Did you know that 20% of Medicare patients are readmitted to a hospital within one month of being discharged? Consider the following:

- One in five Medicare patients ends up back in the hospital within a month of discharge, a practice costing billions of dollars a year.
- Eric Coleman MD, University of Colorado in Denver, said patients often have a honeymoon notion about how things will be once they're home. Then, when they become confused about how to take their medicine or run into other problems, they head back to the hospital - they don't know where else to turn.
- A study in the New England Journal of Medicine April 2009, found about 20% of 11.9 million patients were readmitted to the hospital within a month of discharge - about a third were back in the hospital within three months. Unplanned return visits were estimated at $17.4 billion of the $102.6 billion that Medicare paid hospitals in 2004. "It's a big hunk of money and it's a big hunk of misery," said study co-author, Dr. Stephen Jencks.
- Hospital readmissions and their cost are now receiving even more attention because President Barack Obama's budget calls for reducing spending on Medicare readmissions to help pay for health care reform.
- In 2008 the Gerontological Society of America published a separate study representing almost 3 million community-dwelling Medicare beneficiaries:
  - Persons ***who lived alone*** had a 50% increased odds of early readmission (within 60 days) compared with those who did not live alone.
  - Persons reporting ***any unmet functional need*** had a 48% increased odds of early readmission compared with those who did not report any unmet IADL need.
  - Persons ***lacking self-management skills*** had a 44% increased odds of early readmission compared with those who did not lack self-management skills.
  - Financial income did not demonstrate a statistically significant association with early readmission.

How Pac-J Services Home Health Care Can Help

- Pac-J Services Home Care agency has firsthand experience in ***helping solve the challenges of handoffs and communication*** when the patient transitions from an acute care environment to home.

- Pac-J Services Home Care ***has a responsibility to lead*** by reaching out to our healthcare provider partners to help seal cracks in transitions to home. Agencies can initiate a strategic dialogue with hospital partners on the value of home care in helping meet hospital goals.