TRANSFORMING EPISODE ACCOUNTABILITY MODEL

The forgotten variable

Geriatric surgical patients — and the hidden cost driver inside TEAM episodes.

A hospital leader's guide to why quality for older adults is the lever that moves outcomes, cost, and reimbursement under mandatory episode accountability.

FEATURING THE EXPERTS LEADING THE CONVERSATION

Dr. Hemant Keny
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Founder & CEO · host of the series
Rainfall Health

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FEATURED VOICES

Dr. Hemant Keny
26 years at Kaiser; co-leads senior surgical care across 21 medical centers.

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INTRODUCTION

The patient that TEAM was designed for

Medicare's mandatory episode models put hospitals on the hook for the full arc of a surgical episode — the 90 days before the operation and the 30 days after. Most of the cost, and most of the risk, lives in that window. And for a fast-growing slice of patients, it lives in one specific place: age.

Older adults arrive at surgery frailer, on more medications, and with more that can go wrong. Treated like everyone else, they drive the readmissions, the extended stays, and the complications that decide whether an episode lands above or below its target price.

This guide distills a Rainfall Health webinar with Dr. Hemant Keny — who has spent 26 years at Kaiser Permanente and eight of them scaling a senior surgical care program across 21 medical centers. It's a working map of what better looks like, and why it's also cheaper.

> **“Improving quality will improve cost — not the other way around.”**
>
> Dr. Hemant Keny, Kaiser Permanente Northern California

01 · THE POPULATION

The high-risk group that is only getting larger

We use Kaiser Permanente as our example throughout this guide because it's the system Dr. Keny knows first-hand — 26 years inside it, eight of them building senior surgical care across 21 medical centers caring for 4.5 million Northern Californians. A small share are elderly today, but that share is climbing, and they need more surgery, carry more risk, and arrive more frail than any other group.

Here's what stands out: long before CMS handed down the mandate, Kaiser and Dr. Keny's team were already putting the right pieces in place to address a problem most systems chose to ignore. Why? Because this high-risk group was quietly driving enormous cost — and that cost could be harnessed by putting patient-first protocols in place, ahead of any requirement to do so.

4.5M
patients across Northern California

315K
patients are 75 and older

2%
are 85 and older

21
medical centers under one program

KAISER'S ANSWER

The Geriatric Surgery Verification program

Built by the American College of Surgeons from the body of literature on what actually helps older surgical patients — packaged as a single bundle of interventions. Kaiser was one of the original pilot sites, then scaled it system-wide after seeing the results.

14 of 21
hospitals verified at Comprehensive Excellence — the highest level

~50%
of every hospital in the country at that level

Why go through the extra bar? Because older patients aren't a smaller version of everyone else.

- They need more surgery, more often
- They're on more medications
- They face more complicated situations
- They are, on the whole, more frail

02 · THE VULNERABILITIES

Two 80-year-olds are not the same patient

Given his charge at Kaiser, Dr. Keny can verify that treating an entire population of people the same way simply isn't viable — one 80-year-old is running marathons, the other can barely walk. By assessing each patient and measuring their unique vulnerabilities, you can begin to predict how effective their outcome will be. Four buckets help shine a light on that outcome: frailty, cognitive impairment, mobility, and nutrition.

Frailty

The overall signature of aging and weakness — independently tied to poorer outcomes. The more frail the patient, the worse they tend to do after major surgery.

Cognitive impairment

Underlying dementia or impairment raises the risk of confusion and delirium after anesthesia and a major operation.

Mobility

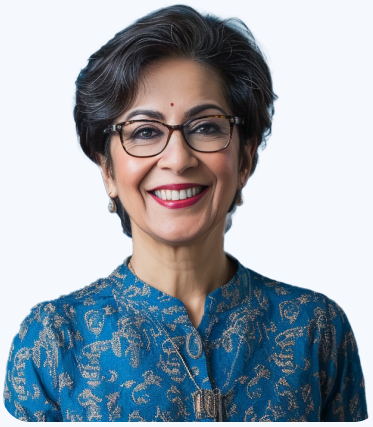
How far a patient can walk shapes both their surgical risk and how well they'll recover once they're home.

Nutrition

Nutritional status is a modifiable input: a better-nourished patient going into surgery is a better-recovering patient coming out.

SPOTLIGHT · DELIRIUM

Delirium is hard to identify and harder to manage. It lengthens the stay, distresses families who no longer recognize their loved one, carries a large cost, and can leave lasting cognitive changes — patients may never fully recover. It is exactly the kind of complication a mandate like TEAM is built to prevent, and exactly why the assessment matters most for the frailest patients.



03 · THE JOURNEY

The episode is won before and after the OR

The mandate measures the 30 days after the operation — but the episode is shaped across the entire journey, on both sides of the OR. Every stage is a chance to head off the avoidable complications that, left unmanaged, escalate quickly and expensively when things go sideways: an unoptimized patient, a missed goals conversation, a preventable delirium, or a discharge to the wrong setting. Get the journey right and those costs never materialize.

REFERRAL

Goals-of-care conversation

Surgeon, patient, and family decide what the patient wants, whether it's realistic, and what recovery looks like. Patients who prefer alternatives to surgery choose that path here.

PRE-OP

Assessment & optimization

A geriatric and frailty assessment surfaces what needs fixing. Optimization can take weeks or months — nutrition, walking distance, coming off high-risk medications — and a better-prepared patient does better.

