eBook

The Invisible Cost of Status Quo: Why Hospital and Health Systems Can No Longer Afford Post-Acute Blind Spots

A Cost-Benefit Analysis for Healthcare Leaders Featuring Documented Customer Outcomes, Quantified Savings, and Real-World Post-Acute Performance Results.

Get Started

PointClickCare®

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Introduction

The regulatory landscape has fundamentally changed. As of 2026, Medicare has fully shifted toward value-based care models, and for the first time, the Transforming Episode Accountability Model (TEAM) is mandatory—with no opt-out. Yet most hospitals continue managing one of their highest-cost, highest-risk patient segments without real-time visibility: **the transition from acute to post-acute care.**

The question is no longer whether to invest in post-acute visibility. It's whether your organization can afford not to. This business case goes beyond theory—drawing on real-world performance data and documented results from health systems that have reduced readmissions, shortened skilled nursing facility (SNF) length of stay (LOS), and lowered post-acute costs.

The Regulatory Shift to Value-Based Care

The Regulatory Shift

Mandatory value-based care by 2026. TEAM is mandatory—with no opt-out.

The Challenge

Most hospitals continue managing high cost, high risk transitions from acute to post-acute care without real-time visibility.

Can your organization afford not to invest in post-acute visibility?

Real world performance data and documented results show health systems successfully achieving:

- Reduced Readmissions
- Shortened SNF Length of Stay
- Lowered Post-Acute Costs

The True Cost of Opacity: The Hidden Costs Accumulating Daily

Post-acute visibility gaps don't show up as a single line item—but they surface every day in preventable readmissions, inflated post-acute spend, and manual work that consumes clinical time. As value-based accountability intensifies, these hidden costs increasingly translate into direct financial exposure.

Preventable Readmissions You Can't See Coming

Without visibility into how patients are progressing in skilled nursing facilities, clinical deterioration goes undetected until it becomes a costly hospital readmission. The Hospital Readmissions Reduction Program caps penalties at 3% of all Medicare fee-for-service payments—and CMS is tightening the screws. By including Medicare Advantage patients in 2027 calculations, an estimated 75-82% of hospitals will face some penalty.

The American Hospital Association warns: "Timely access to post-acute care can be a key determinant in how a patient recovers and, therefore, the likelihood of readmission." Yet most care teams operate without that access.

> "Timely access to post-acute care can be a key determinant in how a patient recovers and, therefore, the likelihood of readmission."

Source: CMS; Advisory Board; American Hospital Association

Hidden Costs of Limited Post-Acute Visibility

Preventable Readmissions

Clinical deterioration goes undetected in SNFs

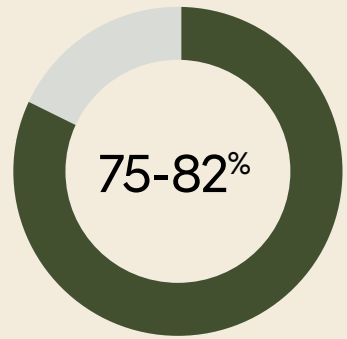
Inflated Post-Acute Spend

Unnecessary LOS and avoidable utilization

Manual Work and Delays

Care teams chase updates instead of acting on them

2027 Readmission Calculation



of hospitals may face penalties, when Medicare Advantage patients are included in the 2027 readmission penalty calculations

The Strategic Imperative: Three Reasons for "Why Now?"

Regulatory Pressure Is Mounting

- **TEAM Now Mandatory:** Hospitals are currently assuming financial risk for five 30-day surgical episodes under the mandatory TEAM model, with no opt out.
- **Readmission Penalties Increasing:** The number of hospitals facing penalties of 1% or more rose for the first time in five years.
- **Medicare Advantage Inclusion:** By 2027, MA patients will be included in readmission calculations, driving penalties higher.

