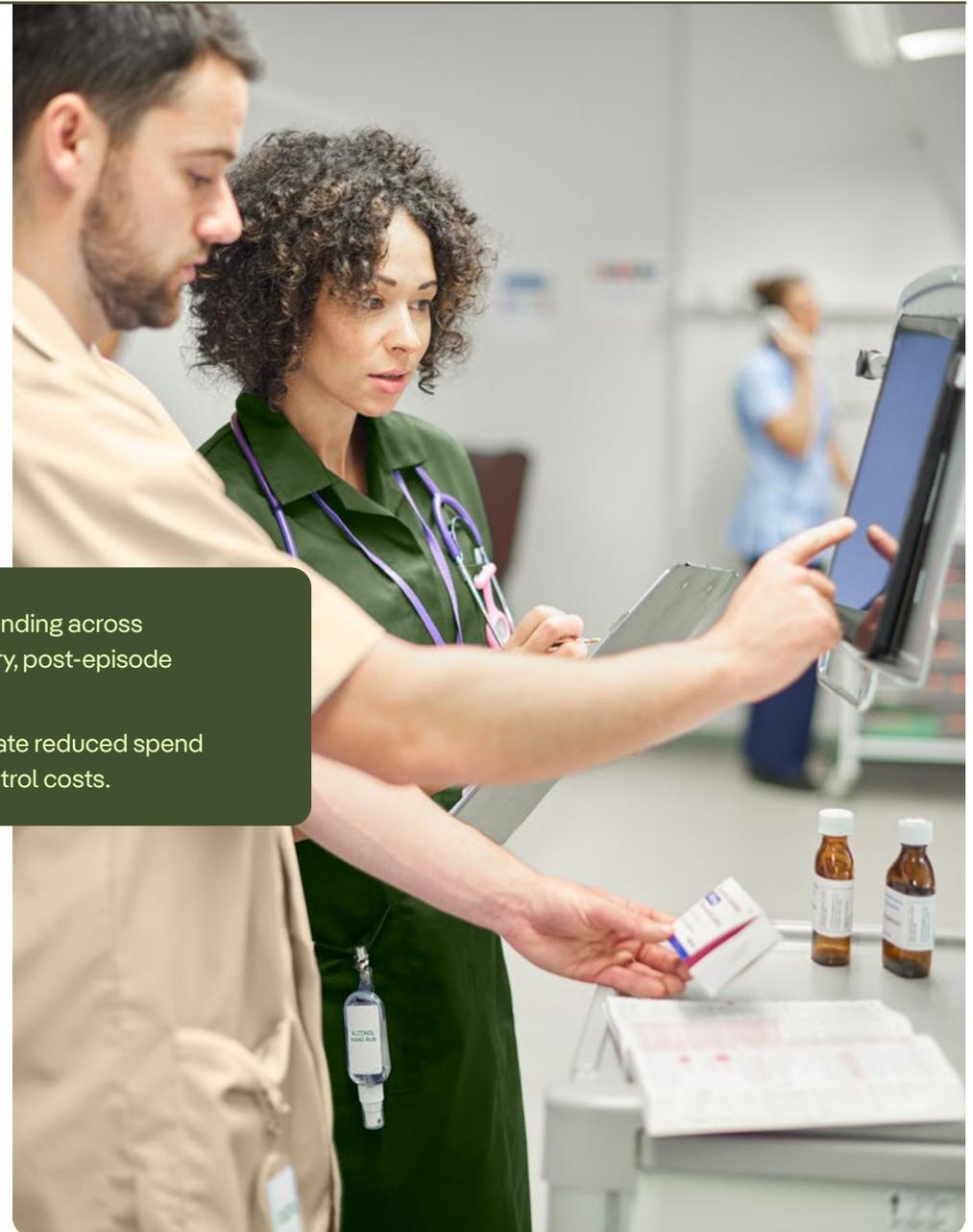
Hospitals face significant variation in post-episode spending across procedures and settings. In fact, according to ATI Advisory, post-episode spending can **range up to 53% of total episode costs**.