SURGERY

In-hospital care

Daily assessments to prevent delirium, geriatric-friendly rooms, and making sure patients have their glasses, hearing aids, and dentures so they aren't confused coming out of surgery.

DISCHARGE

The right next setting

A second assessment decides what post-op care each patient needs — home, rehab, or a nursing facility — with social workers and care coordinators making recovery stick and preventing readmissions.

The two most expensive parts of a post-op — extended stays and readmissions — are exactly what this journey is designed to avoid.

04 · THE ECONOMICS

Quality drives cost — not the other way around

Value-based care has been a 25-year promise. Mandatory models are what finally make it real: 721 facilities this year, every acute-care hospital next, with quality tied directly to reimbursement.

Every complication has a price

Each infection, each readmission, each extra day — and each ICU transfer — carries its own cost. Prevent the complication and you remove the cost with it. Goal-concordant care does the same: patients who choose alternatives to surgery avoid the risk, and its expense, entirely.

One bundle, every specialty

All surgical patients share the same risks. The interventions apply across orthopedics, cardiac, general, vascular, urology, thoracic, spine, and neurosurgery — sitting on top of the procedures CMS is starting with.

THE MANDATE LANDSCAPE

TEAM

Live now — 30-day post-op accountability across **721 facilities**, with up to a 20% swing on Medicare reimbursement at stake.

CJR-X

Next year — an expanded 90-day window on joint replacement, extending accountability further from the OR.

Age-friendly

New CMS measures broadening reach toward every acute-care hospital in the country.

Making it mandatory matters. When a model is voluntary, it's easy to skip the hard parts — and you don't get the full benefit unless you do as much of it as possible. Mandates can feel harsh in the moment, but that pressure is what forges better habits: the protocols become routine, and routine is what produces optimal outcomes and long-term success.

05 · THE TECHNOLOGY

AI helps. The clinician still drives.

Dr. Keny is unequivocal on one point: healthcare happens between a doctor and a patient, and that will never change. AI doesn't get a vote in the room — the clinician does. Every recommendation is a suggestion a human accepts, adjusts, or overrides.

But held to that standard, the power of AI is real. The knowledge to care well for older surgical patients already exists in the literature; the bottleneck has always been putting it into practice, in real time, for the right patient. That's where AI earns its place — doing the reading, the flagging, and the cross-checking at a scale no individual clinician can, so the human is free to decide.

Already in the room

AI scribes are saving clinicians time on charting today. Clinical decision support is earlier — but coming.

Real-time recommendations

Built on current literature and patient data, AI can flag who is frail or high-risk and surface the interventions that are missing.

Only as good as the data

Structured clinical data is the fuel. Without it, the use cases stay limited — so collecting it properly is the work.

“Healthcare is between doctor and patient. That will never change — and I hope it never does. These are just tools to help us do things better.”

Dr. Hemant Keny · on keeping the human in the loop

06 · THE ADOPTION PROBLEM

Built to make slow change fast

Change in a large health system is famously slow — but under the mandate, the alternative is steep penalties that can put a system out of business altogether. TEAM is, in effect, mandating that change happen faster. That tension is exactly what Rainfall was designed around.

17 yrs

the time it takes for something known to become routine in healthcare. The job is to speed that up.

"Changing a health system is like turning a cruise ship."

Even cutting-edge technology can take two years just to clear the process into a hospital for the first time. Mandates help — but so does proof.

6 steps

to adherence in 2–4 months

HOW RAINFALL GOT AHEAD

Rainfall built the only solution with a six-step compliance journey engineered in — a guided path that compresses what would take a system years into a matter of months. It's the first and only RAIN Compliant™ certified platform, so the efficiency the AI delivers is matched by a clear, verifiable route to adherence.

1 — 2 — 3 — 4 — 5 — 6

And here's the payoff: mandatory change is daunting, but adoption spreads on proof. When patients and surgeons see a genuinely better recovery — a second knee replacement that goes far smoother than the first — they want more of it. Real-world outcomes, not mandates alone, are what move the majority.

07 · THE SOLUTION

Rainfall Health: the end-to-end TEAM solution

An accountability and accessibility platform powered by AI — and the first and only company certified for these Medicare-mandated programs, including TEAM and CJR-X. What you get is the three Cs, plus AI-enabled care design that keeps the clinician in the driver's seat.

Compliance

The signal through the noise — mapped to the exact steps required to stay compliant with each Medicare-mandated model.

Case management

A product-based solution that augments your team so no episode — and no older, high-risk patient — is ever left unattended.

Care coordination

We bring the post-acute network onto the same page as your hospital — where most of the episode actually happens.

AI-enabled care design

Every episode personalized to surface missing interventions and maximize the outcomes the model requires — with a human in the loop.

60% of the care — and the cost — happens outside the four walls of the hospital. Winning under TEAM means owning that 60%, not just the operation. For older patients, it's where the episode is decided.

08 · GET CONNECTED

Run your numbers with Rainfall

We'll perform a free analysis of your 2024 and 2025 Medicare billings and build an individualized view of your potential upside and downside under TEAM. Rainfall is the end-to-end solution — technology and services — for hospitals navigating the mandate.

LEARN MORE

www.rainfallhealth.com

SCHEDULE A DEMO + FREE ANALYSIS

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Watch for the next edition of the Rainfall Health webinar series.