Overview

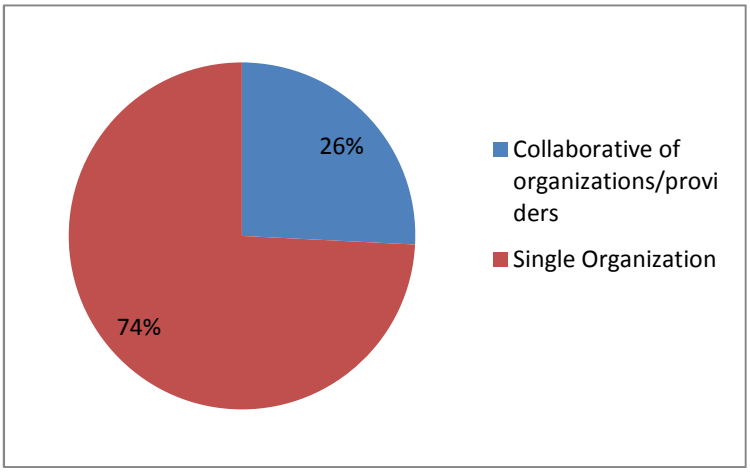
The Long-Term Quality Alliance's Innovative Communities Initiative has shown a light on a central theme – While action on the national level is integral to health care reform, we are convinced that the most important health reform victories will take place at the local level. A collective effort among a broad range of community stakeholders – nursing homes, assisted living, independent living, Area Agencies on Aging, physicians, hospitals, visiting nurses, home care agencies, consumers, to name a few – will be needed to break down silos and work together to implement strategies to that advance and improve care.

Despite many challenges, LTQA has seen evidence that collaborations are possible and are already taking place in a number of communities across the country[1] [2]. In an effort to better understand the work that many communities undertake, and to inform plans for future planning of the Innovative Communities Initiative, LTQA conducted a scan of communities.

A survey was developed to capture demographic data and information about current initiatives and measurement efforts of Innovative Communities. This survey was conducted online and sent to 220 self-identified communities representing a broad base of stakeholders. Respondents provided data for organizations representing a total of 162 communities serving over 1.4 Million individuals annually.

Demographic Information

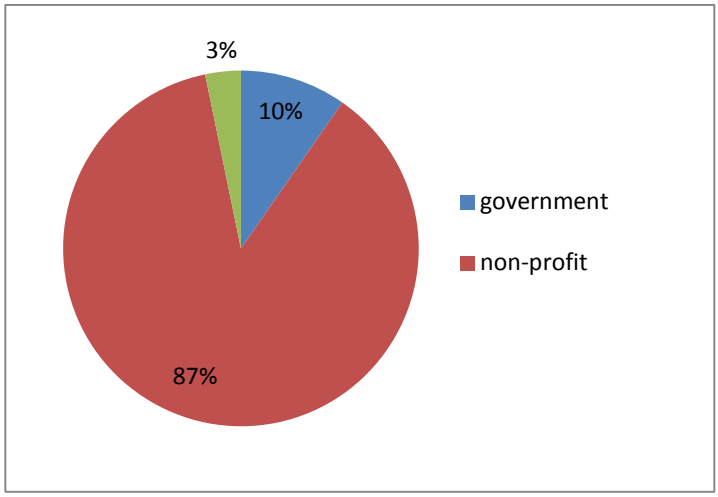
Respondents overwhelmingly (76%) represented single organizations as compared to multi-stakeholder collaboratives. These organizations, however, are inclusive of single-site and multi-site communities.



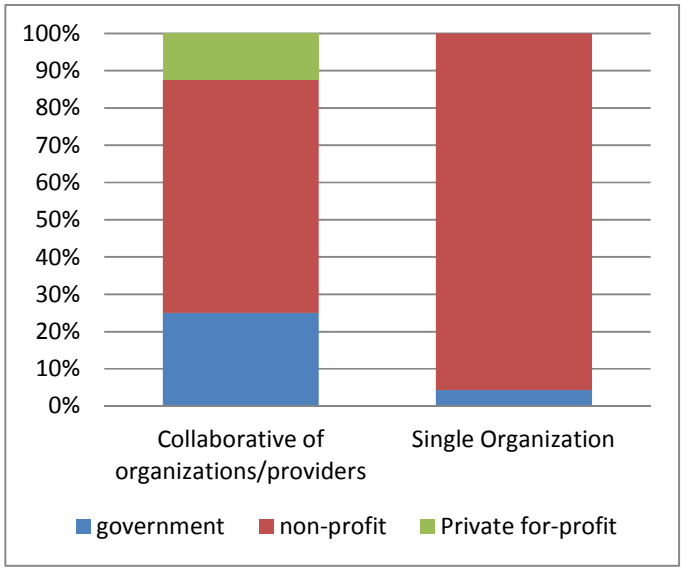
[1] Long-Term Quality Alliance, *Innovative Communities*: *Breaking Down Barriers For The Good of Consumers and Their Family Caregivers*. December, 2010 (Washington, DC)