By identifying post-acute care partners who demonstrate reduced spend per episode, hospitals can improve outcomes and control costs.

CMS estimates that approximately 25% of all Medicare patients who are discharged after a qualifying procedure will experience an avoidable readmission, costing hospitals billions annually.

The model focuses on several key episodes, including:

- Lower extremity joint replacement
- Surgical hip femur fracture treatment
- Spinal fusion
- Coronary artery bypass graft
- Major bowel procedure

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Impact of TEAM

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Impact of TEAM

Hospitals that fail to effectively manage costs and outcomes under the TEAM model may face financial penalties, while those that excel may be rewarded with bonus payments.

Readmissions are a key factor in this model, with penalties averaging around $15,000 per episode of care. If a hospital exceeds the target spending for an episode, they may face penalties based on the difference, which can add up quickly depending on the number of episodes treated. For example, if a hospital's actual cost is on average $2,000 over the target price for 200 episodes, this can result in a significant repayment to Medicare.

Hospitals face higher costs and a potential reduction in their composite quality score (CQS) when patients are readmitted within 30 days, which can influence a portion of TEAM reconciliation payments, according to a recent industry analysis. Understanding the performance of network partners, both in the past and during TEAM performance years, is therefore essential.

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The Imperative of Post-Acute Care Visibility

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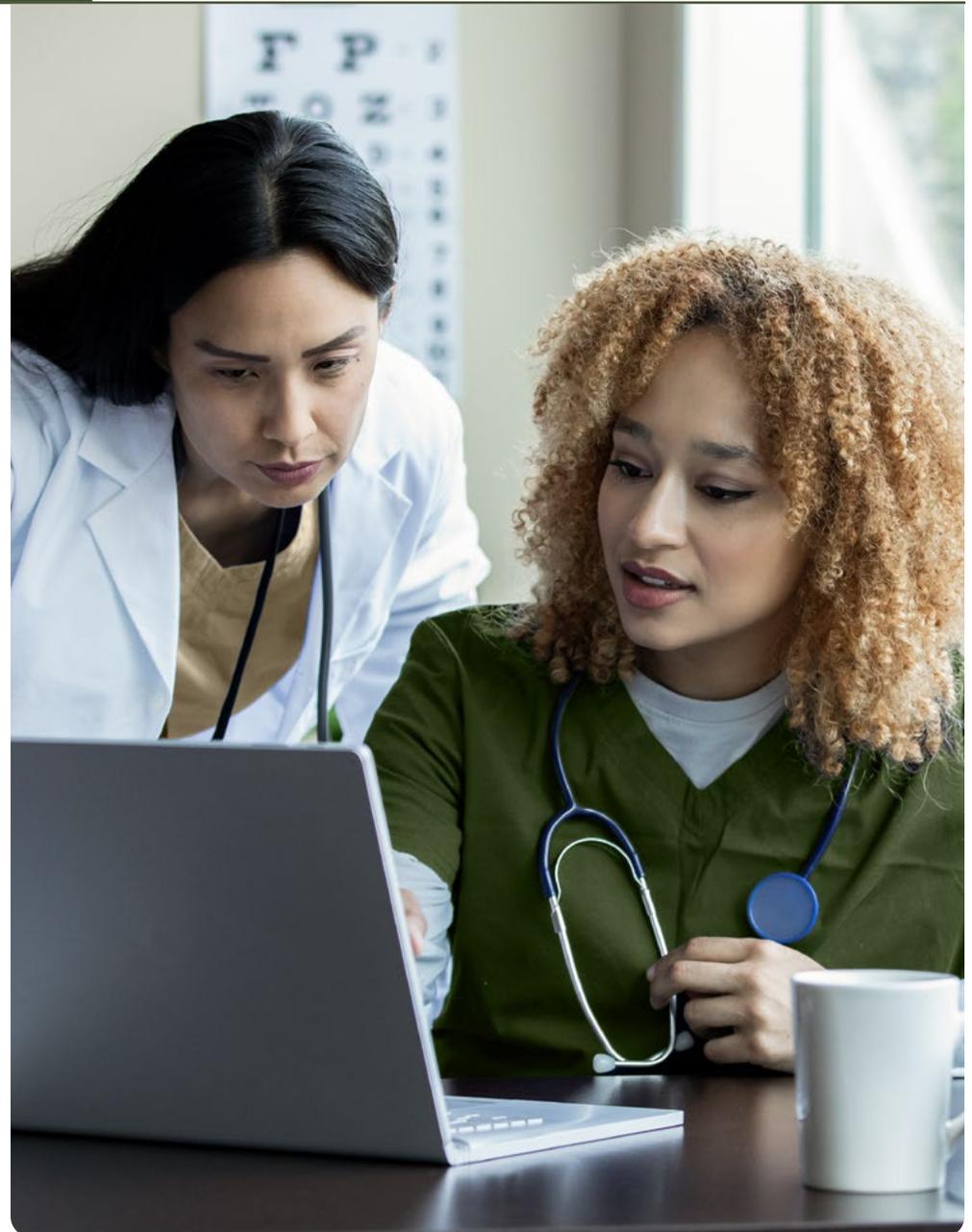# The Imperative of Post-Acute Care Visibility

