Transitional Care Programs Are Ripe For Innovation

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Right now hospitals around the country are being asked to reckon with some stark realities regarding readmissions. About $17 billion a year is spent on readmissions for Medicare patients alone, and 75 percent of those readmissions are considered to be preventable. Of all Medicare patients who are admitted to a hospital, 18 percent will be readmitted in 30 days and of those, 50 percent will not have seen a primary care physician in the interim.

Not to put it too harshly, but with all the money that is poured into healthcare in this country, we in the medical profession should be ashamed of those statistics. And actually, hospitals aren't being asked to reckon with this situation, rather they are facing significant financial loss if they don't shape up.

Various financial incentives, including provisions in the Affordable Care Act as well as state initiatives (in Maryland, there is the Admission Readmission Revenue, or ARR, program [1]), have put nearly every hospital on the hook for reducing readmissions. It is not an easy nut to crack.

Reuters recently reported on a study [2] on patients who were given information packets, personal assistance, and even an "on-call medical librarian" to answer any questions regarding prescriptions they received after being discharged from the ER. None of these strategies made a difference.

Other programs aim to reinvent the hospital discharge process. Still others seek to connect newly discharged patients with community services like home healthcare. And yet perhaps the most aggressive strategy is one rarely, if ever, employed: sending healthcare providers directly from the hospital into the patient's home in the immediate days and weeks following their discharge.

The fact is, for many patients, their medical conditions are just the beginning. When it comes to the sickest of the sick, the patients who are often responsible for a hugely disproportionate amount of healthcare costs and services, there is often a tangled web of interconnected problems, from poverty, to mental illness, to family problems, which can interfere with and ultimately sabotage the healthcare industry's best efforts to provide care.

Sending healthcare providers directly into their home is a start. Until recently, hospitals had few incentives to experiment with these types of transitional care programs. If a patient was readmitted shortly after being discharged, it often meant more revenue for the hospital, not less. Only now is it beginning to be possible to provide care directly to the patient in their home, absent the incredibly expensive infrastructure that surrounds a hospital visit, and have it both be a net savings to

the healthcare system and profitable enough to the care provider to make it feasible.

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