Financial Stakes Are Higher

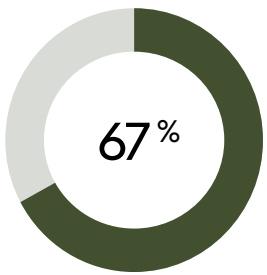
Post-acute performance now represents one of the most controllable drivers of financial exposure under value-based care. A single hospital readmission costs an average of **$15,100**, making even modest increases in preventable readmissions financially consequential at scale. At the same time, **SNF length of stay varies widely**, with average SNF stays ranging from **roughly 20 to more than 35 days** across markets—often driven less by clinical need than by limited visibility into patient progress and discharge readiness. Together, avoidable readmissions and extended SNF stays compound total episode costs and directly erode margins under two-sided risk models.

Source: Guidehouse; MedPAC; Milliman

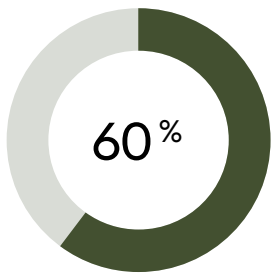
Workflow Efficiency Outweighs "Nice-to-Have" Tools

67% of leaders prioritize workflow efficiency, and **60% rank EHR optimization as a top technology initiative—yet only 17% believe their EHR meets future needs.**

Leaders are looking beyond the EHR for solutions that improve workflows and provide external post-acute data their current systems don't deliver.



of leaders prioritize workflow efficiency



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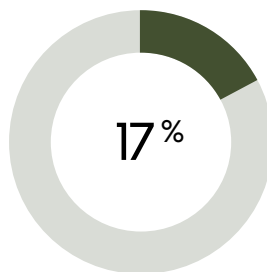
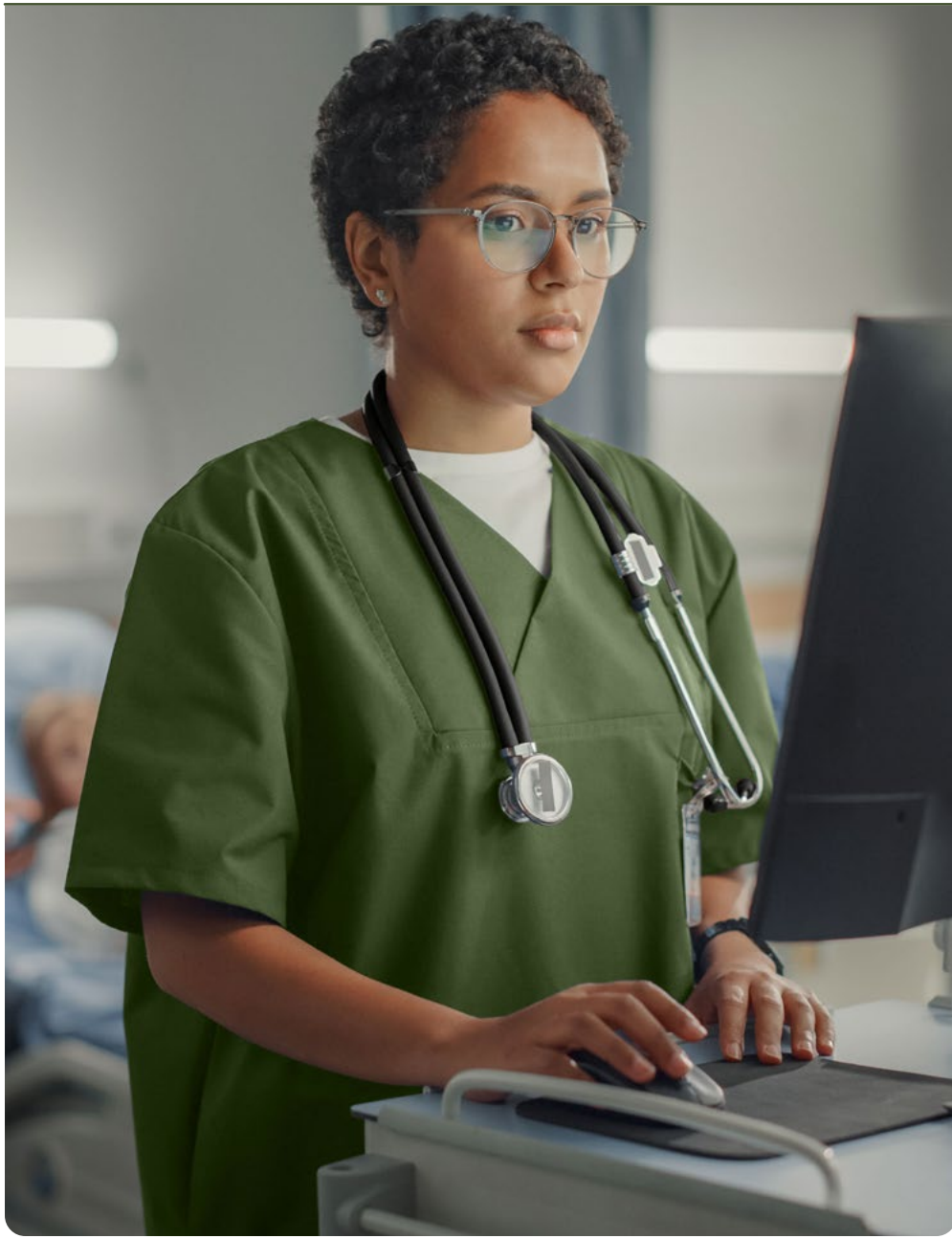


