PointClickCare®

Winning in TEAM

How One Health System Built the Post-Acute Foundation for TEAM Success

This health system moved beyond one-off interventions by building a scalable post-acute foundation grounded in visibility, prioritization, and shared accountability. The result was more consistent execution across episodes, facilities, and value-based programs.

The Challenges

- ☒ Limited visibility once patients transition to SNFs
- ☒ Fragmented coordination with post-acute partners
- ☒ Insufficient time to intervene before LOS/readmissions escalate
- ☒ Financial exposure to readmissions, excess LOS, and performance variation

The Solutions

Four Foundational Pillars

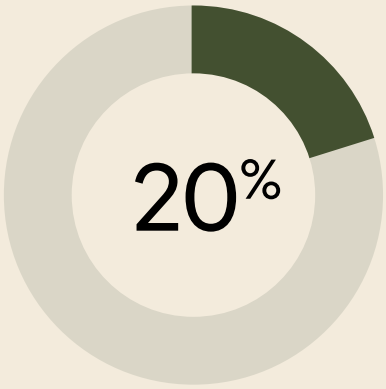
- ☑ Real-time post-acute visibility
- ☑ Performance-driven SNF network
- ☑ Proactive, data-driven care coordination
- ☑ Emergency department optimization to prevent inpatient admissions

The Results

- ☑ 2-day SNF LOS reduction (25 → 23 days)
- ☑ Trajectory toward 20-day target
- ☑ 4-6 days below 27.4-day industry average
- ☑ Same workflows managing TEAM + tens of thousands of ACO lives
- ☑ 3-person team managing statewide operations

Why TEAM Demands a New Approach

The Transforming Episode Accountability Model (TEAM) expands hospital accountability across the **entire 30-day episode,** making post-acute performance a primary driver of cost and quality.

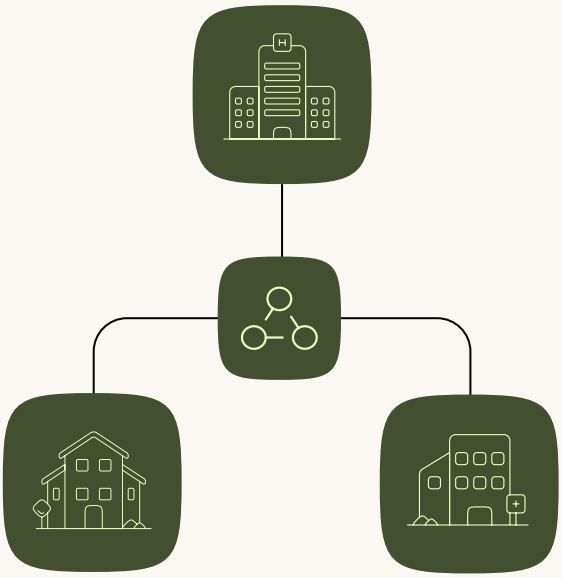


TEAM raises the stakes:

After the glide year, hospitals face up to **20% upside or downside risk.**

The Execution Gap:

Success under TEAM now requires active management after discharge and strong coordination with post-acute providers. For many hospitals, the challenge is not understanding the model. It is **putting it into practice at scale.**



A Four Pillar Solution Enabled by PointClickCare

With insights from a post-acute operations leader at a leading health system

Pillar 1:

Real-Time Post-Acute Visibility

Enabled by PAC Management IQ

- ☑ Live SNF census across all active stays
- ☑ Centralized access to therapy notes, nursing notes, vitals, and medications
- ☑ AI-driven readmission risk indicators
- ☑ Daily length-of-stay tracking to surface risk early

Impact: Care teams know where patients are and how they are doing without phone calls or faxes.

> The teams can go in and see therapy notes, nursing notes, and readmission risk flags, making it easier to identify patients who may need intervention and follow up with SNF partners.

Pillar 2:

Performance-Driven SNF Network Management

Enabled by Enterprise-Wide SNF Visibility

- ☑ Preferred network of 40+ SNFs with defined performance thresholds
- ☑ LOS targets, readmission standards, and care expectations
- ☑ Value-based incentives aligned to performance
- ☑ Visibility maintained across **all 200+ SNFs statewide**, not just preferred partners

Impact: This health system uses data to influence outcomes while helping ensure no patient falls through the cracks.

> The care teams are able to track length of stay and return-to-hospital trends and use that data to support more informed conversations with network facilities.

Pillar 3:

Proactive, Data-Driven Care Coordination

Enabled by Shared Clinical and Risk Insights

- ☑ Daily huddles informed by real-time SNF data
- ☑ Prioritization of patients nearing LOS or readmission risk thresholds
- ☑ Early outreach to SNF partners when risk increases
- ☑ Shared data supports constructive, collaborative conversations

Impact: Teams intervene sooner, helping avoid premature discharge while reducing unnecessary SNF days.

> Teams managing large patient populations can quickly identify which patients are a priority based on real-time risk and length of stay trends.

Pillar 4:

Emergency Department Optimization to Prevent Inpatient Admission

Enabled by Emergency Department IQ

- ☑ AI-powered SNF stay summaries visible at ED registration
- ☑ Recent clinical notes, diagnoses, and medication history in one view
- ☑ Provider-to-provider workflows support rapid decision-making
- ☑ Safe evaluation and return of TEAM patients to SNFs when appropriate

Impact: This helps prevent avoidable inpatient admissions during the episode window.

The Results: Measurable Impact

- ☑ Same workflows now support **TEAM episodes and tens of thousands of ACO lives**
- ☑ Performance approaching **top-quartile benchmarks**
- ☑ SNF length of Stay **– 2 Days** from 25 to 23 days, targeting 20 vs. Industry benchmark **4-6 days** below 27.4-day average

Takeaway: The impact grows as volume scales. With the right foundation in place, hospitals can apply the same model across multiple value-based arrangements.

Why This Matters

This health system's experience shows that sustainable TEAM performance depends on **infrastructure, not heroics:**

- Persistent post-acute visibility
- Coordinated action across care settings
- Early risk identification
- Scalable workflows serving multiple programs

A not-for-profit integrated health system.

Learn More

See how PointClickCare helps hospitals maintain post-acute visibility, extend insight into the ED, and intervene earlier to protect episode performance under TEAM and beyond.

Emergency Department IQ

Explore PAC Management IQ >

PointClickCare®