



Improving Healthcare
for the Common Good

Are you one of the 1.9 million New Yorkers providing care to an elderly family member or friend?

Although it's emotionally difficult to see a loved one in the hospital, it's comforting to know that while in the hospital a team of professionals is monitoring the patient's care around the clock. But what happens when your loved one is discharged and you take over as informal caregiver? You may not know where to turn with questions about care and medication.

- What if I don't understand the discharge instructions?
- How do I know if my loved one is taking too long to heal?
- Who do I call if my loved one has a reaction to their medication?
- When should I schedule a follow-up appointment?
- Will the results of any tests done in the hospital be sent to the primary care physician?

Older people are vulnerable during this time and open to serious, even life-threatening events that may lead to re-hospitalization. The Centers for Medicare & Medicaid Services (CMS) has developed the Care Transitions Initiative to better establish the coordination and continuity of care when patients transfer between different health care settings and to ensure that health care professionals, patients and caregivers communicate every step of the way.

IPRO, the federally funded, not-for-profit Quality Improvement Organization (QIO) for New York State, in contract with CMS, is facilitating the three-year community-wide effort in Rensselaer, Saratoga, Schenectady, Warren and Washington counties to improve care transitions for Medicare patients and their caregivers.

The Care Transitions Initiative

A care transition is defined as the movement of patients between health care practitioners and settings as their conditions and care needs change.

Upon discharge from a health care location, it is essential that important health care information is shared among and understood by patients, caregivers and other health care professionals who will be providing future care for the patient.

This project empowers the patient and caregivers to take control of their health information. IPRO is working with local health care providers to ensure patients and their caregivers:

- Are better informed about their condition and their medications;
- Regularly update and share their health information with all health care providers;
- Be aware of the symptoms of a worsening condition and how to respond;
- Schedule follow up visits with their doctor(s); and
- Ask their health care provider questions when they don't understand something that is said during a visit.

For more information, contact: CareTransitions@nyqio.sdps.org

Additional Resources:

Ask Medicare http://www.cms.hhs.gov/Partnerships/25_CaregiverInitiative.asp

NY Connects <http://www.nyconnects.org>

National Family Caregivers Association <http://www.nfcares.org>



**About one in five
Medicare patients
is re-hospitalized
within 30 days of
discharge from the
hospital, and more
than 85% of these
re-hospitalizations
are unplanned.**