[2] Long-Term Quality Alliance, Building Innovative Communities: *Promoting Health Reform Principles Through Community-Based Learning and Collective Action*, June 2011 (Washington, DC)

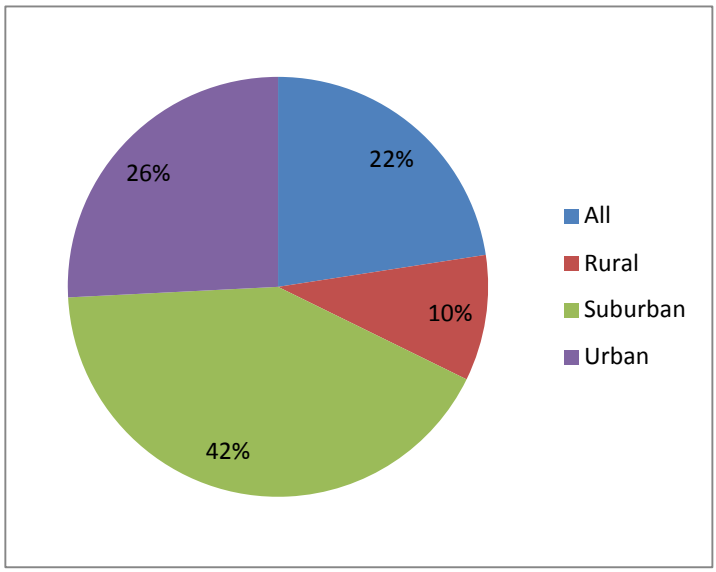
Respondents largely represent non-profit organizations. Only ten percent identified themselves as being affiliated with state or local government, and three percent identified as a private for profit organization.



While the majority of collaboratives identified as non-profit, those identifying as collaboratives saw greater diversity in their organizational type.