believe their EHR meets future needs.



The Cost of Inaction

Without solving post-acute opacity, leadership is implicitly accepting:

- Readmission rates materially higher than necessary
- Prolonged and variable SNF length of stay
- Preventable ED visits
- Care managers consumed by clerical work
- Weak SNF partnerships due to limited shared insight
- Shared data blind spots with payers, both relying on timely post-acute insight to manage risk and cost

Source: CMS; JAMA Network

Average hospital readmission costs $15,100 per readmission

+

SNF Length of Stay 20-35+ days, with variability across markets

+

Compounding higher episode costs under two-sided risk models

The Case for Visibility: Proven Cost Savings and Clinical Impact

Leading health systems have not only improved outcomes but translated post-acute visibility into measurable financial savings.

Health System	Key Metric	Result	Financial / Utilization Signal
TriHealth	Readmissions	Patient information arrives in a summarized notification at the point of care	Within seconds of registering, ED staff receive automated summary of notifications directly in ED track board
Sentara Health	Post-acute costs	24.6% decrease	$2,900 saved per patient
Tandigm	SNF visibility	From 50% to > 95% SNF visibility	16.7% reduction in overall readmissions
Ascension Illinois	ED utilization	109 visits prevented	Avoided ED costs: Fewer unplanned ED encounters and acute-care costs
Lehigh Valley	Care team time	Streamlined post-acute coordination workflows	Reclaimed clinical hours: Increased clinical capacity without added headcount

Source: PointClickCare customer case studies; CMS Innovation Center

What These Organizations Did Differently

TriHealth

TriHealth: Early Detection Prevents Expensive Readmissions

By gaining reliable, real-time visibility into post-acute transitions across a 200+ SNF network, TriHealth achieved a **7-point reduction in SNF-related readmissions (from 25% to 18%)** and **28% shorter SNF length of stay.**

The benefit: Fewer penalties, lower total cost of care, faster patient throughput, and improved quality scores.

SNF-Related Readmissions

25% ➡ 18%

SNF Length of Stay

⬇ 28%

Sentara

Sentara Health: Clearer Discharge Pathways Reduce Waste

When hospital and SNF care managers share real-time status updates from patients discharged from acute setting to skilled nursing facilities, discharge barriers become visible—and manageable. Sentara reduced **post-acute patient costs by 24.6%**, with in-network costs decreasing from **$11,800 to $8,900.**

The benefit: Optimized SNF lengths of stay, reduced unnecessary days, and stronger financial performance under value-based contracts.

Post-Acute Patient Costs

⬇ 24.6%

In-Network Costs Decrease

$11,800 ➡ $8,900

Ascension

Ascension Illinois: Catching Deterioration Before It Escalates

In many systems, ED visits are the first moment anyone outside the SNF discovers a problem. By making clinical changes visible earlier, Ascension Illinois recorded **109 avoidable ED visits in a single year**.

The benefit: Lower utilization costs, reduced ED burden, improved patient safety.

