

Reducing Medicare readmissions will keep down costs, help patients

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Maryland is a recognized leader among the states when it comes to health care. The excellence of care provided in Maryland institutions brings national prominence and economic strength to the state, and Marylanders have better access to primary care than residents of almost every other state in the nation, according to "America's Health Rankings, 2008."

But Maryland also leads the country in the rate of hospital readmissions among Medicare patients. According to a study recently published in the *New England Journal of Medicine*, 22 percent of Medicare patients in Maryland - more than one in five - are readmitted to the hospital within 30 days of being discharged.

Transitions from hospital to home can be complicated and risky, especially for individuals with multiple chronic illnesses. Faced with complex, costly treatments - and often conflicting instructions from different health care providers - people with chronic conditions and their family members often struggle to coordinate care and get appropriate help. This lack of coordination can lead to medical errors, unnecessary tests, avoidable hospital stays, and stress for patients and their families.

It also drives up Medicare costs. In 2004, Medicare spent an estimated \$17.4 billion on potentially avoidable re-hospitalizations nationwide.

Too many people are leaving the hospital with a handful of prescriptions and little else. It's weighing on our health and driving up the cost of health care for all Americans.

One way to improve outcomes while reducing costs is to establish a Medicare follow-up care benefit. This benefit would support patients as they transition from the hospital to their own home or another setting, such as a skilled nursing facility or rehabilitation center.

Under a follow-up benefit, a team of professionals working with patients and their family members could provide transitional care services including: a comprehensive assessment of the individual's needs (and the primary caregiver's needs); development of a care plan; a visit in the next care setting shortly after hospital discharge; home visits; help with medication management; arranging and coordinating community resources and support services; and accompanying the individual on follow-up physician visits.

Multiple clinical studies - including the Guided Care Model pioneered at the Johns Hopkins University - have shown that transitional care services not only reduce readmissions but improve patient outcomes and satisfaction. As Congress debates overdue reform of the nation's health care system, AARP has urged lawmakers to ensure that comprehensive reform includes a Medicare follow-up care benefit.

We enthusiastically endorse the Medicare Transitional Care Act, introduced in the House last week by Rep. Earl Blumenauer, Democrat of Oregon, and Rep. Charles Boustany, Republican of Louisiana, which would ensure that Medicare beneficiaries leaving the hospital and their caregivers get the support they need for up to 90 days after being discharged.

Transitional care services would be provided through hospitals, home health agencies and primary care practices by nurses or other health professionals. The Transitional Care Act includes provisions to phase in the benefit as well as payment incentives that will help with the issue of increased workload.

As representatives of the state with the highest re-admission rate in the country, members of Maryland's congressional delegation should likewise support this legislation with enthusiasm.

Keeping people healthy and out of the hospital benefits everyone. We can improve the quality

of our health care and at the same time contain rising health care costs with a follow-up care benefit in Medicare. As a common-sense approach to stop avoidable hospital readmissions, ease pressure on caregivers and save money, it's a crucial piece of the health reform puzzle.