One of the biggest challenges hospitals face in preparing for TEAM is the lack of visibility into what happens to patients once they leave the hospital. Traditionally, hospitals lose sight of patients as they transition to post-acute care settings. To succeed under TEAM, hospitals must gain real-time insights into their patients' post-acute journey, including their progress in skilled nursing facilities (SNFs) and other care settings.

> Today, hospitals lose sight of patients once they discharge from the hospital and enter post-acute care.

Increasing visibility enables hospitals to:

- Monitor patient progress and identify potential risks
- Proactively intervene to prevent readmissions
- Coordinate care transitions more effectively
- Optimize resource utilization

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Key Strategies for TEAM Preparedness

To thrive under the TEAM model, hospitals must implement a comprehensive strategy that addresses all aspects of post-acute care management to prevent and reduce avoidable and costly readmissions. Key strategies include:

1 **Enhance Care Coordination:** Foster seamless communication and collaboration between hospital staff, post-acute care providers, and patients. This includes sharing relevant patient information, developing coordinated care plans, and conducting regular check-ins.

2 **Improve Discharge Planning:** Implement a robust discharge planning process that identifies patient needs, assesses risk factors, and connects patients with appropriate post-acute care services and resources.

3 **Strengthen Post-Acute Care Partnerships:** Build strong relationships with high-quality post-acute care providers to ensure patients receive the best possible care after discharge.

4 **Leverage Technology:** Implement technology solutions that provide real-time visibility into patient progress in post-acute care settings. Real-time data at the point of care in the emergency department (ED), for example, can prevent unnecessary inpatient admissions. Ensuring ED staff have access to up-to-date patient information, especially current medications and discharge details, can help prevent avoidable inpatient readmissions and guide appropriate care decisions, reducing costly inpatient stays.

Hospitals that implement a robust discharge planning process **can reduce readmissions by up to 30%**, reducing penalties.

