



Key Findings

- While many AAAs consider being part of a governmental structure a barrier to implementing care transitions programs, over half (55.0%) of these care transitions AAAs are part of a governmental entity.
- Of the AAAs reporting a specific care transition program model, 85.7% are using the Coleman model.
- Although they are a clear minority, many AAAs indicated they have an informal partnership with new health entities including, Accountable Care Organizations (18.8%), health information exchange or electronic health record consortiums (16.3%) and state health insurance exchanges (15.9%).
- Seven in 10 AAAs said they have a formal (29.1%) or informal (41.9%) partnership with their local State Quality Improvement Organization (QIO) for their hospital to home care transitions program.
- Common barriers to collaboration with the health care community are: achieving financial sustainability of initiatives (proposed or already implemented) (58.1%), a lack of shared or compatible technology (42.3%), a lack of data sharing (40.7%), unwillingness of health care partners to take financial risk (30.0%) and differences in technology availability (29.3%).

BRIDGING THE AGING NETWORK AND MEDICAL COMMUNITY SURVEY: CARE TRANSITIONS FROM HOSPITAL TO HOME

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Background

Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over \$26 billion every year (www.healthcare.gov). A number of programs and resources are helping communities reduce these readmissions through safe and effective transitions of older adults from one care setting to another. The Affordable Care Act introduced the Partnership for Patients to improve the quality, safety, and affordability of America's health care. Section 3026 of the Act includes the Community-Based Care Transitions Program (CCTP). Reducing readmissions for high-risk Medicare beneficiaries resulting in measurable savings in the Medicare program is the ultimate goal of the CCTP. In addition, the CCTP focuses on improving the quality of care throughout the continuum of care in a multi-pronged approach which identifies the various factors that impact hospital readmissions, so interventions may be developed and implemented.

With a grant from the Administration on Aging (AoA), the National Association of Area Agencies on Aging (n4a) partnered with the Scripps Gerontology Center to conduct the 2012 Bridging the Aging Network and Medical Community Survey of all 627 Area Agencies on Aging (AAAs) in the nation. The survey was designed to provide descriptive information about the connections between the Aging Network and the health care community.

The survey was launched in March 2012 and data collection concluded in May 2012 with 56% (350) of AAAs responding. Three in 10 (30.1%) AAA respondents indicated they have a program specifically for care transitions from hospital to home for some or all of their clients. It is important to note that AAAs are also involved in other care transitions work including care transitions from hospital to nursing home/assisted living facilities (15.0%) and care transitions from nursing home to home/assisted living facilities (30.4%).

This research brief provides key findings from the survey for the 103 AAAs involved in care transitions from hospital to home.

Organizational Infrastructure and Capacity

Organizational Infrastructure

There is great variation among AAAs particularly in the areas they serve, the governance structures of the organizations, and their size as reflected in financial resources. The characteristics of the AAAs with a hospital to home care transition program are shown below.

Area Served – proportion of AAAs that serve the following areas:

Urban - 9.9%
Suburban - 6.9%
Rural - 28.7%
Remote or Frontier - 4.0%
A mix of urban and suburban - 14.9%
Mix of suburban and rural - 12.9%
Mix of urban, suburban and rural - 22.8%

Structure – proportion of AAAs that identify their structure as the following:

Independent, non-profit - 42.2%
Part of city government - 1.0%
Part of county government - 27.5%
Part of COG or RPDA - 26.5%
Other - 2.9%

Budget – proportion of AAAs that reported the FY 2012 total operating budget ranges:

