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Educational Webinar Series

Strategizing for TEAM success: A cross-continuum guide to smarter episodic management

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Transforming Episode Accountability Model (TEAM)

TEAM requires acute care hospitals to be responsible for the cost and quality of care for Medicare beneficiaries undergoing specific surgical procedures as well as the the 30-day post-discharge period.

Participation from January 1, 2026, through December 31, 2030

TEAM Surgical Episodes of Care		
Surgical Episode Category	**IPPS MS-DRGs**	**OPPS HCPCS Codes**
Coronary Artery Bypass Graft (CABG) Includes both elective CABG and procedures performed during initial AMI treatment.	231 - 236	
Lower Extremity Joint Replacement (LEJR) Includes hip, knee, or ankle replacement.	469, 470, 521, 522	27447, 27130, 27702
Major Bowel Procedures Includes any small or large bowel procedure.	329 - 331	
Surgical hip/femur fracture treatment (SHFFT)	480 - 482	
Spinal Fusion Includes any cervical, thoracic, or lumbar spinal fusion procedure.	402, 426 - 430, 447, 448, 450, 451, 471-473	22551, 22554, 22612, 22630, 22633

TEAM Goals

- Quicker recovery after surgery
- Fewer avoidable hospital and ED visits
- Shorter hospital and post-acute stays
- Smoother transitions of care
- Lower costs
- More equitable patient health outcomes

Included in the **30-day episode of care**

Initial hospitalization

This covers inpatient or outpatient hospital services that constitute the anchor stay or procedure.

Post-acute care services

These include services provided by Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF), Long-Term Care Hospitals (LTCH), Home Health Agencies (HHA), and Hospice Services.

Readmissions

Any inpatient hospital readmission services and other outpatient hospital services.

Physician services

Including certain Part B professional services provided within the three days prior to the hospital admission or outpatient procedure.

Part B drugs

Certain drugs covered under Medicare Part B, with some exceptions.

Clinical lab services & DME

Also included in the episode.

What best describes your experience with value-based care or bundled payment programs like TEAM?

Building a TEAM strategy: From prehab to post-discharge

Identify and engage TEAM patients early

Surface eligible patients

Use attribution tagging to identify patients with elective DRGs and HCPCS codes early in their care journey — enabling care teams to proactively engage and align referrals with high-performing post-acute providers from the start.

Drive proactive discharge planning

Accelerate patient readiness by setting expectations for discharge to home, identifying needs and barriers before discharge, and initiating prehab assessments, patient education, and early coordination with post-acute partners.

Coordinate across the network

Match TEAM patients to high-performing PAC providers using DRG- and HCPCS-specific outcome data — ensuring referrals are guided by performance benchmarks and enabling shared accountability across care settings.

Building and maintaining post-acute high-performing networks

1

Data-driven Foundation

Use of CMS data and real-time performance data focusing on cost, quality, and utilization metrics to initially build a high-performing network

2

Shared Incentive Models

Explore gainsharing agreements with strategic high-performing partners to build shared accountability and incentives

3

Performance Monitoring

Utilization of real-time LOS and rehospitalization data for proactive management of SNF performance for your patients

4

Home Health Oversight

Utilization of real-time start of care and rehospitalization data for proactive management of Home Health performance for your patients

5

Actionable Partner Metrics

Provide visibility to your High-Performing Network partners on their performance for your patients so they have actionable data