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Building Strong Post-Acute Care Partnerships

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Building Strong Post-Acute Care Partnerships

Successful TEAM implementation hinges on strong partnerships between hospitals and post-acute care providers. Hospitals must move beyond phone calls and chasing charts. Before contacting the SNF, care coordinators should already have patient information. True collaboration with SNFs and other post-acute care providers means building relationships over shared data versus phone tag and faxes.
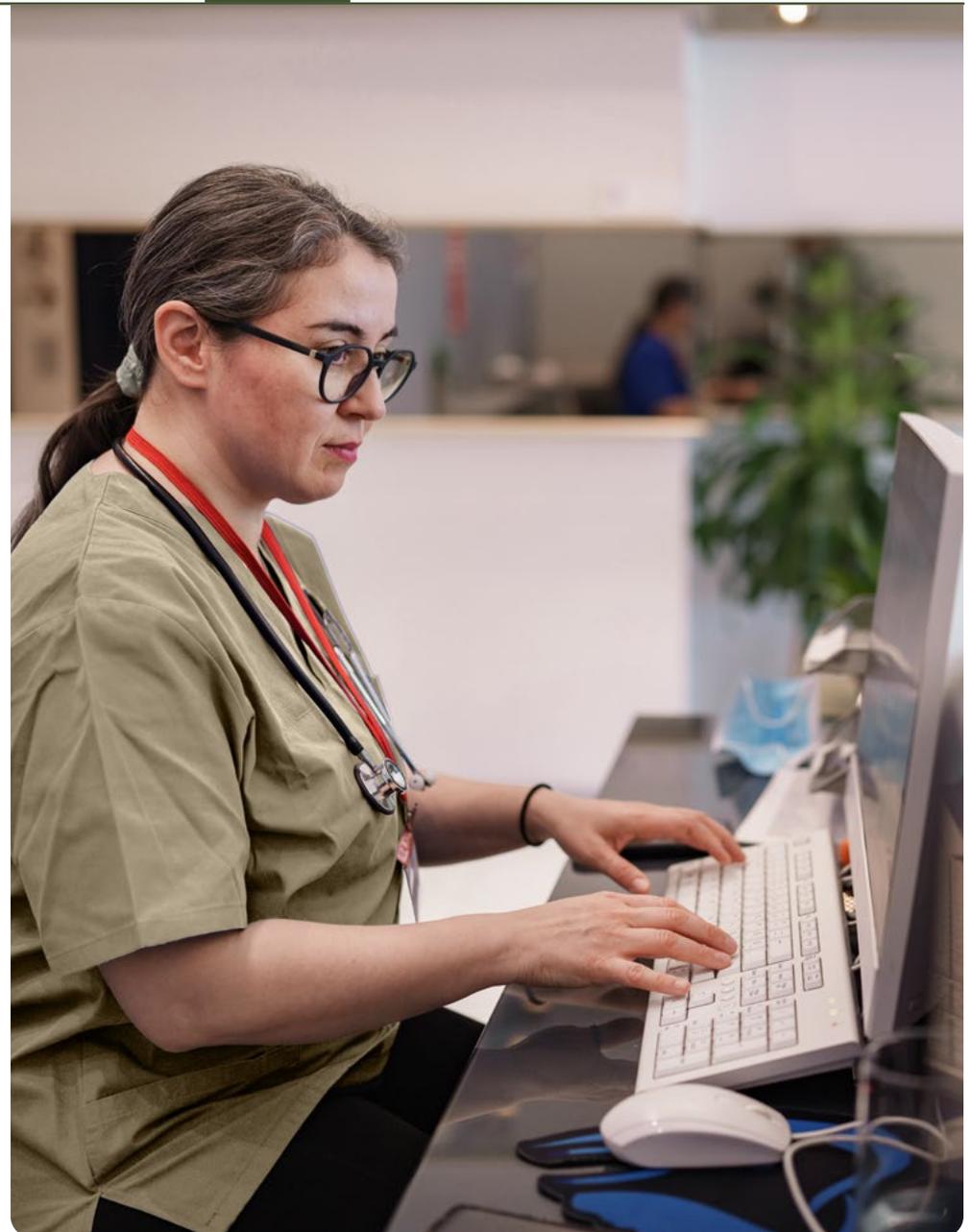
These partnerships should focus on:

- Sharing data and best practices
- Developing joint care plans
- Coordinating care transitions
- Monitoring patient outcomes