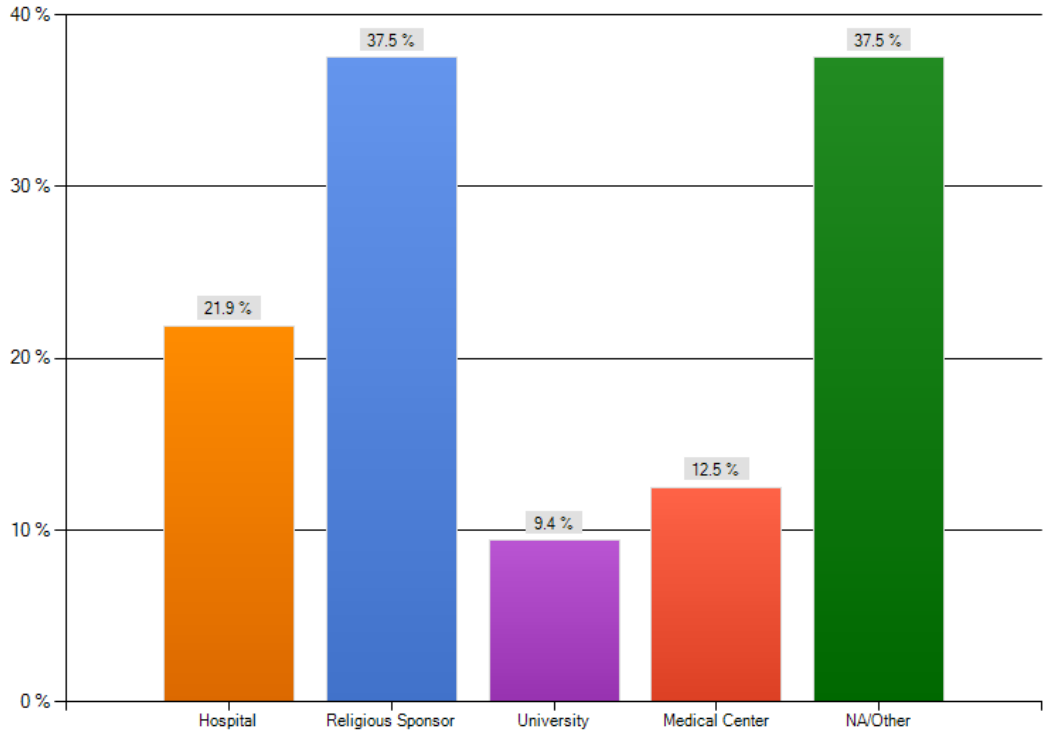


Geographically, the respondents are diverse with 42% located in suburban locations, 26% in urban locals, 10% identifying as rural, and 22% representing multiple areas.



Organizational Affiliations

Organizations identified several affiliations and many noted affiliations with multiple entities. Perhaps expectantly due to the largely non-profit group of communities, more than a third (37.5%) of organizations identify a religious affiliation. Hospital affiliations were also common (21.9%). There were also a large number of organizations that noted other affiliations; these included: Programs of All-inclusive Care for the Elderly (PACE), government, advocate/community partnerships, and a health delivery system. Nine percent noted that they did not have any affiliations.



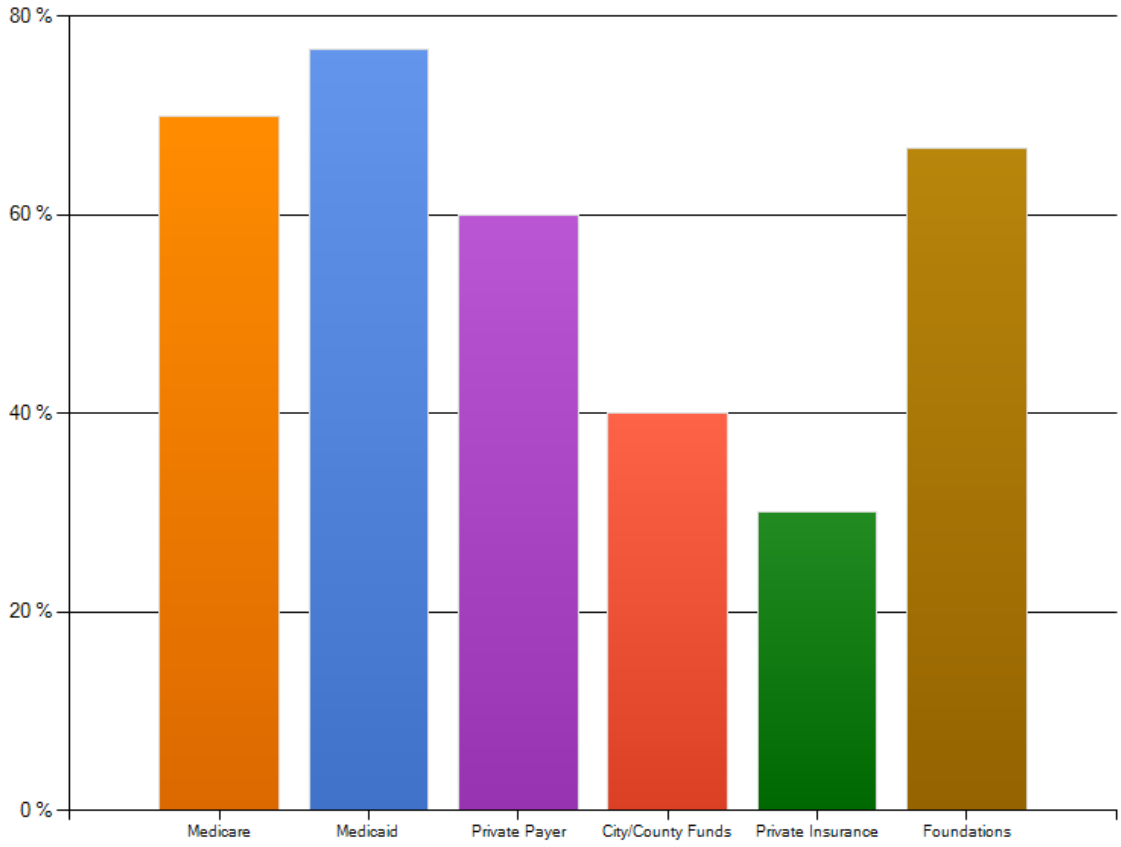
Of those that noted an affiliation with a hospital, 43% identified additional affiliations, most notably, medical centers. They also identified affiliations with universities and a religious sponsor.

