



Medicare Transitional Care Act of 2009

Congressman Earl Blumenauer | Third District of Oregon | www.blumenauer.house.gov

The Medicare Transitional Care Act would create a new benefit under Medicare designed to support and coordinate care for beneficiaries as they move from the hospital setting to their homes, skilled nursing facilities or rehabilitation centers.

Transitions from hospital to home can be complicated and risky, especially for individuals with multiple chronic illnesses. Patients frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. And in cases where multiple providers are involved, patients often get conflicting instructions from different providers.

A study published in April 2009 in the *New England Journal of Medicine* found that almost one third of Medicare beneficiaries studied who were discharged from a hospital were re-hospitalized within 90 days. Additionally, one-half of the individuals re-hospitalized had not visited a physician since their discharge, indicating a lack of follow-up care. The study also estimated that Medicare spent \$17.4 billion in 2004 on unplanned re-hospitalizations.

The Medicare Transitional Care Act would directly address continuity of care problems by increasing support to patients as they move from the hospital to their new care setting and ensuring that appropriate follow-up care is provided during this vulnerable period. The benefit would be phased-in, initially targeting the most at-risk individuals by providing evidence-based transitional care services tailored to their specific needs. The transitional care clinician (generally a registered nurse with special training) would provide the following services under the benefit:

- Develop a transitional care plan that identifies potential health risks, treatment goals, current therapies, and future services.
- Review medications to avoid adverse drug reactions, and teaching the patient and caregiver how to organize, manage and take medications.
- Accompany the beneficiary to follow-up physician visits.
- Advise beneficiary and caregiver how best to follow the clinician's instructions and care for conditions.
- Assure appropriate referrals to specialists, tests and other services and helps navigate the health care system.
- Assist the beneficiary and caregiver with coordinating support services (such as medical equipment, meals, homemaker services, assistance with daily activities, shopping, and transportation).

The legislation is modeled after the Transitional Care Model which was developed by the University of Pennsylvania and has shown through multiple randomized clinical trials to produce significant health outcome improvements, reductions in health care costs among chronically ill older adults, and increased patient satisfaction. AARP and Consumers Union have endorsed the bill.

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