Example Patient Journey: Meet Sarah

Age: 72 | **Family:** Lives alone | **Coverage:** Medicare

Health Conditions:
- Degenerative disc disease
- Chronic low back pain

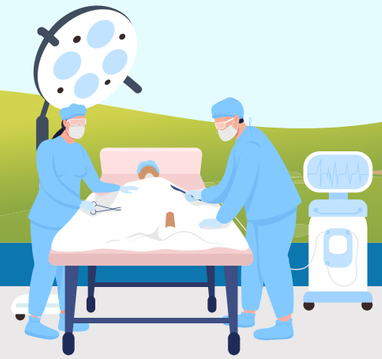
Situation:
Sarah has difficulty with everyday activities despite pain medication and physical therapy. Her orthopedic surgeon recommends spinal fusion surgery.

Coordinated Care with TEAM

For more information, visit the Transforming Episode Accountability Model (TEAM) page at: https://www.cms.gov/priorities/innovation/innovation-models/team-model

Goal for TEAM Experience:

Sarah experiences **seamless care**. Her hospital is accountable for her outcomes and has strong interest in coordinating with her care team to prevent complications.



1-5 Days

Smart planning
- **TEAM SNF waiver** allows skilled nursing facility coverage without 3-day hospital stay; for Sarah, care team determines she's best to recover at home
- Sarah receives clear recovery instructions and is connected to a **primary care provider**

6-10 Days

Going home with support
- Home health nurse arrives on time with Sarah's complete medical records and care plan
- Nurse reviews physical therapy schedule with Sarah

11-18 Days

Coordinated doctor visits
- Sarah attends follow-up appointments that are scheduled during her hospital stay.
- Her doctors work together from a shared care plan

19-25 Days

Preventing problems before they start
- Sarah reports increased pain at her routine video check-in, enabled by the TEAM **telehealth waiver**
- Care coordinator immediately schedules a same-day visit with surgery team
- Treatment is adjusted before complications develop

26-30 Days

Smooth recovery
- Sarah shows excellent progress during final video check-in
- She meets her physical therapy goals ahead of schedule

Outcomes: Reduced pain, timely care, lowered out of pocket costs, and avoided costly, unnecessary care

Potential Experience Without TEAM:

Sarah could experience some of these example challenges, resulting in a **more difficult recovery**.

1-5 Days

Limited discharge planning

6-10 Days

Lack of navigation support to account for Sarah's needs and preferences

11-18 Days

Disconnected care team

19-25 Days

Lack of regular check-ins as complications arise

26-30 Days

Crisis management instead of prevention

31-35 Days

Prolonged recovery

Outcomes: Pain, delayed care, increased out of pocket and health care system costs, and hospital readmission