Operating framework for effective program management in TEAM

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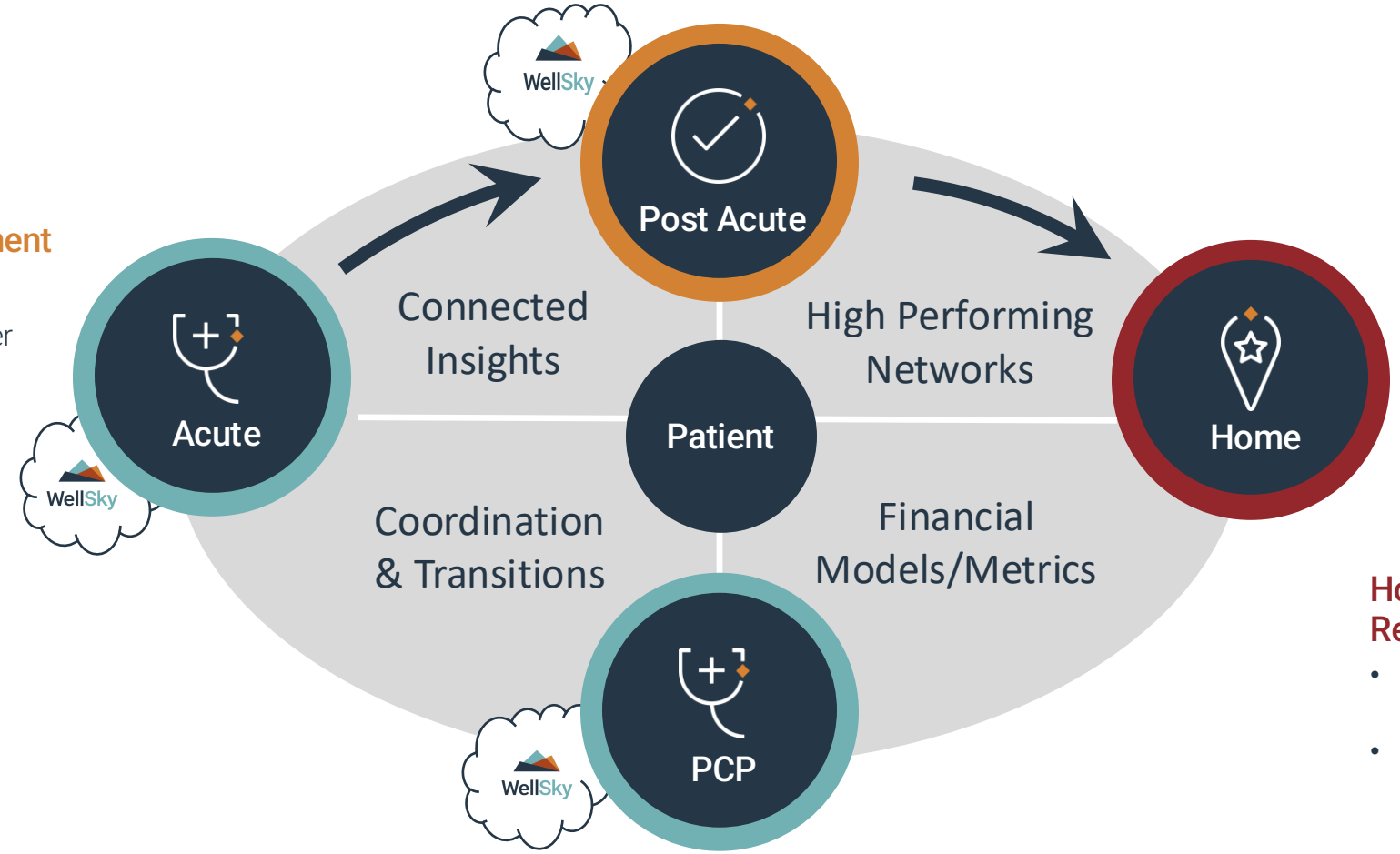
PAC Episode Management

- Right level of care
- Right high-quality provider
- Right Length of Stay
- Right transition of care



TEAM Model Concept

Home Network and Readmission Avoidance

- Risk stratification and Care Coordination
- Home providers with aligned incentives

Improved Outcomes

Financial | Clinical | Operational

Patient Experience

Which of the following are part of your current care management efforts?