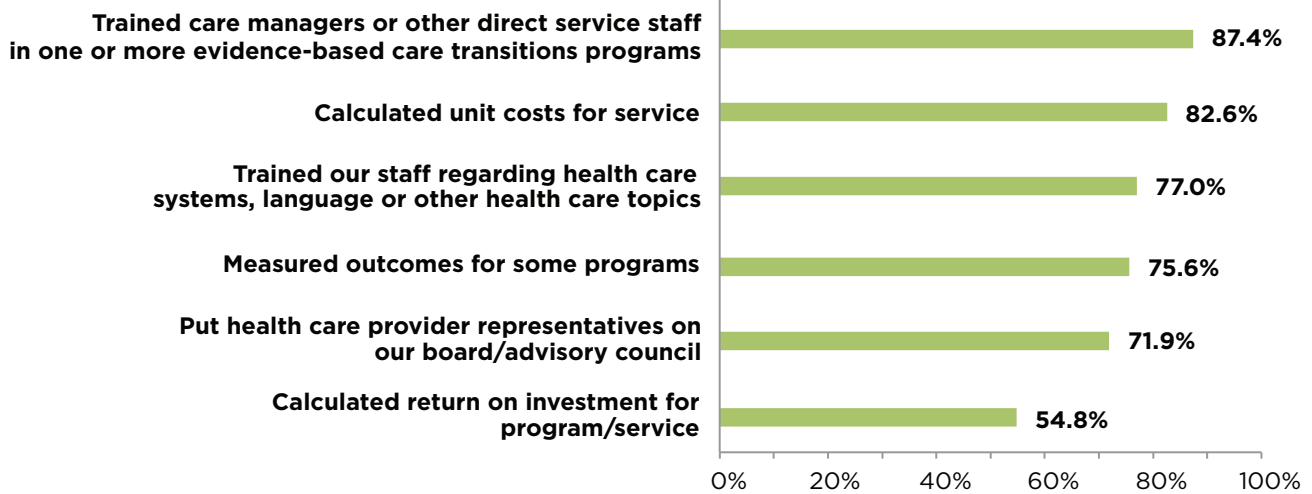
Less than 499,000 - 1.0%
500,000-999,999 - 2.0%
1,000,000- 4,999,999 - 38.2%
5,000,000- 9,999,999 - 20.6%
10,000,000-49,999,999 - 31.4%
Over 50,000,000 - 6.8%

- A third (32.7%) of AAAs with hospital to home transitions programs serve areas that are rural and remote or frontier.
- Although being part of a governmental structure has been discussed by AAAs as a barrier to implementing care transitions programs, over half (55.0%) of these care transitions AAAs operate as part of some governmental entity.

Organizational Capacity

Initiatives that engage the health care system such as hospital care transitions have required AAAs to develop new areas of knowledge and competence. Figure 1 shows the extent to which AAAs have undertaken a range of activities to develop their organizational capacity for successful implementation of their care transition programs.

Figure 1. Proportion of AAAs Who Have Made Progress or Have in Place Organizational Capacity Building Activities



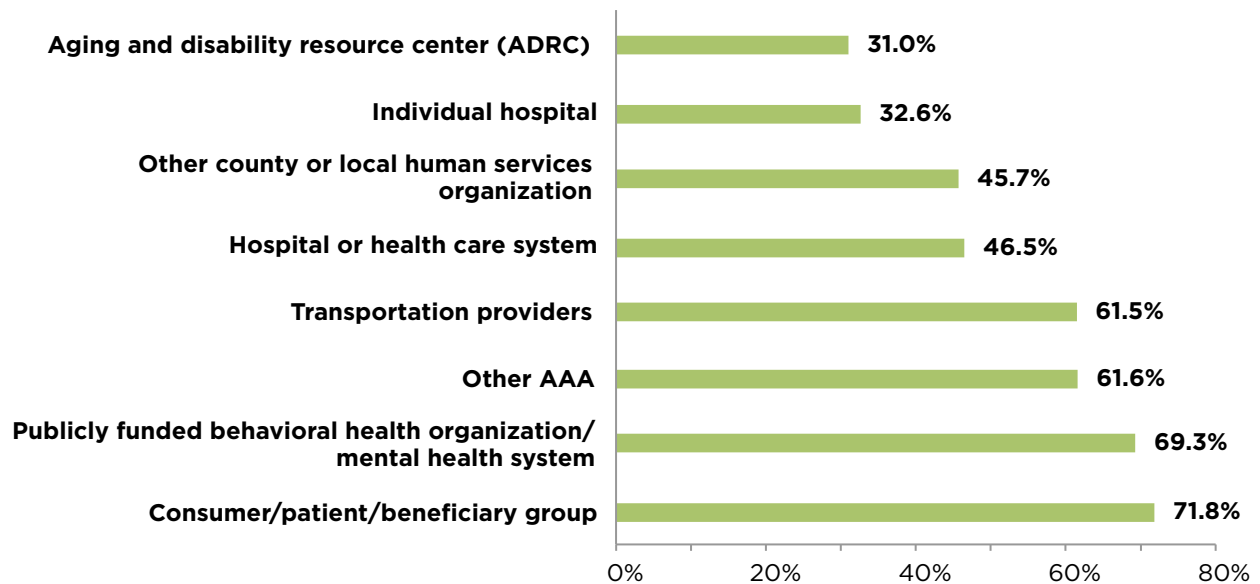
- A number of the activities these AAAs have made progress on or have in place are specific requirements of the Community-based Care Transitions Program (CCTP) including calculating unit costs for service (82.6%), measuring outcomes for some programs (75.6%) and putting health care provider representatives on their board/advisory council (71.9%), (See Figure 1).
- Of the AAAs reporting a specific care transition program model, an overwhelming majority (85.7%) are using the Coleman model.
- Areas which may be beyond the current scope and mission of most of these AAAs are those where a majority of AAAs have little or no current involvement and no plans to move forward. These include contracting with or placing a physician on staff (78.0%), hiring a nurse practitioner or other advanced care nurse (77.8%), contracting with or employing a health law attorney (75.3%), and contracting with or placing a health care administration professional on staff (53.8%).
- There are a number of activities related to the development and implementation of hospital to home care transitions programs that over a quarter of AAAs plan to work on but have not begun. These include contracting with health care providers to purchase AAA services for a fee (35.7%), implementing a self-evaluation of health initiatives (29.1%) and calculating return on investment for program/service (27.4%).