Health systems that invest in long-term relationships with SNFs see a 15-20% reduction in post-acute care costs while improving patient satisfaction and quality outcomes (source: National Post-Acute Care Association).
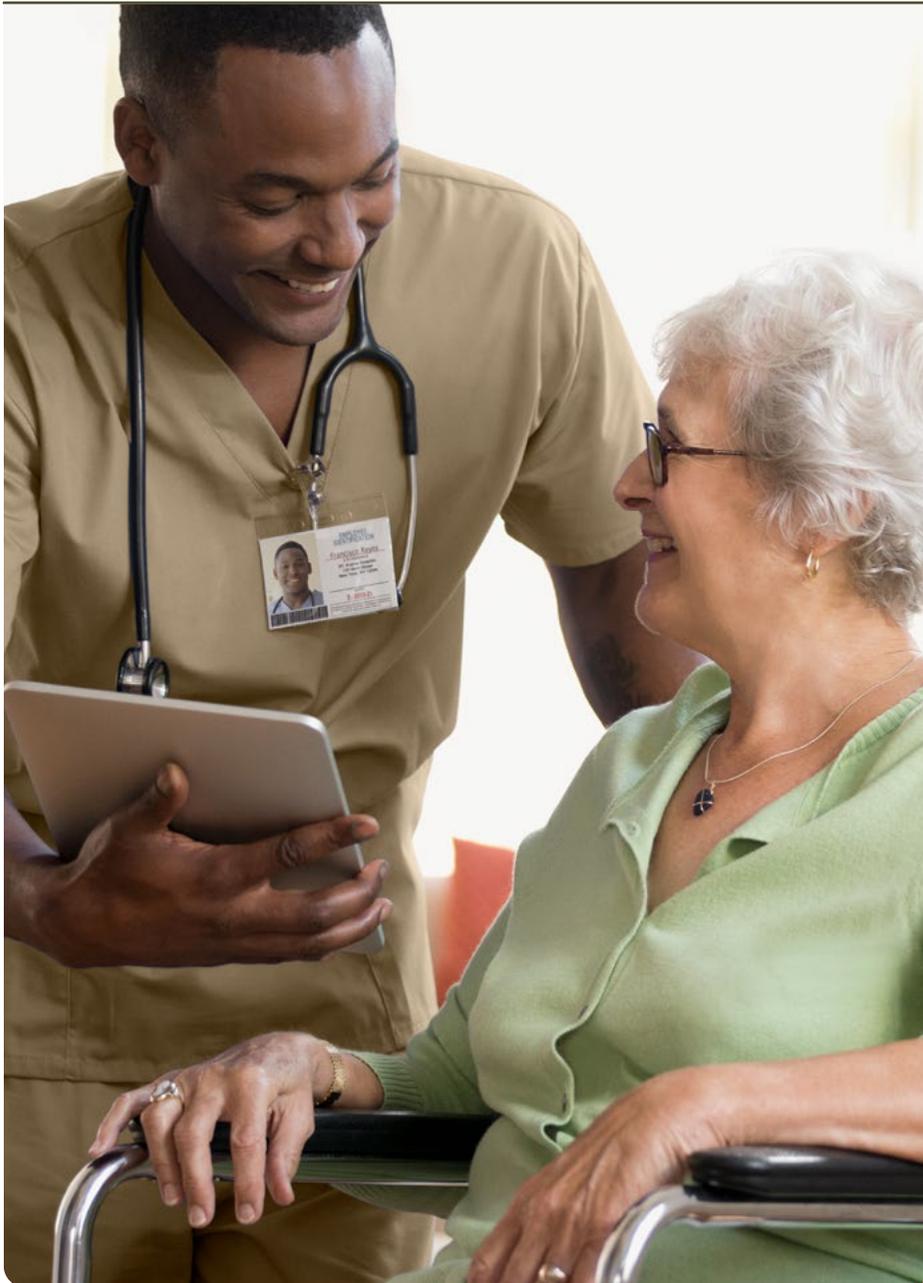
> "With PointClickCare, we were able to look at the multiple skilled nursing facilities' readmissions and length of stay — and move high performers up to the probational tier. We couldn't have expanded our preferred partner network without this real-time data."
>
> **Samantha Caruso,**
> Manager, Ambulatory Care Management, Ascension

