Coordination of Care

National research shows 17.5 percent of Medicare beneficiaries are re-hospitalized within 30 days of a hospital discharge. The problems associated with poor transitions of care and 30-day hospital readmissions are not solely the responsibility of hospitals; they often result from a breakdown in communication between care settings. Weaknesses include the transfer of information between providers and patients, a failure to assure patients and caregivers can self-manage their condition, and a lack of standard processes to effectively manage the transition between settings.[1]

Throughout the region, the **New England QIN-QIO** is convening community coalitions or providers, patients and other stakeholders in an effort to address these problems and improve care coordination.

The **Coordination of Care** initiative is focused on enhancing transitions for patients who are most vulnerable for poor transitions, including those who:

- are dually-eligible for both Medicare and Medicaid;
- have multiple chronic conditions;
- have behavioral health conditions;
- suffer from Alzheimer's or other dementia; or
- experience other social determinants of health.

Working together with the community coalitions, we aim to improve transitions of care for all patients, reduce unplanned hospital admissions and readmissions and decrease the prevalence of adverse drug events.

The community based approach convenes:

- **Community support services**
- **Patients & Caregivers**
- **Payers**
- **Pharmacies**
- **Traditional providers (e.g., hospitals, home health, nursing home)**

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[1]*U.S. Department of Health & Human Services. New HHS Data Shows Major Strides Made in Patient Safety, Leading to Improved Care and Savings. May 7, 2014.* http://innovation.cms.gov/Files/reports/patient-safety-results.pdf

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