Partnerships and Partnership Activities

Holistic approaches to service delivery for older adults in conjunction with federal initiatives such as the Partnership for Patients have fostered connections between the Aging Network and the health care community. The Partnership programs focus on collaboration among health care providers, hospitals, nursing homes and other facilities, social service providers such

as AAAs, patients' caregivers, and patients themselves (www.healthcare.gov). AAA survey participants were asked to indicate, from a list of 34, which organizations they partner with to provide their care transitions from hospital to home programs and whether the partnership is a formal working partnership with some form of legal agreement or an informal working partnership. AAAs were also asked to indicate which organizations they do not work with in any capacity for their hospital to home care transitions program.

Figure 2. Most Common Formal Partnerships for Care Transition: Hospital to Home Programs



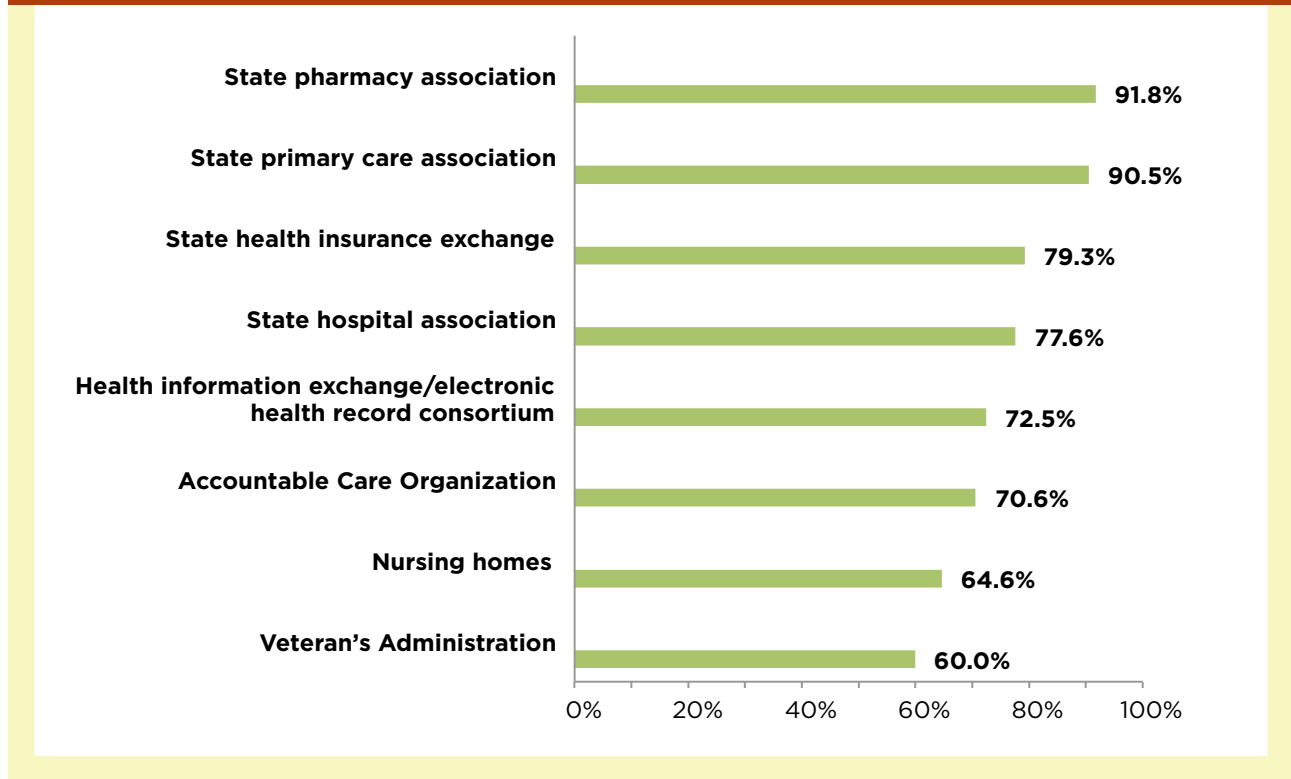
- On average, these AAAs have three formal partnerships for their care transitions from hospital to home program.
- As illustrated in Figure 2, AAAs are most likely to have formal partnerships with ADRCs (71.8%), individual hospitals (69.3%) and other county or local human services organizations (61.6%) for these programs.
- The most common activities that occur in the formal partnerships include, exchanging client referrals, training and technical assistance and exchanging HIPAA compliant client/patient data.
- AAAs with a care transitions from hospital to home program who had a formal partnership with individual hospitals and a hospital or health care system are much more likely to receive client referrals, to provide and receive training and technical assistance, exchange HIPAA compliant client/patient transmissions and receive or exchange electronic health records than AAAs who did not have a hospital to home transitions program.

