

Winning in TEAM: A Practical Checklist for Cost and Quality Control

The Transforming Episode Accountability Model (TEAM) holds selected hospitals accountable for the total cost and quality of surgical episodes beginning in 2026. This includes the 30 days following discharge, making post-acute management the decisive lever for financial and quality performance.

This checklist distills what it takes for selected hospitals and their partners to succeed: real-time visibility into active SNF stays, actionable clinical context for proactive outreach, network scorecards to steer placement, and ED SNF-transfer workflows that safely avoid unnecessary admits. Because post-acute spending can reach up to 53% of total episode costs (source: ATI Advisory), the biggest wins come from preventing readmissions, controlling length of stay, and closing 48-hour post-discharge follow-up loops with partners.

For a full educational primer on TEAM, see the companion [“Navigating TEAM eBook”](#) which explains the model, its impact, and strategies for post-acute success with real-world examples. Then, apply this phased plan and its defined success metrics, which cover governance, data-sharing foundations, length of stay guardrails, daily huddles, and network reviews.

Your Goal: Be ready on Day 1 to hit target prices by preventing avoidable readmissions, controlling post-acute length of stay, and smoothing cross-continuum handoffs between acute and post-acute.

Post-Acute “Must-Haves”



Real-time visibility to who is in the SNF today, with LOS counters, risk indicators, and 72-hour admit/discharge views.



Actionable clinical context (including vitals, meds, therapy notes, progress notes) to support proactive outreach.



Network scorecards to benchmark facilities, drive placement decisions, and improve plans.



ED SNF transfer workflow with summarized SNF insights at registration to reduce unnecessary admits.



ACO coordination (including alerts, cohorts, shared care plans) so partners close loops within 48 hours.

Phase 0: Pre-Implementation Readiness (3-6 months before go-live)

Action Item	Detail	Suggested Owner/ Champion	Progress Notes
Review historical performance vs target prices	By August, you should have your TEAM procedure target prices in hand. Use them to benchmark your historical performance and identify cost drivers. Focus on high-impact areas such as readmissions, SNF length of stay, and post-acute utilization patterns. This analysis will inform where to prioritize interventions before go-live.	CFO, Data Analytics Lead	
Appoint leadership and governance	Name an executive sponsor and a day-to-day program lead. Stand up a cross-functional “TEAM room” (surgery service lines, case management, ED leadership, finance, IT/data, compliance, post-acute relations).	CEO, Board of Directors	
Quantify baseline exposure	Pull episode volumes for TEAM surgical procedures, baseline inpatient LOS, SNF ALOS, 7- and 30-day readmission/ED return rates, and current post-acute spend patterns. Use this to size variance vs. target prices and prioritize service lines.	CFO, Actuarial/ Finance Team	
Map your post-acute footprint	Inventory every post-acute partner receiving your discharges using tools like PAC Management . Capture quality, readmissions, ED transfers, therapy intensity, and documentation timeliness to identify “keep, improve, or replace” candidates.	VP Care Coordination, COO	
Lock in data and legal foundations	Execute/refresh data-sharing agreements with network SNFs and HHAs; confirm ADT, CCD/clinical summaries, and secure, role-based access for care managers. PointClickCare can help facilitate through Network Activation.	CIO, Compliance/ Legal Lead	

Phase 0: Pre-Implementation Readiness (continued) (3-6 months before go-live)

<p>Stand up care collaboration enabling technology</p>	<p>Post-acute visibility and collaboration: Real-time census and clinical context for active SNF stays; admit/discharge feeds; daily LOS view; readmission-risk flags; network scorecards using PAC Management.</p> <p>ED point-of-care insight for SNF transfers: An at-registration “SNF stay summary” view (facility, recent meds, diagnoses) surfaced in your ED workflow to reduce unnecessary admits and speed safe return-to-SNF when appropriate.</p> <p>ACO/population coordination: Real-time discharge alerts, cohorting, and shared care plans so ACO partners can close loops within 48 hours post-discharge. VBC for ACOs from PointClickCare can be used for this purpose.</p>	<p>CIO, Care Management IT Lead</p>	
<p>Define success metrics and dashboards</p>	<p>Choose a small, durable set: episode cost vs. target price, SNF ALOS by facility, 30-day readmits from SNF, 72-hour follow-up completion, preventable ED returns, and discharge-planning timeliness.</p>	<p>Quality/Patient Safety Lead, CIO</p>	

Phase 1: Design and Contracting (2-3 months before go-live)