Nearly all those that identified an affiliation with a religious sponsor stated that this was their only affiliation. Only 8.3% noted an additional affiliation (hospital & medical center).

Those that identified a university affiliation also identified a medical center affiliation. As might be expected, those identifying a medical center affiliation also noted hospital and university affiliations.

Funding

Responding organizations reported several sources of funding for their services, 96.8% of which reported multiple funding streams. Of the 3.2% that reported a single source, all reported Medicare as the sole source.



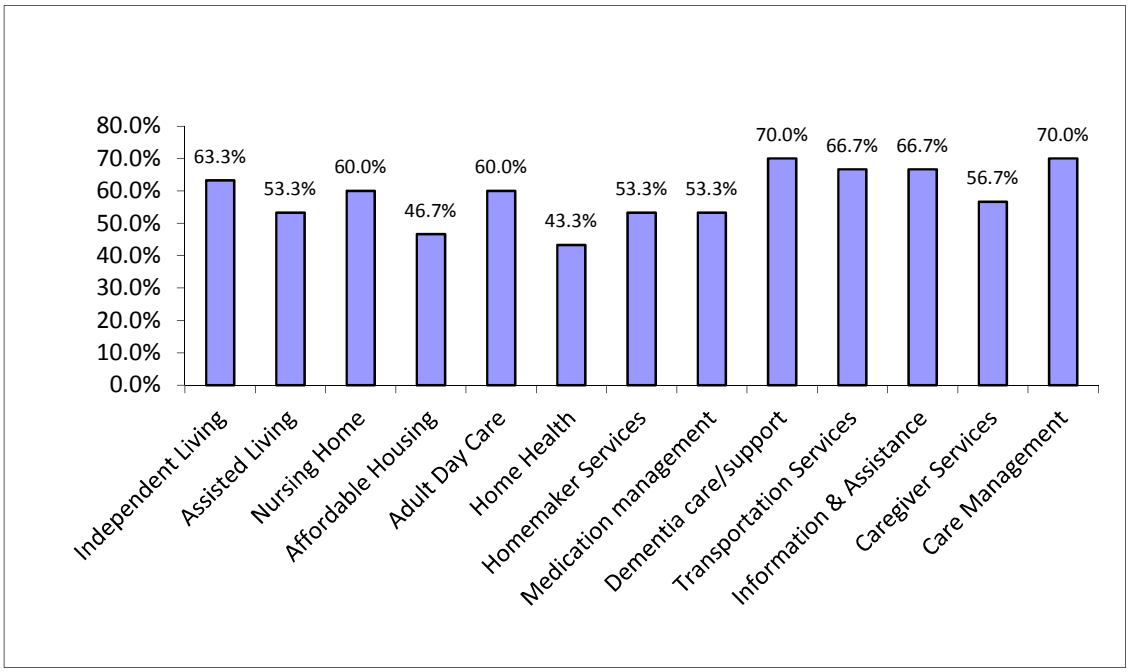
Sixty percent or more organizations identified Medicare, Medicaid, Private Payers, and Foundations as funding streams. 12.9% also reported receiving state or federal grant funding. Six percent reported that they received charitable contributions from local individuals, businesses and organizations.

If an organization reported receiving Medicare reimbursements, they were also highly likely to report Medicaid reimbursements; 90% receiving Medicare reimbursements also receive Medicaid reimbursements. 75% reported Medicare reimbursements and Private Payer revenue; 65% reported Medicare reimbursements and Foundation support; 30% also receive City or County funding, and 25% report also receiving monies from Private Insurance.

Respondents not receiving Medicare reimbursements were most likely to report receiving City or County funds (54%) or Foundation support (63%). No organization reported a single funding source other than Medicare reimbursements.

Services Provided

Responding organizations provide a wide variety of services to their clients. Our survey suggested several, and offered space to note additional services.