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Case in Point:
Success Stories in Reduced Readmissions and Improved Post-Acute Transitions

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Case in Point: Success Stories in Reduced Readmissions and Improved Post-Acute Transitions

TriHealth, an integrated health system and ACO, successfully reduced readmissions and improved post-acute transitions by implementing **PointClickCare's PAC Management** solution. With real-time visibility into their patients' SNF stays, TriHealth was able to proactively intervene on at-risk patients, resulting in an anticipated $8 million annual savings.

> "**PAC Management** helped us to reduce readmissions by 28% and at the same time stimulated more meaningful working relationships with our post-acute partners."
>
> **Lori Baker,**
> Director of Population Health Care Management and Post-Acute Network, TriHealth

Ascension Illinois prevented 109 emergency department visits by proactively identifying medication errors through **PAC Management**—avoiding unnecessary admissions and improving care transitions.

> "During a system outage, **PAC Management** was the only tool my team begged to get back online first. That's how critical it is to our workflow."
>
> **Samantha Caruso,**
> Manager, Ambulatory Care Management, Ascension

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How PointClickCare Can Help

PointClickCare is a leading health tech company with one simple mission: to help providers deliver exceptional care. With an unparalleled post-acute dataset, we power AI driven healthcare solutions that span the patient journey — from basic visibility into patient location and status, to real-time, chart-level data and readmission risk insights, meeting you wherever you are on your value-based care journey.

ED Optimization SNF Stay Summary from PointClickCare empowers ED staff with real-time visibility into recent post-acute encounters, including most recent medications and dosages, directly into your existing ED workflow for more informed, efficient, and appropriate care delivery. Simplified access to the latest SNF encounter data reduces unnecessary tests and admissions and enables more informed and efficient discharge or admit decisions, helping to avoid CMS readmission penalties.

Real-Time SNF Data Supports TEAM-Aligned Decisions

The SNF Stay Summary delivers timely insights—such as recent medications and dosages—directly to ED teams, enabling them to assess whether a patient can be safely returned to a skilled nursing facility (SNF) rather than admitted. This supports safer, more cost-effective care decisions that align with TEAM's 30-day accountability goals.

Workflow-Integrated Insights Drive Measurable TEAM Performance

By embedding SNF encounter data directly within ED systems, the solution reduces documentation burden and enables faster, more informed care. This empowers care teams to reduce readmissions, control episode costs, and optimize SNF network performance—all key TEAM objectives.

PAC Management from PointClickCare arms physicians and care managers with key patient information as they move to post-acute care, enabling TEAM-mandated hospitals to better monitor their post-acute populations. Quickly identify patients of concern, provide timely interventions, and better manage value-based performance.

Real-Time SNF Data Supports TEAM-Aligned Decisions

A real-time Admits and Discharges tool helps actively monitor the post-acute transition process to ensure proper admission at the referred SNF. Easily access and validate completed clinical assessments and med reconciliations. Prevent readmissions from post-acute care with PointClickCare's AI-driven Predictive Return to Hospital, which identifies patients at high or rising risk of readmission by weighing factors like labs, clinical notes, demographics, and food intake. Monitor SNF length of stay to ensure appropriate resource utilization.

Workflow-Integrated Insights Drive Measurable TEAM Performance

A real-time Network Scorecard offers the ability to view key performance metrics, such as 30-day readmission rate and ALOS for SNFs in a hospital's network. Additionally, Quality Insights supports hospitals in tracking and comparing CMS quality metrics, including quality management, health inspection, Staffing 5-Star, and rehospitalization and ED visit rates for PAC providers. This allows enhanced collaboration that helps drive superior performance from post-acute partners.

