Annually,
**readmissions** cost

**$26 BILLION**[*2]

Potentially
**avoidable readmissions**
are estimated to account for

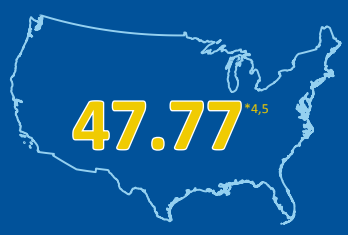
**$17 BILLION**[*2]

Adverse drug events (ADEs)
affect up to

**450,000**

**hospitalized patients YEARLY** [*3]

**NATIONAL READMISSION RATE**
per 1,000 Medicare Beneficiaries:




*notes citation

# IMPROVING Care Coordination

If you want to go ***quickly*, go *alone*.**
If you want to go **FAR**, go **TOGETHER.**

## Join Us

Coalitions of diverse providers, organizations and beneficiaries have been shown to improve readmission rates in their communities at a faster rate than uncoordinated efforts.[1] Together, we can help ensure that beneficiaries receive the care they need, when they need it, in the correct setting. When all entities work together regardless of competition, beneficiaries will spend more days healthy and in their own homes. Don't be left out of this opportunity to improve your community by working with others to:

- ↓ Reduce hospital readmission rates among Medicare beneficiaries
- ↓ Reduce hospital admission rates among Medicare beneficiaries
- ↓ Reduce emergency department visits and hospital readmissions related to ADEs
- ↑ Increase the number of days Medicare beneficiaries spend at home and out of the hospital

## Community Partners

- Accountable Care Organizations (ACOs)
- AAA/ADRC
- Beneficiaries and Families
- Consumer Engagement Organizations
- Community Based Organizations
- Home Health Agencies
- Hospice
- Hospitals
- Long Term Services and Supports
- Palliative Care
- Payers, Regulators and Legislators
- Pharmacies (community, hospitals, long-term care, clinic, etc.)
- Physician Offices
- Skilled Nursing Facilities

# IMPROVING Care Coordination

| Participants will: | Telligen will: |
|---|---|
| Commit to working in your community collaboratively to reduce avoidable readmissions and/or adverse drug events | Assist in convening community providers and stakeholders to collaborate and share time and resources to meet the needs of the population of Medicare beneficiaries that they serve<br>Support the understanding of current quality measures and alignment with existing or co-occurring improvement initiatives |
| Become part of a network working to actively reduce readmissions and ADEs locally, across the state and nationally | Coach leaders and leadership teams as they work within their communities to develop and achieve local health care improvement goals<br>Provide access to learning opportunities and sharing activities, and access to content experts in care coordination, medication safety and hospital readmissions |
| Identify the causes of readmissions in your community | Provide access to pertinent data Medicare Fee- For-Service claims data and assistance in finding and interpreting publicly available data<br>Assist with analysis and feedback on community-specific claims, interventions and outcomes data to support decisions, metric development and continuous quality improvement |
| Select and implement a targeted intervention to improve care transitions for beneficiaries living in your community | Provide expertise in areas such as conducting community assessments and selecting and implementing interventions<br>Provide tools and resources to support application of evidence-based practices, such as standardized templates, flowcharts, process maps, communication techniques, etc. |
| Track progress using data templates and community-level logic models | Support data collection and meaningful metric development<br>Access to expertise in areas such as conducting community assessments and selecting and implementing interventions |

## About Telligen QIN-QIO

The Telligen Quality Innovation Network - Quality Improvement Organization (QIN-QIO), in collaboration with the Centers for Medicare & Medicaid Services (CMS), is supporting the HHS National Quality Strategy to accomplish better care, better health for people and communities and affordable care through improvements.

Working together within a three-state network, teams in Iowa, Illinois and Colorado will work side-by-side with providers in all settings of care on quality improvement initiatives, while pooling resources and common elements to best serve the needs of beneficiaries, families, caregivers and healthcare providers across the region.

## Contact Us

For more information, please contact a Telligen Care Coordination quality improvement facilitator.

**www.telligenqinqio.com**


1. *Brock J, Mitchell J, Irby K, et al. Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries. JAMA. 2013;309(4):381-391. doi:10.1001/jama.2012.216607.*
2. *Rau, Jordan. 2014, October 2. Medicare Fines 2,610 Hospitals In Third Round Of Readmission Penalties. Kaiser Health News. Retrieved from http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/.*
3. *Medicine Committee on Identifying and Preventing Mediation Errors. Preventing Medication Errors: Quality Chasm Series. Washington, DC: the National Academies Press, 2006.*
4. *ICPC NCC (Telligen). (2016). ICPC Scorecard July 1, 2015-June 30, 2016: Telligen. Report date October 2016..*
5. *Readmissions per 1,000 Benes: Number of all cause readmissions within 30 days of hospital discharge among eligible Medicare FFS beneficiaries residing in the United States and US territories per 1,000 eligible Medicare FFS beneficiaries residing in the United States and US territories from July 2015 to June 2016.*



*This material was prepared by Telligen, Medicare Quality Innovation Network Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-QIN-C3-02/06/17-2011*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