Table 1. Comparison of Formal Partnership Activities with Individual Hospitals and Hospital or Health Care Systems

Partnership Activity	AAAs <u>with</u> Care Transitions: Hospital to Home Program N=78	AAAs <u>without</u> Care Transitions: Hospital to Home Program N=143
We receive client referrals from them	93.6%	84.6%
We make client referrals to them	37.2%	54.5%
We provide them training and technical assistance	47.4%	28.7%
They provide us training and technical assistance	38.5%	16.8%
We exchange HIPAA compliant client/patient transmissions	57.7%	21.7%
We receive or exchange electronic health records	21.8%	5.6%

Note: The number of respondents to these items is lower than the total of all survey respondents (n=350) since some respondents did not answer all questions.

Figure 3. Least Likely Partner Organizations For AAAs with Hospital to Home Care Transitions Programs



- Although a majority of AAAs do not work with these organizations as shown in Figure 3, many AAAs indicated they have a formal or informal partnership with several new health entities including Accountable Care Organizations (29.4%), health information exchange/electronic health record consortiums (27.6%) and state health insurance exchanges (20.8%). In addition, seven in 10 AAAs said they have a formal (29.1%) or informal (41.9%) partnership with their local State Quality Improvement Organization (QIO) for their care transitions from hospital to home program.