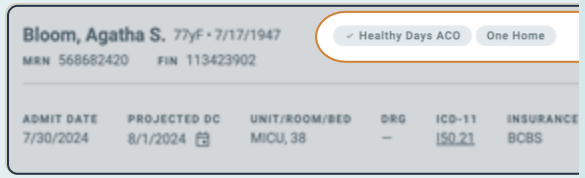
Managing the 30-day episode: Visibility, transitions, and risk

Real-time surveillance for TEAM success

Empower care teams with real-time visibility and proactive engagement through the WellSky CarePort Connect solution

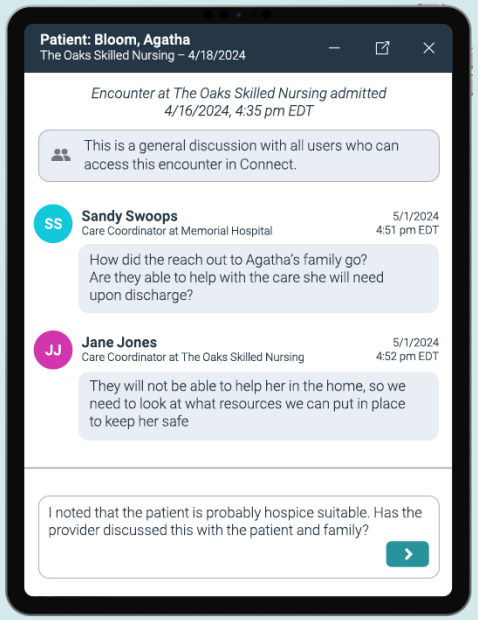
1. Patient visibility

Track TEAM patients across the 30-day post-discharge period with real-time visibility into transitions and care progress.



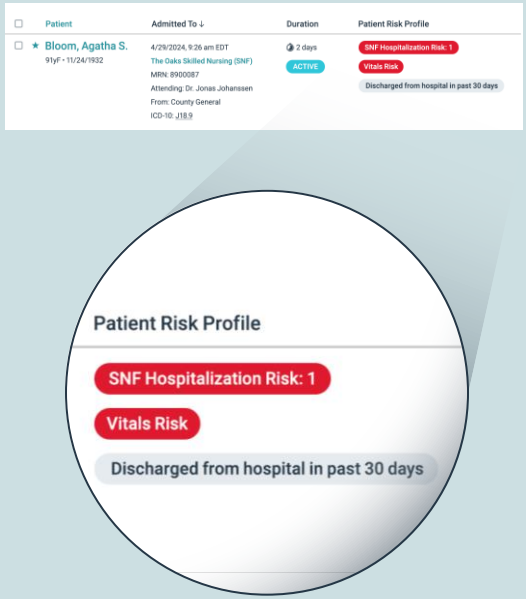
2. In-solution messaging

Engage care teams anywhere through **secure chat, shared plans, and real-time alerts** when care deviates.



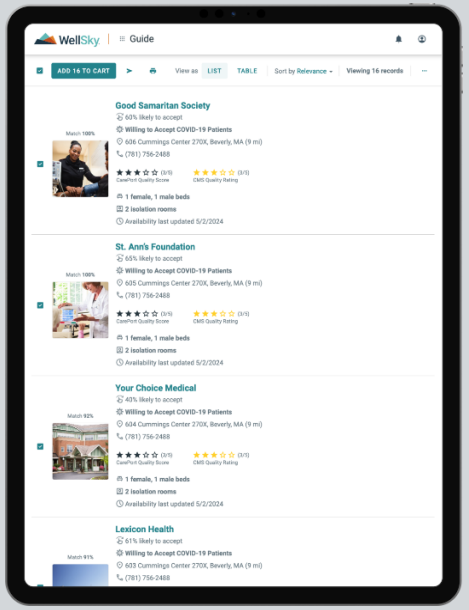
3. Risk warnings

Know when your **TEAM patient is going off course** during a post-acute stay with risk warnings and care insights.



4. Provider network

Leverage a **connected network** to coordinate care for TEAM patients, guiding them to top-performing providers based on DRGs and HCPCS codes.



