YOUR UPDATE FROM AGEOPTIONS

AGEOPTIONS NOW

April 2012

AgeOptions and Partners in Hospital Transitions Program Receive Funding for Programs to Reduce Hospital Readmissions

AgeOptions and a group of community agencies have been awarded funding by the Centers for Medicare & Medicaid Services (CMS) for programs to reduce hospital readmissions among people with Medicare.

The funding was awarded to AgeOptions on behalf of the Bridge Transitional Care Partnership through the CMS Community-based Care Transitions Program. Community-based agencies that will provide care transition services at six hospitals are: Aging Care Connections, Kenneth Young Center, North Shore Senior Center, PLOWS Council on Aging, Rush University Older Adult Program and Solutions for Care. Health and Medicine Policy Research Group will provide additional technical assistance and support to the community agencies.

The hospital network includes Adventist LaGrange Memorial Hospital, Advocate Lutheran General Hospital, MacNeal Hospital, Palos Hospital, Rush University Medical Center and St. Alexius Medical Center.

The Community-based Care Transitions Program is part of the Affordable Care Act's policies to improve the quality of care available to people with Medicare. It is needed because 20 percent of Medicare beneficiaries who are discharged from a hospital are readmitted within 30 days. These readmissions cost Medicare about $12 billion a year and impede patients' recovery.

"This is a collaboration between health care and social services, and it saves money and provides better care," said Jonathan Lavin, AgeOptions CEO. "Every time someone with Medicare is readmitted to a hospital it costs the American people $9,600. Many readmissions can be avoided if we properly connect people to the services they need so they can follow through with their discharge plan."

The Bridge Transitional Care Partnership will use the Bridge Program, a nationally recognized evidence-based program developed by Rush University Medical Center and Aging Care Connections. It reduces hospital readmissions by connecting people with community supports that help them follow discharge instructions.

(continued on page 2)

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The Bridge program targets people at high risk of hospital readmission and starts almost as soon as an at-risk person is admitted to a hospital. Bridge Care Coordinators, who are social workers at community based organizations, do an assessment with the patient and family to determine the risks for readmission and what interventions are needed. For example, older adults just discharged from a hospital might need help with meals or getting to a follow-up appointment. They might not be able to pick up a prescription or reconcile new medications with those they already take.

The coordinator starts setting up services as soon as the person's needs are determined, then calls 48 hours after the patient is discharged and again at 30 days to make sure all the services are in place and find out if there are any new risks or problems.

The Community-based Care Transition Program is part of the CMS Partnership for Patients initiative, which has two goals: to substantially decrease hospital acquired conditions and to improve care transitions. The first goal has the potential to save up to 60,000 lives and prevent millions of injuries and unnecessary complications in patient care. Combined, the two goals would save $50 billion for Medicare over 10 years if fully realized.

The Care Transitions Program is part of a larger nation-wide effort to reduce all hospital readmissions by 20 percent by 2013. If achieved, it would result in a total of 1.6 million avoidable hospitalizations throughout the U.S. population.

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