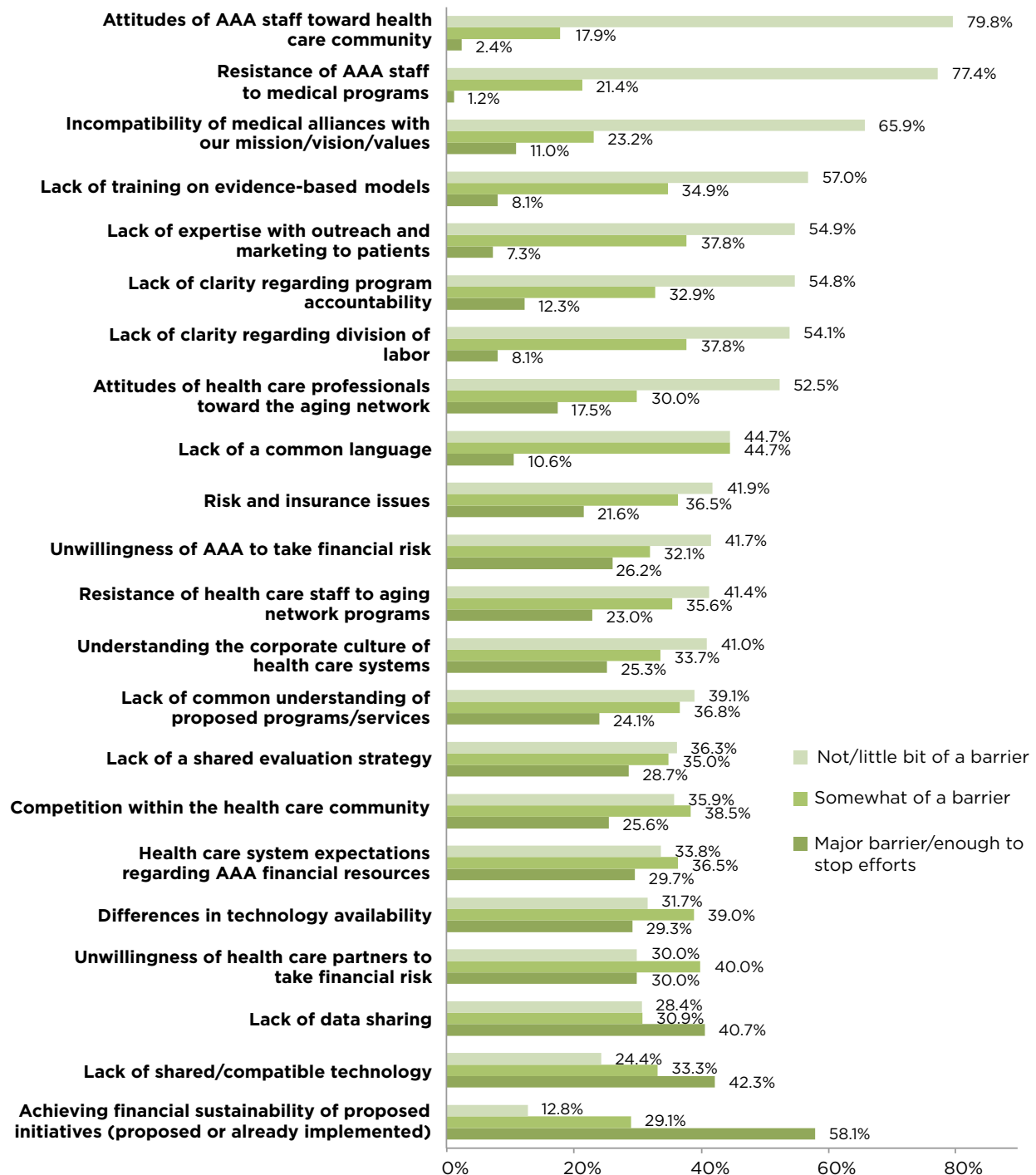
Opportunities and Challenges

The Aging Network is expanding its programs and services through collaborative initiatives between the Aging Network and the health care community, particularly, in the area of hospital care transitions. Their work faces historic policy developments in the health and aging services arenas. This situation creates a number of challenges while providing opportunities for growth and change. Respondents were asked to indicate, from a list of 23 potential issues, barriers to their collaborative efforts with the health care community. Respondents indicated the extent to which each item was a barrier, ranging from “not a barrier” to “enough to stop efforts.” Figure 4 shows the responses grouped into categories of “not a barrier or a small barrier,” “somewhat of a barrier,” and “a large barrier.”

- As illustrated in Figure 4, the most commonly reported major barriers to collaborative efforts with the health care community are: achieving financial sustainability of initiatives (proposed or already implemented) (58.1%), a lack of shared/compatible technology (42.3%), a lack of data sharing (40.7%), unwillingness of health care partners to take financial risk (30.0%) and differences in technology availability (29.3%).

- The shift in organizational culture that is required for bridging the social and medical models may not be as much of a concern as often thought. About three-quarters of AAAs indicated that the attitudes of AAA staff toward the health care community (79.8%), resistance of AAA staff to medical programs (77.4%) and incompatibility of medical alliances with our mission/vision/values (65.9%) did not pose barriers to collaborative efforts (see Figure 4).

Figure 4. Proportion of Hospital to Home AAAs Experiencing Barriers With Collaborative Efforts With the Health Care Community



Conclusion

A significant number of AAAs have engaged in programs to assist older adults in safe and effective transitions from care in the hospital to care at home. Their programs engaged formal partnerships with hospitals and health systems, and relied on advances in technology such as HIPAA compliant client data transfers and electronic health records. The group of AAAs described in this brief report is likely to grow and change as more AAAs take advantage of incentives found in the Affordable Care Act and other public and private initiatives.

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