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Manage transitions with precision to minimize risk

Patients are most vulnerable, and the risk of readmission is highest, during transitions of care

Ensuring continuity and timely placement

- Begin discharge planning at the point of scheduling to ensure continuity and readiness for post-acute care
- Use attribution tagging and referral workflows to match patients to the **appropriate level of care** based on clinical needs and DRG/HCPCS-specific performance
- Leverage **post-acute authorization services** to reduce administrative delays and support **timely discharge** to the right setting
- Share care plans, expectations, and risk factors with PAC providers to ensure seamless handoffs and aligned care goals

Preventing readmissions and care gaps

- Monitor transitions with **real-time alerts**, predictive analytics, and shared documentation to identify early warning signs and intervene before issues escalate
- Track readmission risk, PAC utilization, and provider performance to continuously improve outcomes and accountability across the network

WellSky Clinical Operations as an extension of your team

Acute

- Collaborate and identify patients for discharge to home
- Educate acute hospitals on high-performing post-acute care networks
- Collaborate with hospitalists (if appropriate) to add consult vs. admission request on SNF returns
- Ensure care is coordinated between acute and post-acute
- Targeted outreach post discharge based on patient's risk stratification
- ED transition program

Skilled Nursing Facility

- Review clinicals and preform a progress review towards targeted discharge date.
- Participation in IDT rounds with SNF
- Collaborate with the SNF to discuss:
  - Patients with rising risk of rehospitalization
  - LOS and those who have exceeding estimated length of stay
  - Patients who may qualify for hospice
  - Barriers to discharge
- Coordinate post-discharge services and appointments

Discharge from SNF to Home

- Ensure home health or other post-discharge services are in place Assist in making referral(s) if new services are needed
- Coordinate care with patient and patients care team
- Weekly outreach to patients for 4-weeks:
  - Ensure follow-up appointments are completed including discharge instructions and medication adherence
  - Address escalations, risk for readmissions and SDoH needs