As expected, nearly all organizations reported multiple services provided to their clients. Only 6.4% reported a sole service (Information and Assistance). While the majority of listed services were reported more than 50% of the time as a part of an organization's menu, the most often provided services include Care Management (70%) and Dementia Care/Support (70%). Additional services mentioned include Hospice Care, Physician House Calls, Outpatient Rehab, Insurance Counseling, Home Delivered Meals, and Health Wellness Programs.

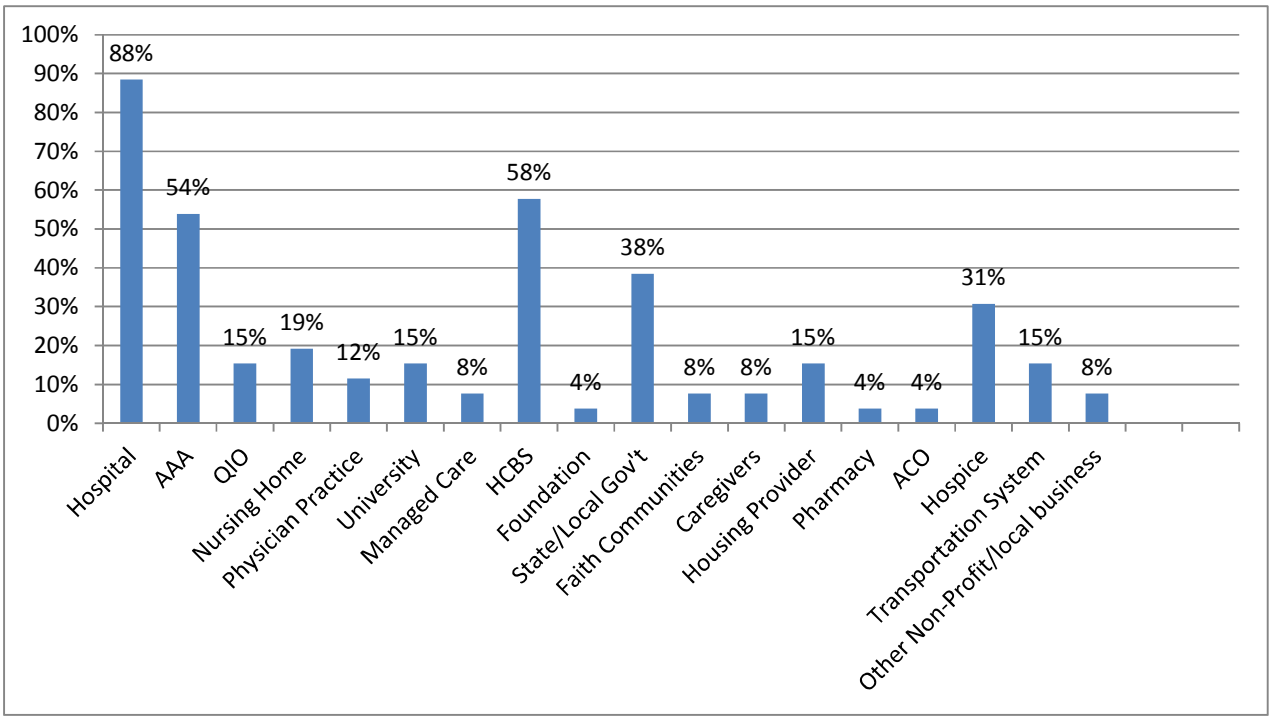
Organizations that provide Dementia Care & Support are highly likely to offer Transportation Services (81%), Adult Day Care (76%), Homemaker Services (48%), Medication Management (45%), Care Management (48%), and Caregiver Services (76%). When Adult Day Care and Caregiver Services are offered, there's a 96% chance that Dementia Care & Support is also offered.

All Respondents that provide Medication Management also provide some sort of housing service.

Seventy-four percent of respondents that provide some sort of housing service (Independent Living, Assisted Living, Nursing Home, Affordable Housing). Of those, 74% provide Transportation Services, 69% provide Dementia Care & Support, and 61% provide Adult Day Care.

Partnerships

Exploring the partnerships that already exist between communities and other organizations was a fundamental goal of this Scan. Respondents reported several different partnerships, and never identified only one type of organization with which a partnership was formed. Seventy-seven percent of respondents indicated that they participated in an established community coalition or collaborative group. Of this group, 62% indicate that they are a leading force in that collaboration.



