

Quality Forum

North Carolina Alliance for Effective Care Transitions

The North Carolina Quality Center for Hospital Quality and Patient Safety recognizes that there must be care coordination between multiple stakeholders to improve transitions across the continuum of care and preventing readmissions. To meet this goal, the Center has sought to gather information about and assess care coordination efforts in communities across the state. A diverse group of stakeholders has been assembled to examine statewide efforts to improve care transitions, to assess organizational willingness to partner on a statewide effort, and to identify best practices for improving care transitions and decreasing avoidable hospital readmissions. This group conducted its first meeting at the North Carolina Hospital Association in September 2011 and has met 4 subsequent times.

The first stakeholder meeting included a report from the transitions of care subcommittee that grew out of the North Carolina Institute of Medicine's Health Reform workgroups. This was followed by each stakeholder organization sharing a brief overview of their care transitions work, their efforts to reduce readmissions, their partnerships, challenges experienced, and lessons learned. In subsequent meetings, the group discussed gaps in care transitions, assessed the use of metrics and outcomes, and began the development of the vision, mission, and objectives for the stakeholder group.

To formalize the identity of the group, the members chose to call themselves the "North Carolina Alliance for Effective Care Transitions." The Alliance is a gathering of stakeholders who represent hospitals, long-term care, assisted living, home health, hospice, mental health, case management, insurance plans, community care networks, patients, and others, and who meet to coordinate efforts to improve care transitions across all settings for all North Carolinians. The organizing partners of the North Carolina Alliance for Effective Care Transitions are the North Carolina Quality Center and the North Carolina Department of Aging and Adult Services. The latter participates with support of their person-centered hospital-discharge planning model grant the Centers for Medicare and Medicaid Services. The mission of the North Carolina Alliance for Effective Care Transitions is to provide person-centered quality services and supports when North Carolinians transition from one health care setting to another. The organizations represented at the initial stakeholder meetings are listed in Table 1.

Coordinated by the North Carolina Alliance for Effective Care Transitions, 27 organizations have submitted detailed profiles of their work to improve care transitions. These profiles can be accessed at www.ncqualitycenter.org/ncact/. Organizations wishing to share what they are doing to improve care transitions can find a blank form and submission instructions at the same link. The alliance is also working on developing a care transitions Web site that will serve as a clearinghouse of information related to improving care transitions, as well as provide a mechanism for providers to connect, coordinate, and share best practices and resources.

The work of the North Carolina Alliance for Effective Care Transitions was further defined during the January 13, 2012, North Carolina Partnership for Patients Summit. This meeting was held in Greensboro and co-sponsored by the North Carolina Division of Aging and Adult Services, Carol Woods Retirement Community: Community Connections for Seniors, the Carolinas Center for Medical Excellence, the North Carolina Hospital Association, and Community Care of North Carolina. The summit brought together hospital leaders, employers, physicians, nurses, patient advocates, home- and community-based long-term service providers, and other community organizations in a shared effort to improve health care outcomes and promote well-being for all citizens. The event also provided a forum to discuss issues, opportunities, and innovations for improving care transitions in North Carolina, as well as the next steps for the North

Carolina Alliance for Effective Care Transitions. A total of 276 providers and stakeholders participated in the summit. The next North Carolina Alliance for Effective Care Transitions meeting is scheduled for May 2012.

In partnership with the Carolinas Center for Medical Excellence, Community Care of North Carolina, and the North Carolina Alliance for Effective Care Transitions, the North Carolina Quality Center is also planning a 12-month collaborative program focused on reducing avoidable hospital readmissions. The North Carolina Quality Center was recently selected by the Centers for Medicare and Medicaid Services to be 1 of 26 hospital engagement networks, to help hospitals achieve the Partnership for Patients' goal of reducing harm by 40% and avoidable readmissions by 20%. The North Carolina Quality Center is partnering with the Virginia Hospital and Healthcare Association to form a regional hospital engagement network, the North Carolina-Virginia Hospital Engagement Network.

TABLE 1.
Organizations Represented at the North Carolina Alliance for Effective Care Transitions Stakeholder Meeting

Organization
AARP North Carolina
North Carolina Center for Hospital Quality and Patient Safety
Area Agency on Aging: Triangle J
North Carolina Chapter of the American Case Management Association
Association of Home and Hospice Care of North Carolina
North Carolina Division of Aging and Adult Services
Care Partners Health Services
North Carolina Division of Mental Health
The Carolinas Center for Hospice and End of Life Care
North Carolina Health Care Facilities Association
The Carolinas Center for Medical Excellence
North Carolina Health Quality Alliance
Community Care of Western North Carolina
North Carolina State Health Plan for Teachers and State Employees
Community Care of North Carolina
Northern Piedmont Community Care Network
Carol Woods Retirement Community
Sanford Health and Rehabilitation
Cone Health
Southern Atlantic Healthcare Alliance
Duke Raleigh Hospital
University of North Carolina Pharmacy Representative
FirstHealth Home Care
University Health Systems of Eastern Carolina
Institute for Healthcare Improvement
WakeMed Health and Hospitals
North Carolina Area Health Education Centers
Western North Carolina Health Network
North Carolina Assisted Living Association
Blue Cross Blue Shield North Carolina
North Carolina Association, Long Term Care Facilities
ActiveHealth Management

The North Carolina-Virginia Hospital Engagement Network's Prevent Avoidable Readmissions collaborative is scheduled to kick off in June 2012. The goals of this initiative will be to decrease all payer hospital-wide 30-day readmission rates by 20% and to provide medication reconciliation for 95% of individuals discharged from the hospital. Additional hospital-specific goals will be developed on the basis of hospital assessments of readmission patterns. Collaborative strategies will include: (1) utilizing the Institute for Healthcare Improvement's Creating an Ideal Transition Home to Reduce Avoidable Rehospitalizations model, (2) performing hospital self-assessment and analysis of 5 readmissions, and (3) identifying and connecting with relevant community based organizations. Key areas for improvement are the following: enhancing the assessment of patient posthospital needs, achieving effective teaching and enhanced patient learning, ensuring posthospital care follow-up, and providing real-time hand-over communications.

Registration for the NC-Virginia meeting is scheduled to open March 2012. Organizations seeking more information can contact Dean Higgins, project manager, at dhiggins@ncha.org or 919.677.4212, or Laura Maynard, director, collaborative learning, at lmaynard@ncha.org or 919.677.4121. NCMJ

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