Ready to improve outcomes with ED Optimization SNF Stay Summary?
Scan or click QR code to discover more

Ready to improve outcomes with PAC Management?
Scan or click QR code to discover more

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Illuminating the Post-Acute Black Hole:
The Critical Role of Data, AI, and Predictive Analytics

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Illuminating the Post-Acute Black Hole: The Critical Role of Data, AI, and Predictive Analytics

Post-acute care has long been a "black hole" for hospitals—an area of uncertainty that's difficult to navigate and even harder to manage. With the TEAM mandate, this blind spot is no longer sustainable. Hospitals must leverage data and predictive analytics, not just as a tool, but as a necessity.By analyzing patient data, hospitals can identify at-risk patients, assess emerging trends, and develop proactive interventions. Predictive analytics becomes the key to preventing readmissions and costly adverse events, turning uncertainty into actionable insight and giving care teams the foresight they need to prevent negative outcomes before they happen.

Real-time hospital readmission risk scores are informed by PointClickCare's AI-driven Predictive Return to Hospital (pRTH) model, trained from the largest senior care dataset in North America. This helps care teams zero in on patients requiring immediate attention, allowing for proactive care collaboration between acute and post-acute settings.

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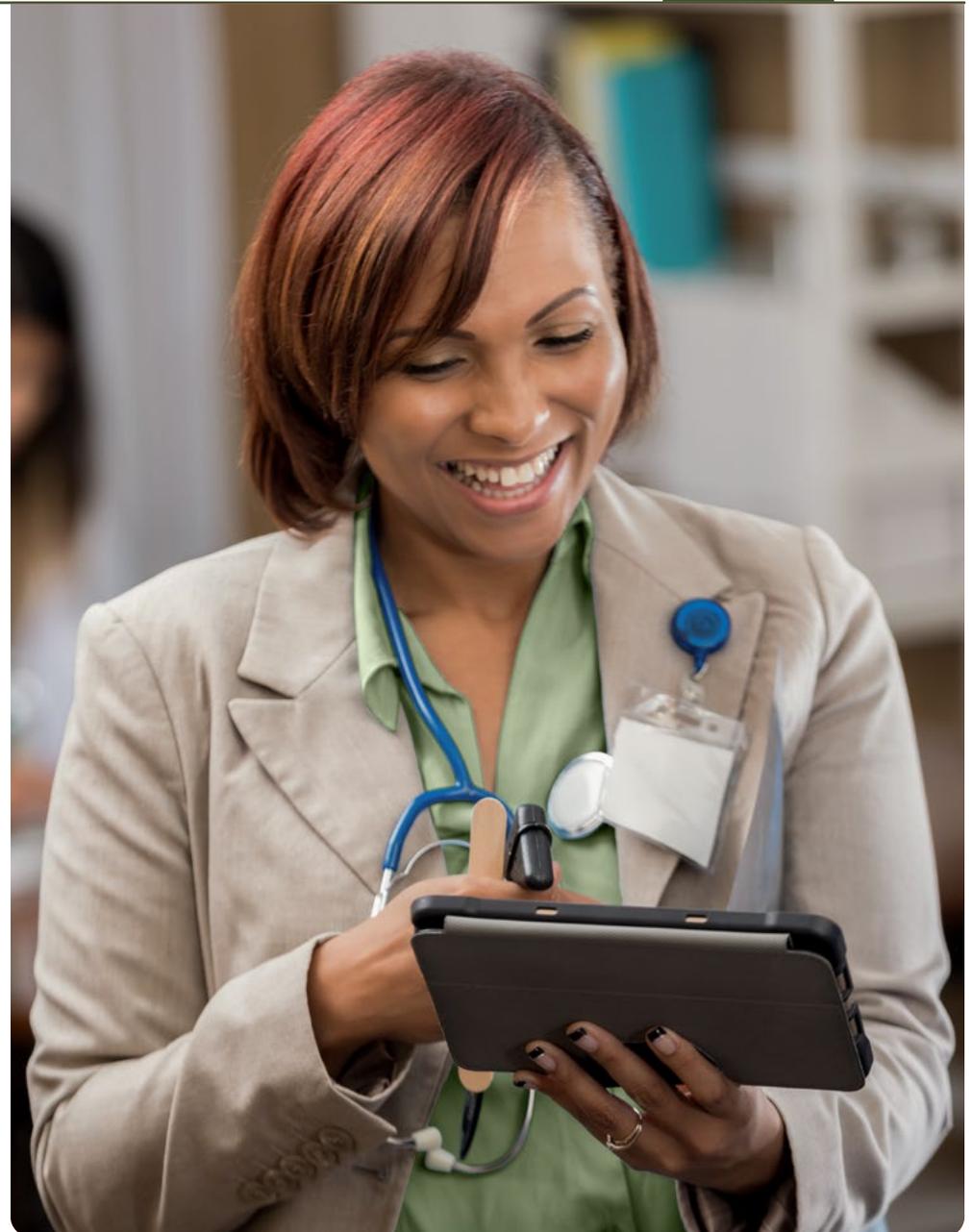
Conclusion: Embracing Value-Based Care