Action Item	Detail	Suggested Owner/Champion	Progress Notes
<p>Post-procedure recovery pathways</p>	<p>For TEAM procedures, codify criteria for site-of-recovery (home, home health, SNF), required education, equipment, and milestone-based SNF LOS “guardrails.”</p>	<p>CIO, Care Management IT Lead</p>	
<p>Select and align a preferred post-acute network</p>	<p>Set clear quality metric thresholds (e.g., rehospitalization, ED visits, staffing/therapy indicators). Build joint improvement plans, monthly data reviews, and escalation paths for outliers.</p>	<p>Quality/Patient Safety Lead, CIO</p>	

Phase 1: Design and Contracting (continued)
(2-3 months before go-live)

<p>Explore gainsharing arrangements with preferred SNFs</p>	<p>As you finalize your preferred post-acute network, evaluate whether gainsharing agreements make sense to align incentives. These arrangements can reward SNFs for meeting quality and efficiency benchmarks—such as reducing readmissions, shortening LOS, and improving documentation timeliness—while helping your hospital manage downside risk under TEAM.</p>	<p>CFO, Legal/ Compliance Lead</p>	
<p>Operationalize high-risk cohorts</p>	<p>Pre-define “watch lists” (e.g., high risk of rehospitalization, >10 days SNF LOS, complex meds, new dialysis) and establish proactive rounding expectations for case managers.</p>	<p>Population Health/ Case Management Lead</p>	
<p>Define proactive interventions for rising-risk patients</p>	<p>Agree on specific escalation steps for patients showing early signs of deterioration before an ED transfer becomes necessary. These interventions (such as rapid clinical review, telehealth consults, or intensified SNF rounding) should be standardized and documented in your care pathways.</p>	<p>Population Health/ Clinical Ops Lead</p>	
<p>Engineer the SNF-to-ED loop</p>	<p>Define ED intake protocols for SNF arrivals (rapid med list, diagnosis history, risk indicators), standardize return-to-SNF criteria, and script warm line workflows to the facility to avoid unnecessary inpatient admits.</p>	<p>VP Care Coordination, Nurse Navigator</p>	

Phase 2: Build and Test (1-2 months before go-live)

Action Item	Detail	Suggested Owner/ Champion	Progress Notes
Integrate and validate the data flows	Confirm live SNF census, admissions/discharges, and clinical signals are landing in care manager tools; verify the ED SNF summary displays at registration; test alerting and routing.	CIO, Data Analytics Lead	
Table-top and shadow rounds	Run scenario drills (e.g., post-op complications day 9 in SNF; ED arrival day 18 from SNF). Validate handoffs, escalation, and documentation across hospital-SNF-ED.	CMO, Nursing Leadership, Quality Lead	
First network performance review	Meet with top SNF partners; align on LOS guardrails, documentation timeliness, and shared readmission-reduction tactics for go-live.	CEO, COO, Population Health Lead	

Phase 3: Go-Live to Day 90

Action Item	Detail	Suggested Owner/ Champion	Progress Notes
Run the daily huddle	Review active post-acute stays, high-risk flags, and approaching LOS guardrails; remove barriers with SNF partners in real time.	Nursing Leadership, Case Management	
Protect the ED front door	For SNF transfers, leverage SNF stay summary (active meds, primary diagnosis, etc.) at triage to help prevent admissions where possible; coordinate with the facility to treat and return when clinically appropriate.	ED Medical Director, Nursing Leadership	
Weekly cross-continuum case review	With top SNFs, dissect readmissions/ED returns and agree on corrective actions; adjust placement and pathways based on findings.	Care Coordination, Social Work Lead	

Phase 4: Quarterly and Year-End (Ongoing)

Action Item	Detail	Suggested Owner/ Champion	Progress Notes
Reconcile performance vs. target price	Quantify performance drivers (e.g., readmissions from SNF, SNF ALOS variance, ED return patterns). Update service-line and network playbooks accordingly.	CFO, Data Analytics Lead	
Tune the network	Expand or right-size the preferred post-acute network based on performance; renegotiate expectations; add home health partners as indicated.	COO, VP Care Coordination	
Prepare for Year-2 downside risk	Stress-test negative scenarios, set internal stop-loss guardrails, and scale interventions that showed ROI in Year 1.	CFO, CEO	

About PointClickCare

PointClickCare is a leading health tech company with one simple mission: to help providers deliver exceptional care. With the largest network of acute and long-term and post-acute care (LTPAC) data, we power AI-informed healthcare for intelligent care transitions and improved clinical outcomes that drive reimbursement. Enhanced by an ecosystem of integration partners that unite care, billing, and operations, our solutions unify care, empower faster evidence-based decisions, and deliver measurable impact. It's why we're trusted by over 30,000 provider organizations and every major U.S. health plan. We're building a stronger, leaner healthcare system that lasts.