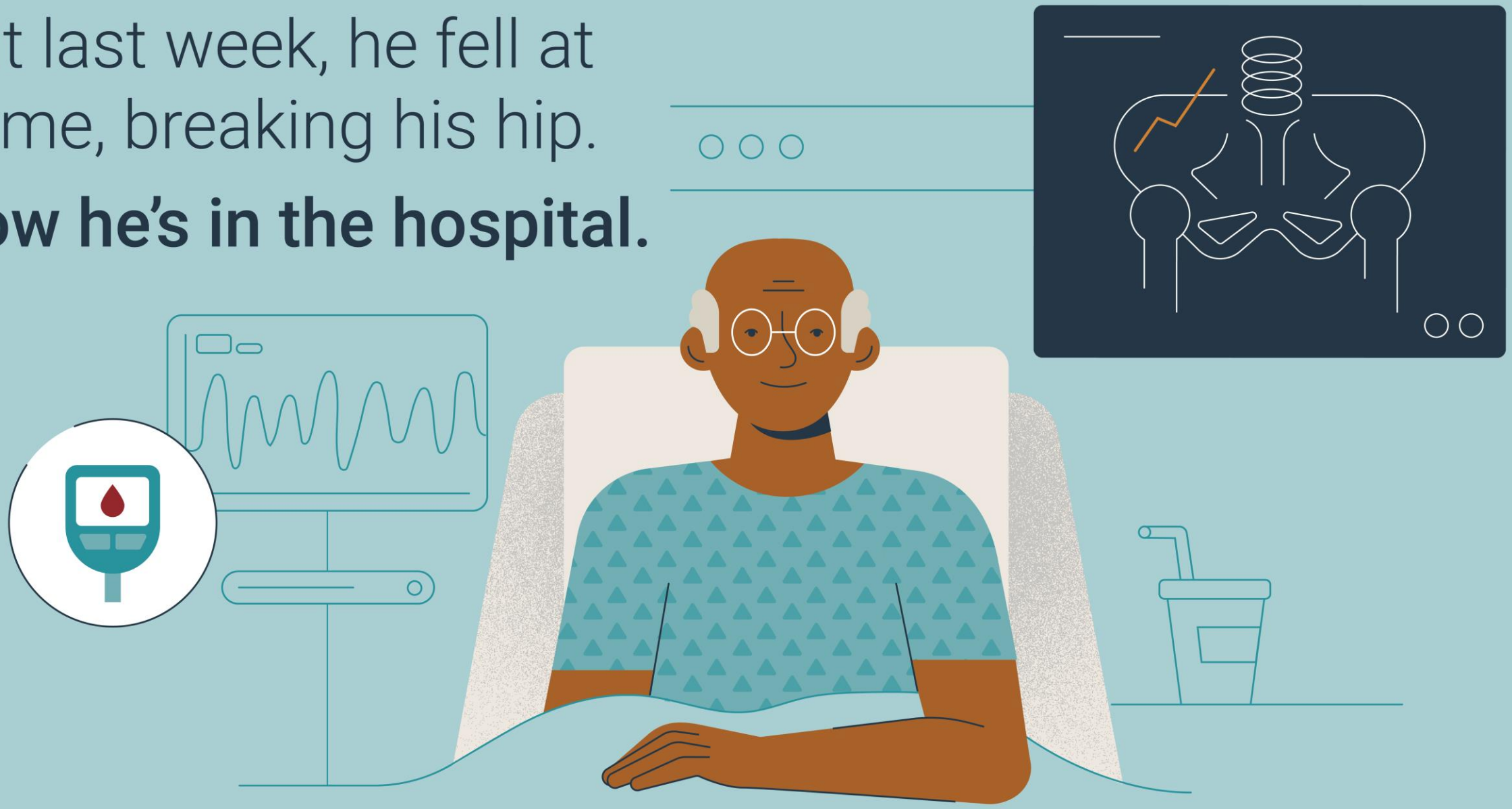
Case scenario:
A TEAM episode in action

Meet Mr. Clark

A retired school teacher, who loves to dance.

But last week, he fell at home, breaking his hip.

Now he's in the hospital.



Luckily, the care team uses WellSky to **support & enhance every step of Mr. Clark's journey.**

From care management to care coordination and everything in between…

Care Management

When patients are directly under an organization's care

EHRs ● Patient engagement ● Discharge planning ● Workforce management

Care Transitions

When the patient is moving to another level of care

Intelligent referral management ● Care setting suitability ● Network management ● Intake

Care Coordination

When the patient's care needs collaboration across stakeholders

Assessments ● Risk summaries ● Alerts ● Care plans ● Social Determinants of Health

Optimized Services

When organizations need expert services, strategic consulting, or education

Coding & billing ● Revenue cycle management ● Clinical care coordination ● Operational consulting & training ● Clinical protocols ● Technology deployment

