

Creating a Medicare Transitional Care Benefit: How it Can Save Billions and Improve Care

- **More than 20% of older Americans suffer from five or more chronic conditions that account for 75% of total Medicare spending—mainly due to high rates of hospital admission and readmission.**
 - One fifth of Medicare beneficiaries were re-hospitalized within 30 days of discharge; one-third were readmitted within 90 days, according to a recent study reported in the New England Journal of Medicine study (April 2009).
 - Half of those re-hospitalized within 30 days had not seen a doctor since discharge. The study estimated that Medicare spent \$17.4 billion on largely preventable re-hospitalizations in 2004.
- **Preventable readmissions often result from poor communication among health care providers, older adults, and family caregivers. Transitions from hospital to home are especially risky.**
 - In a recent AARP study of older adults with chronic conditions (March 2009), nearly 20% said their health had suffered due to poor communication. Many reported getting conflicting instructions from different providers. Nearly one in five (18%) said that their transitional care was not well coordinated.
 - Patients discharged without transitional care services frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. Without assistance, most family caregivers lack the knowledge, skills and resources to effectively address the complex needs of older adults coping with multiple conditions.
- **Transitional care services for older adults with multiple chronic conditions can help prevent hospital readmissions, significantly improve health outcomes, increase patient satisfaction—and substantially reduce health care costs.**
 - Clinical trials showed a 45% reduction in hospital readmissions achieved by the Transitional Care Model at the University of Pennsylvania; net savings on hospital care with the Transitions Intervention at the University of Colorado; and savings and better health outcomes from the Guided Care Model pioneered at Johns Hopkins University.
- **Effective transitional care includes:**
 - Comprehensive assessment soon after hospital admission and development of transitional care plans for patients hospitalized with multiple chronic conditions; home visits after discharge to coordinate complex care with multiple clinicians, teach self-care management skills, manage medications, and promote access to long-term services and supports as needed; facilitation of communication among patients, family caregivers, and providers; and working with providers to assure appropriate referrals to specialists, tests and other services.