The TEAM model represents a significant shift towards value-based care, holding hospitals accountable for the total cost and quality of care for Medicare fee-for-service patients. By preparing for TEAM, hospitals can manage post-acute care costs, prevent negative outcomes, and drive better results in this new era of value-based care.

Learn More

Your Solution to Key Priorities and Opportunities for Innovation in Navigating TEAM

If you're ready to learn more about leveraging technology for real-time visibility into to critical information needed to meet time-sensitive quality measures, request a demo today.

Book a Demo

Sources:

$10 Billion Expected for Performance-Based Incentive Payments Under the TEAM Model

The Centers for Medicare & Medicaid Services (CMS) allocated $10 billion for the operation of the Center for Medicare and Medicaid Innovation (CMMI) from 2011 through 2019, with an additional $10 billion allocated for each subsequent decade. These funds are designated for testing and evaluating healthcare payment models aimed at lowering program expenditures while maintaining or enhancing the quality of care.
https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/

25% of All Medicare Patients Readmitted After Discharge, Costing Hospitals Billions Annually

Hospital readmissions have been associated with adverse outcomes and elevated financial costs to patients, families, and hospitals across the United States. Historically, nearly 20% of all Medicare discharges had a readmission within 30 days.
https://pmc.ncbi.nlm.nih.gov/articles/PMC4439931/

Hospitals That Implement Robust Discharge Planning Reduce Readmissions by Up to 30%

Implementing a robust discharge planning process can reduce readmissions by up to 30%, improving Star Ratings and reducing penalties.
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798623

15–20% Reduction in Post-Acute Care Costs from Long-Term Relationships with SNFs

Health systems that invest in long-term relationships with skilled nursing facilities (SNFs) see a 15–20% reduction in post-acute care costs while improving patient satisfaction and quality outcomes.
https://www.aapacn.org/resources/post-acute-care-news/

68% Reduction in Readmissions, 28% Reduction in SNF Length of Stay from TriHealth's Use of PAC Management

TriHealth, an integrated health system and accountable care organization (ACO), successfully reduced readmissions and improved post-acute transitions. By implementing PointClickCare's PAC Management solution, TriHealth gained real-time visibility into their patients' progress in skilled nursing facilities (SNFs), enabling them to proactively intervene and prevent readmissions.
https://pointclickcare.com/resource/hospital-health-systems-software/customer-success/trihealth-pac-management/

Transforming Episode Accountability Model (TEAM) | CMS

Characteristics of 30-Day All-Cause Hospital Readmissions, 2016-2020

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