Value-Based Analytics

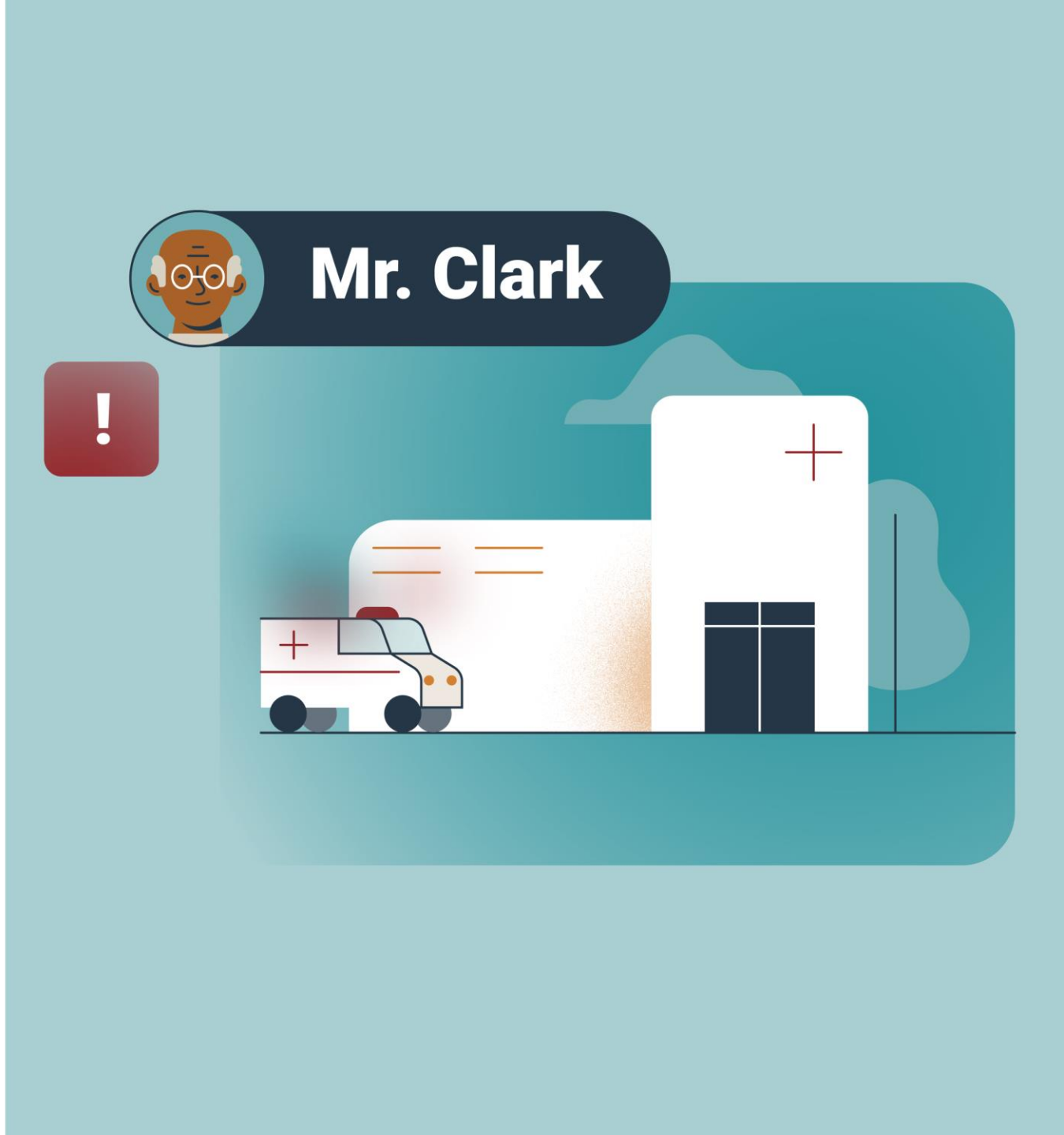
When payers & providers need data-driven insights to identify and manage risk

Performance insights ● Market opportunities ● Payer insights ● Care setting & care plan optimization ● Predictive insights


WellSky®
Only WellSky connects every part of healthcare.

1

Mr. Clark is admitted as an inpatient. His discharge planner begins his care transition plan.



2

He is identified upon admission as included in a TEAM episode.

3

Mr. Clark is referred to a high-quality skilled nursing facility since he lives alone and has stairs.