109

Avoidable ED visits in a single year

tandigm

Tandigm Health: Turning SNF Visibility into Fewer Readmissions

Delayed claims data and limited visibility into SNF admissions, patient progress, and discharge timing forced care teams into a largely reactive approach to readmission management. With Predictive Return to Hospital (pRTH), care management nurses now identify patients immediately upon admission and use AI driven readmission risk scores to prioritize outreach and guide multidisciplinary collaboration with SNF clinicians.

The benefit: Earlier intervention without added staff and measurable readmission reductions, including improvement across both partner and non-partner SNFs.

AI driven readmission risk scores to prioritize outreach and guide multidisciplinary collaboration with SNF clinicians.

Lehigh Valley Health Network

Lehigh Valley Health Network: Returning Time to Clinicians

Highly trained care teams were spending hours per week tracking down basic patient updates. With consolidated, real-time visibility, Lehigh Valley reported **major time savings and improved collaboration**, replacing hours of manual outreach spent "navigating in the dark."

The benefit: Increased clinician capacity, reduced burnout, better care team morale.

Major time savings and improved collaboration

PeaceHealth

PeaceHealth: Proactive Risk Management Across Three States

Operating across Alaska, Washington, and Oregon, PeaceHealth improved coordination and proactive risk management by using **real-time post-acute insights to streamline transitions and guide early intervention.**

The benefit: Consistent quality across geographically dispersed networks, earlier clinical interventions, stronger SNF partnerships.

Real-time post-acute insights to streamline transitions and guide early intervention

Moving Beyond Status Quo: The PAC Management IQ Solution

Every health system leader now faces a foundational question: Do we want to continue managing one of our most expensive and variable segments of care without timely visibility—or do we want post-acute episodes to be as observable and influenceable as inpatient care?

What PAC Management IQ Delivers

PAC Management IQ is a proven solution that empowers care teams with real-time visibility into patient transitions, enabling proactive interventions and stronger collaboration across the care continuum.

How It Works

- **Unified Post-Acute Visibility:** Real-time, EHR-level signals from SNFs—including those outside preferred networks—so discharge planners, case managers, and 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, minimizing duplicate data entry.
- **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 Bottom Line: A Cost-Benefit Calculation You Can't Ignore

The Cost of Status Quo

- Readmission penalties capped at 3% of all Medicare payments, with 75-82% of hospitals projected to face penalties by 2027
- $27.2-$78.2 billion wasted annually on care coordination failures
- 64% of organizations using manual workarounds, consuming clinical hours on administrative tasks
- 71% of leaders struggling with post-acute data gaps, the most critical and least accessible data source

The Benefit of Visibility: Quantifiable

- 28% shorter SNF length of stay
- Reduction in post-acute costs
- Thousands saved per rehospitalization avoided
- Fewer avoidable ED visits annually
- 28% reduction in overall readmissions
- 95%+ visibility into SNF stays

Take Action: Your Next Step

The organizations cited in this brief made a deliberate shift toward real-time insight, and the measurable results speak for themselves.

PAC Management IQ is a proven solution that directly addresses transition blind spots, reduces readmissions, and lowers the total cost of care. By making this investment, your organization can strengthen value-based care outcomes, improve patient safety, and realize substantial cost savings.

Ready to Move Beyond the Status Quo?

Request a personalized Data Visibility Report to benchmark your organization against national and state peers and pinpoint where improved post-acute visibility can reduce readmissions, speed transitions, and protect revenue.

Get Your Personalized Data Visibility Report

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PointClickCare

Aggregated customer data and de identified case studies evaluating post-acute visibility, readmissions, length of stay, and care coordination efficiency
https://pointclickcare.com

Attribution Note

Customer results reflect outcomes achieved by individual organizations and may vary based on implementation approach, network composition, patient populations, and care models. Proprietary performance metrics are based on aggregated PointClickCare customer data.

PointClickCare is a leading health tech company with one simple mission: to help providers deliver exceptional care. With the largest long-term and post-acute care dataset, we power AI-driven healthcare to deliver intelligent transitions, insightful interventions, and improved financial performance. Enhanced by our Marketplace of 400+ integrated partners and trusted by over 30,000 provider organizations and every major U.S. health plan, we're redefining healthcare, so it doesn't just survive — it thrives.

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