In looking more closely at the types of partnerships that our respondents reported, it is not surprising that Hospitals are the most prevalent partnership mentioned. Care transitions and preventable rehospitalizations has been a major focus for many organizations of late. The number of patients discharged from hospital to home health care increased 53% between 1997 and 2006, while the number of patients discharged to nursing homes or rehabilitation facilities increased by 25% during the same period.[3] The impact of these increases become all the more

[3] Agency for Healthcare Research and Quality. 2008. "Hospital Discharge to Home Health, Nursing Homes Increasing." *AHRQ News and Numbers*, Oct. 23.

apparent when considering that nearly half of community-dwelling older adults discharged from a hospital to a nursing or rehabilitation facility experienced four or more care transitions to another institution over the next 12-month period.[4] These transitions and preventable rehospitalizations are expensive – preventable hospitalizations cost approximately $29 Billion and preventable rehospitalizations cost approximately $15 Billion annually[5] – and there are is a renewed focus on improving transitions and preventing avoidable hospitalizations.

Following partnerships with Hospitals (88%), organizations have entered regularly entered into partnerships with their local AAA (54%) and with local Home and Community Based Service providers (58%). Other common partnerships include State and Local Government Agencies (38%), local Hospice and Palliative Care Organizations (31%).

As previously mentioned, nearly all respondents reported multiple partnerships. Most common were those with a Hospital and a local AAA and/or Home and Community Based Service providers. Sixty-one percent of those who had an established partnership with a hospital also reported a partnership with a local AAA, and 65% has a partnership with a Hospital and Home and Community Based Providers.

Care Transitions Interventions and Measurement

We were also interested in exploring the efforts currently underway to improve care delivery, transitions and decrease preventable hospitalizations. We were not surprised to learn that 82% of respondents reported that they were currently implementing some sort of program. Several initiatives were noted, including: INTERACT, Coleman's Care Transitions Intervention, Naylor's Transitional Care Model, SASH, Evercare, and models developed for their own site/organization. The most widely reported intervention was Coleman's Care Transitions Invention which is reported to being used by 57% of those employing an intervention. Three-quarters of those implementing the Coleman model have done so for one-year or less, thus outcomes have not been fully documented, however, respondents anecdotally report decreases in rehospitalizations.

While a large percentage of respondents reported implementing an intervention to improve care transitions and reduce rehospitalizations, fewer (65%) reported measuring ER/Hospitalization/Re-Hospitalization utilization among their clients. As one might expect, a positive correlation was found between those implementing an intervention and those tracking

[4] Ma, E, et. al. 2004. "Quantifying Post-Hospital Care Transitions in Older Patients." *Journal of the American Medical Directors Association*, (5) 71-74

[5] Boutwell, A., et. al. 2009. *State Action on Avoidable Rehospitalizations (STAAR) Initiative: Applying Early Evidence and Experience in Front-line Process Improvements to Develop a State-based Strategy*. Cambridge, MA: Institute for Healthcare Improvement.

ER and Hospital utilization. Ninety-five percent also reported that they participate in other measurement activities. This measurement encompasses a large variety of data including HEDIS 5 Star Advantage Program, process and satisfaction measures, readmission by diagnosis, physician utilization, pharmaceutical utilization, post-acute care utilization, and reported access to services.

Conclusion

Because the responding population was overwhelmingly dominated by non-profit organizations, we are unable to draw any conclusions about the intervention and measurement efforts being implemented by the for-profit sector, however, several themes have emerged from this scan.

Organizations are choosing to implement established, evidence-based interventions to improve care transitions and reduce preventable hospitalizations. Few respondents reported undertaking non-tested programs. While most noted that they had newly adopted their intervention, several shared, anecdotally, that they had seen a decline hospitalization readmissions.

The scan also revealed that most partnerships are stand-alone and not a part of a broader collaborative effort. That is to say, few have taken on full-scale community collaborations like Community Connections (Chapel Hill) and Cathedral Square (VT)[6]. This confirms the anecdotal evidence gathered during LTQA's two Innovative Communities Summits. It also presents an opportunity for LTQA to provide leadership.

While this scan provided some useful baseline information, it is limited at that. Our intention is to take this a step further and conduct a more in-depth analysis of several existing programs. These robust profiles will then be used to promote a series of best practices.

[6] Long-Term Quality Alliance, *Innovative Communities*: *Breaking Down Barriers For The Good of Consumers and Their Family Caregivers*. December, 2010 (Washington, DC)