4

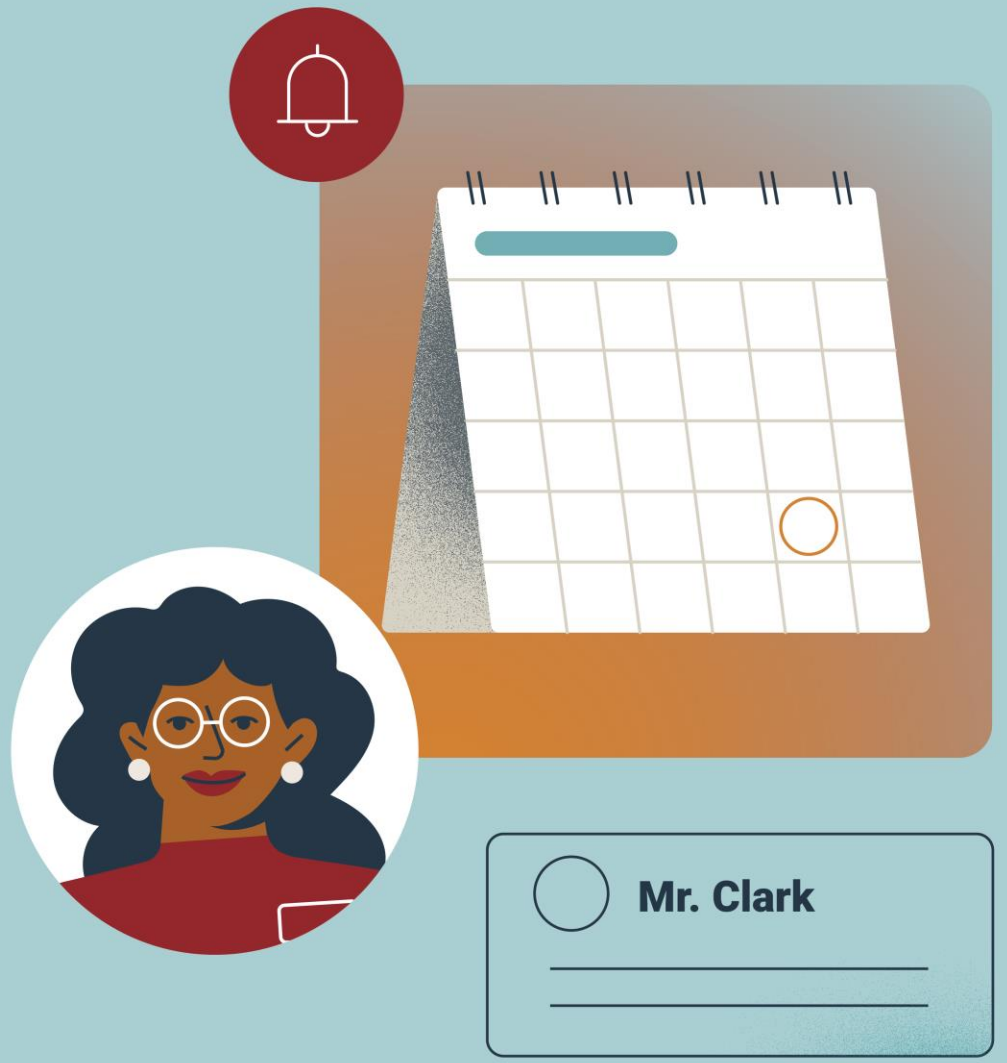
Meeting his targeted LOS at the SNF, he is stable enough to return home with services.

5

DME is ordered and ready on his arrival. A home health nurse visits within 24 hours.

6

His care coordinator follows up and books a follow-up appointment within 7 days.



The right care.
At the right place.
At the right time.

With the support of home health services, Mr. Clark can recover at home and stay out of the hospital.

WellSky®

Where are you in your TEAM strategy journey?

WellSky offers a portfolio of solutions specific to the CMS TEAM model

Program-specific opportunity analysis

informed by CMS claims data and preliminary target prices

Surveillance:

track patients across the continuum with technology that enables proactive engagement

Readmission Solution:

pre-discharge transitions planning and real-time ED engagement

Post-Acute Solution:

real-time access to post-acute clinicals in a platform that promotes collaboration

Monthly claims processing during the performance year with predictive analytics to forecast reconciliation

