From Kentucky's QIN-QIO: *Care Coordination*

Improving communication and the coordination of clinical decision making has moved to the forefront of both the National and CMS Quality Strategies. CMS and its federal partners have employed many focused strategies on improving the care coordination and transition of Medicare beneficiaries across settings. During the QIO 10th Statement of Work, programs were focused on improving care transitions from the acute care setting of the hospital to the post-acute care setting. The programs and interventions that began during that timeframe have contributed to national declines in readmission and admission rates in hospitals across the country. (Centers for Medicare and Medicaid Services Center for Clinical Standards & Quality Improvement Group, 2014)

While significant gains have been realized in reducing hospital admissions and readmissions, we recognize that care coordination goes beyond the acute care setting. Patients and families receive medical care from multiple providers and practitioners within their communities. With poor coordination of care, the possibility of duplicative and unnecessary medical services is very high. Repeated or unnecessary diagnostic tests, risk of adverse drug events from multiple medications and infection from unnecessary exposure during an unnecessary readmission, coupled with the high costs of health care has prompted CMS to continue to task the QIN-QIO to work on assisting communities to better coordinate care across settings for Medicare recipients.

Kentucky has been very active and successful in decreasing unnecessary readmissions and admissions over the past three years. Six community coalitions have worked with the QIO in developing strong community ties and successfully improving the care transition process for Medicare beneficiaries and their families. These communities have worked with providers and practitioners to improve the discharge process from one care setting to the next. They have invested in training coaches, who visit the patient in the hospital prior to discharge and then visit them in the home to assure there are no unresolved issues that might increase the likelihood of returning unnecessarily to the hospital. There has been an ongoing investigation creating evidence-based practice to learn and to teach others how to care for patients and families once they are discharged from the acute care setting.

CMS has contracted with QSource and the QIN-QIO *atom Alliance*, to continue improving care coordination for Kentucky Medicare recipients and their families. This five-year endeavor will include activities across the state, as we work together to improve care by decreasing costs and improving processes.

For further information or to participate in this activity, please contact Kentucky's QSource Care Coordination Quality Improvement Advisor Cindy Todd, MSN, RN at 502-680-2954.