North Carolina Alliance

for effective

Care Transitions (NC ACT)

Charter

BACKGROUND

Hospital readmissions are frequent, costly, potentially harmful, and many are avoidable. It is estimated that 20% of U.S. hospitalizations are rehospitalizations within 30 days of discharge.[1],[2] An analysis by the Medicare Payment Advisory Committee (MedPAC) indicated that up to 76% of rehospitalizations within 30 days in the Medicare population are potentially avoidable.[3] Medicare claims data from 2003-2004 reveal that of 11,855,702 discharges of Medicare beneficiaries from the hospital, 19.6% were rehospitalized within 30 days, 34% were rehospitalized within 90 days, and 50.2% of those who were rehospitalized within 30 days had no bill indicating a visit to a physician's office during that 30 days.[4] The cost of the estimated 5 million rehospitalizations per year among the Medicaid population is $17 billion in hospital payments.[5] One study shows that upon discharge from the hospital, 30% of patients have at least one medication discrepancy with the potential to cause harm.[6]

Hospital Compare, the Centers for Medicare and Medicaid Services (CMS) hospital reporting website, provides hospital 30-day readmission rates for Medicare beneficiaries for three disease conditions: heart attack, heart failure and pneumonia. Based on this data the NC average for each of these conditions are 19.4%, 24.2% and 18.5% respectively.[7] The national averages are 18.5% for heart attack, 21.2% for heart failure and 15.3% for pneumonia.[8] Expanding analysis to the NC Hospital Discharge data reveals that the North Carolina's 30-day, all cause, all payer readmission rate is 10.0% for CY 2011.

The Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. One of the goals of the Partnership for Patients is to decrease preventable complications during a transition from one care setting to another so that all hospital readmissions would be reduced by 20% by the end of 2013, compared to 2010. Achieving this goals would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring rehospitalization within 30 days of discharge. For NC a 20% decrease in readmissions would equate to 24,666 readmissions being avoided and representing a savings of more than $157 million. In NC 289 healthcare organizations pledged their support to the goals of the Partnership for Patients.

PURPOSE

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[1] Fazzi R, Agoglia R, Mazza G, Glading-DiLorenzo, J. The Briggs National Quality Improvement/Hospitalization Reduction Study. *Caring: National Association for Home Care Magazine.* 2006; 25(2):70.
[2] Alliance for Health Reform. Covering Health Issues 2006-2007: http://www.allhealth.org/sourcebooktoc.asp?sbid=1. Accessed Jul21, 2011.
[3] Hackbarth G, Reischauer R, Miller M. *Report to Congress: Medicare Payment Policy.* Washington, DC: MedPAC; March 2007.
[4] Jencks S, Williams M, Coleman E. *Rehospitalization among Patients in the Medicare Fee-For-Service Program.* New England Journal of Medicine, April 2, 2009; 306(14)1418-28.
[5] Rutherford, P. *Overview of IHI's Approach to Reducing Avoidable Rehospitalizations.*
Reducing Avoidable Readmissions by Improving Transitions in Care seminar, Institute for Healthcare Improvement, July 14, 2011.
[6] Cornish PL, et al. Archives of Internal Medicine 2005; 165:424-9.
[7] http://www.nchospitalquality.org/dashboard.lasso. Accessed 01.01.13.
[8] http://aharesourcecenter.wordpress.com/2012/05/15/30-day-readmission-rates-national-state-county-benchmarks. Accessed 01.01.13

The purpose of the NC Alliance for effective Care Transitions (NC ACT) is to bring together in partnership and collaboration organizations across North Carolina committed to improving the transition of care from one healthcare or home setting to another. Collectively NC ACT will combine resources and establish best practices to ensure North Carolinians are provided effective, person-centered and optimal transitions of care.

VISION, MISSION AND GOALS

Vision
North Carolinians are provided effective, person-centered and optimal transitions of care.

Mission
NC ACT stakeholders connect care transitions services and resources, identify best practices and needs, and educate the public, providers and decision makers on person-centered quality services and supports for optimal healthcare transitions.

GOALS

- Reduce rehospitalizations by 20%.
- Enhance diversion activities to increase use of community services in prevention of rehospitaliztion.
- Engage the patient and family in every care transition.

PARTNERING ORGANIZATIONS or ALLIANCE MEMBERS

Hospital leaders, health care employers, physicians, nurses, patient advocates, and home and community-based long-term service providers, along with other community organizations who wish to improve health care outcomes and promote well-being for all citizens.

MEMBERSHIP CATEGORIES

Partner
- Work aligns with vision and mission of NC ACT
- Actively involved and engaged in the activities of NC ACT
- Willing to commit some resources (people, venue, data, funding, It, marketing) to ensure NC ACT is successful

Lead Partner
- Ultimate accountability and responsibility for the Alliance's success
- Provides administrative support, leadership and is accountable for annual objective.
- Serves on Leadership Team.

Expectations of Partners
- Upon joining the Alliance the member will complete a profile and choose an Alliance category.
- Submit profile for publishing on the NC ACT website.
- Attend and participate in meetings.

- Look for opportunities to support other members and to share resources.
- Collaborate with others to improve care transitions
- Look for opportunities to partner with others on local and statewide projects, efforts.
- A member can change Alliance membership category at any time.
- Don't compete with other members

Endorsing or Sponsoring Partner

- Limited resources (people, time or funds) and not actively engaged with the activities of NC ACT, but philosophically supports the alliance.
- Offers to promote programs and limited marketing for programs
- Offers name to the Alliance as a form of endorsement
- This partner category includes those willing to make a financial contribution which may include grants, scholarships, direct funding and donation of materials

LEADERSHIP TEAM

- The Leadership Team for NC ACT consists of the Lead Partners.
- Expectations/Duties – plan and monitor yearly objectives set by the Alliance
- Frequency of Meetings – at least quarterly

MEETINGS AND COMMUNICATIONS

- Annual NC Care Transitions Summit
- Annual NC ACT Stakeholder Meeting
- Website – management by a lead partner
- Publish an annual report of activities – lead partner to organize, with support from the membership
- PR from Lead Partners
- Webinars
- Campaigns