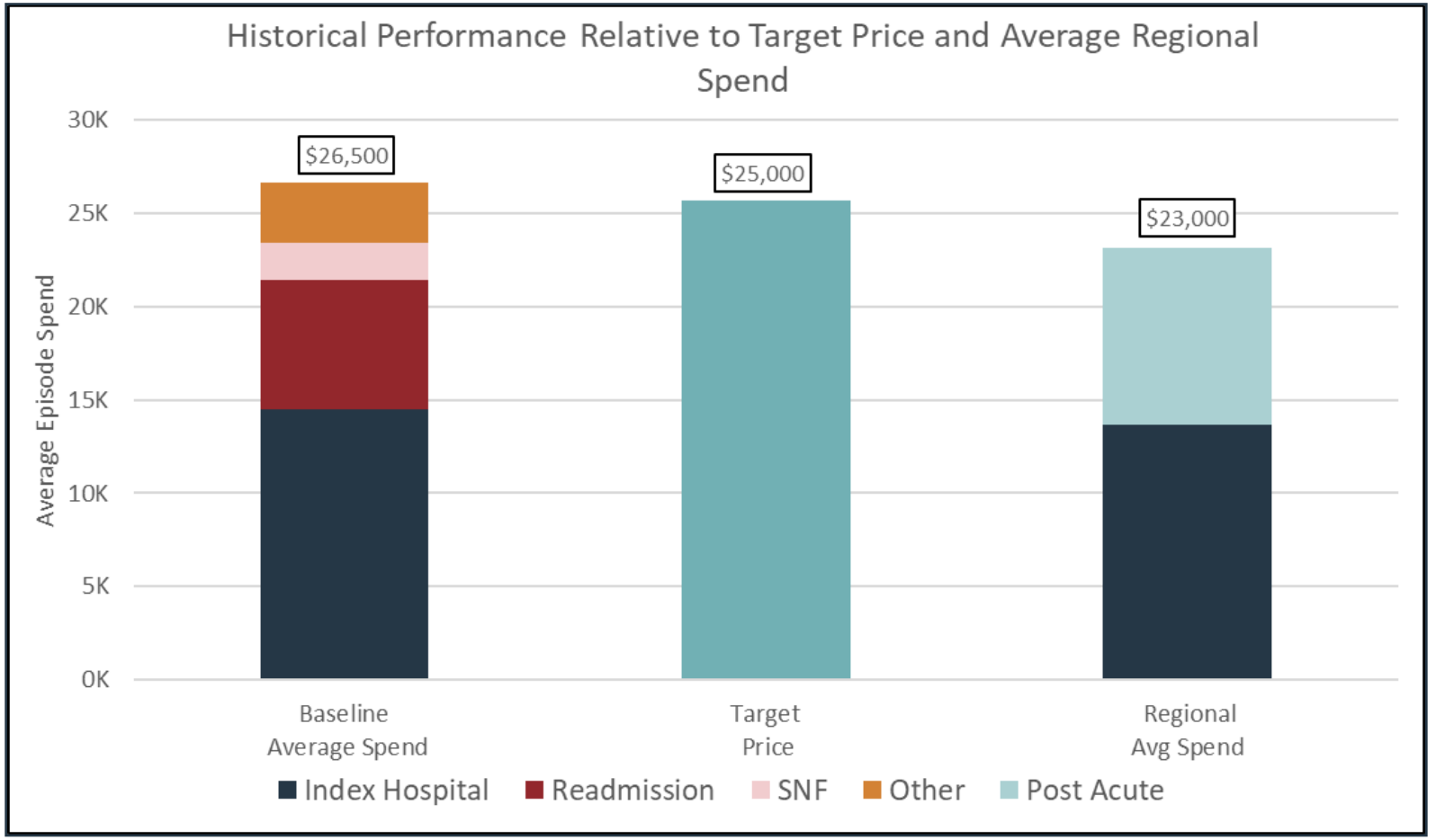
Get an opportunity analysis to identify priorities and drive action

Visualize performance, identify risk, and optimize care pathways under the TEAM model

A customized analysis of CMS-issued TEAM data and target prices to identify financial risk, variation, and post-acute performance

What you'll gain:

- Episode-specific cost-driver insights
- Opportunity prioritization
- Estimated savings potential



Q&A

PEOPLE & PURPOSE

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Thank you!

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