FOR HOSPITAL CARE TRANSITION AND BUNDLED PAYMENT TEAMS

Hospital TEAM Model Behavioral Health Brief

Reference: TEAM Model (Transforming Episode Accountability Model) - CMS Innovation Center

THE REGULATORY MANDATE

CMS's TEAM model holds hospitals accountable for 90-day episode costs beginning with an anchor hospitalization. Unaddressed behavioral health needs following discharge are a proven driver of readmission and episode cost overruns.

The 90-day episode risk

Patients with co-occurring depression or anxiety are significantly more likely to be readmitted within 30 and 90 days. Behavioral health support during the post-acute period is a high-leverage intervention for TEAM episode performance.

The post-discharge gap

Most hospitals lack a structured behavioral health referral pathway for discharged Medicare patients. Social work and case management teams identify behavioral health needs at discharge but have no reliable partner to hand off to.

Why telehealth fits the transition period

Patients returning home after a hospitalization are often unable to travel to outpatient appointments. Telehealth-delivered therapy by phone or video removes the transportation barrier and increases appointment adherence.

How Total Life supports TEAM participants

Total Life's care coordinators can receive warm handoffs from hospital social workers and match discharged patients with a licensed therapist within days. Services are billed under the patient's Medicare benefits - no episode cost to the hospital.

Ready to close this compliance gap?

Total Life provides hospitals participating in TEAM with a structured behavioral health referral pathway for discharged Medicare patients, reducing readmission risk and episode cost exposure.

Book a partnership discovery call: totallife.com/partners/hospital-discharge
Email: partners@totallife.com
