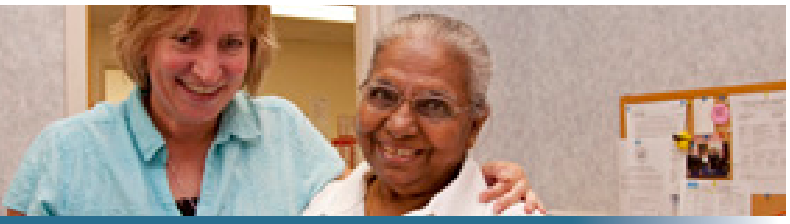

Chapter Three: Developing Effective Partnerships with Health Care Providers

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Chapter Overview

Strong community-wide partnerships with multiple health care stakeholders and other community based service providers are the backbone of a successful care transitions program. This chapter discusses two interrelated levels to developing the partnerships necessary for care transitions work:

- Identifying and building quality partnerships that take a community-wide approach with multiple health care stakeholders
- Making the business case for your program's/organization's involvement in care transitions to various health care audiences, including hospitals

Identifying Potential Care Transitions Partners

In your community, there is likely to be more than one possible health care/community partner that may be interested in implementing a care transitions program. The Aging Network has collaborated with a variety of different organizations to improve care transitions, including physician practices, hospitals, quality improvement organizations, home health agencies, skilled nursing facilities, and insurance companies. Completing a comprehensive environmental scan or market analysis of all possible partners will help maximize your opportunities for collaboration. Consider existing partnerships and build upon those relationships to develop and implement a care transitions program.

There are many different strategies to consider when developing new relationships with health care partners. Although this section is specific to hospitals, similar strategies can be applied to other partners as well.

Identify specific hospitals. If you have access to hospital utilization or discharge data, it may be useful to target your initiative at specific hospitals that have higher rates of rehospitalization (which may have more reason to partner with you). Think about choosing a hospital that serves your target population in sufficient numbers to justify your presence. A great place to start is Medicare's Hospital Compare website.

Resources

- AoA Care Transitions Webinar: Making the Programmatic Case
  - Slides
  - Transcript
  - Recording

Contact hospitals directly. Your organization may also have strong relationships with hospital staff associated with other programs, which can create opportunities to explore care transitions partnerships. This is a good place to start. You might choose to work directly with the office responsible for discharge planning or start by attempting to contact the president or CEO. Developing multiple avenues and contacts at various levels of the hospital or health system structure is a good long-term strategy in the event of turnover among key staff members.

Resources

- AoA Care Transitions Webinar: Care Transitions in Action
  - Slides
  - Transcript
  - Recording

Work through your State's hospital association. Every State has a hospital association and most associations publish newsletters, host conferences, and stay in touch with members about new initiatives. Your State's hospital association might be interested in your program and might suggest partners or highlight the transition initiative in a monthly newsletter.

Streamline collaborations. Connecting with other local AAAs or ADRC sites in your area to develop a collaborative approach can help support discharged patients across county and regional service area lines.

Lay a foundation. Successful partnership work is challenging and requires patience. In some cases it can take years for partners to fully understand and benefit from each other. A good foundation for all partners in care transitions efforts can include:

- Formal agreements
- Formal referral protocols
- Co-location of key staff
- Cross-training key staff
- Joint marketing and outreach
- Consumer/patient service coordination
- Sharing consumer/patient data (where possible, with the client's/patient's permission)

Engaging Your Quality Improvement Organization

Quality Improvement Organizations (QIOs) require special consideration for partnership recruitment and engagement. QIOs can help build trust and reliable interfaces among project partners. For more information about the QIO's role in community recruitment and engagement, visit: http://www.cfmc.org/caretransitions/toolkit_cre.htm

Cross Cultural Strategies for Strengthening Partnerships

It takes sensitivity, commitment, and patience to overcome cultural and organizational differences. Familiarity, trust, and acceptance developed on all levels of staffing, including leadership, administrative support, and front line staff, are important so that when a failed transition occurs, issues can be identified and addressed appropriately, before they become a major problem. Performing site visits, shadowing staff from partner organizations, and participating in joint trainings are

all good methods of engaging partners and developing a more detailed understanding of how the organizations operate and how they can contribute to the care transitions initiative.

Each partner has its own unique perspective and way of conveying information. This can be especially true for partners that span different care settings such as hospitals, physician offices, home health providers, aging and disability networks, and other community-based long-term service and support providers. Without understanding your partners' organizational culture, critical information can be lost in translation. In order to successfully communicate about responsibilities, protocol, and terminology, the interpretation of information must be clear. Be aware of these cultural differences and address them upfront.

Address partner expectations. It is important to state upfront what expectations each party has and how they can be addressed through the partnership. For example, how quickly will your organization respond to referrals received from the hospital? Will it provide access and space within the hospital to host a co-located AAA or ADRC staff member? Does your organization need access to certain hospital data in order to evaluate the program? How will information be shared and in what format? How will Aging Network staff be incorporated in the discharge planning process early on? How will your organization provide access to services immediately upon discharge? Addressing these expectations upfront will help your partnership identify possible solutions and help avoid possible barriers.

Communicate frequently. Misconceptions between new partners can be caused by lack of knowledge of organizational culture and service delivery models. The need for frequent communication and collaboration can overcome these potential conflicts. Additionally, there may be turnover within partner organizations, and planning to repeat your outreach and education efforts will reinforce your partnership. Some helpful strategies employed by current care transitions partnerships include:

- Making a routine of sending information on new community programs directly to key members of the partnership
- Attending department meetings to describe care transitions activities and provide program results
- Developing free or low cost continuing education classes—health care professionals may access these classes to maintain professional certification and meet continuing education requirements
- Exploring opportunities to promote the care transitions collaboration and share outcomes through staff communication media, such as internal newsletters or staff web portals

Resource

- Cross Cultural Strategies for Strengthening the Relationship between Hospital and Community Systems (Slides)

Making the Business Case

Developing a business case is another step in building collaboration that can facilitate infrastructure development and support sustainability efforts. Like other components within the care transitions program, this will take planning and preparation by your organization before approaching new partners. It is important to understand the target hospital/partner(s) and whether their organization and mission overlap with the mission and goals of your organization. As you formulate the business case for partnership, potential partners should easily understand why an investment of time and resources in collaboration with the care transitions program is valuable to them, their customers/clientele, and/or the greater community.

Resource

- n4a Aging Business Academy Program

Develop a strong message about the Aging Network. You may need to explain the role of the Aging Network in care transitions programs and the value of these programs in brief but with enough detail to justify continuation when evaluated by key administrators who need to trim costs. This message could be adapted for different stakeholders and audiences within the same organization (e.g., directors of discharge planning, chief fiscal officers, hospital CEOs). Visually representing information to illustrate the Aging Network structure and connections between Older Americans Act services and care transitions strategies has been helpful to other AAAs or ADRCs operating care transitions programs.

Resources

- What is the Aging Network?
- OAA Services and Care Transitions Crosswalk

Diffuse messages throughout your organization. It is also important for all levels of staff to understand how collaboration will help hospital and community partners meet their goals and be able to convey messages that articulate these opportunities. Understanding how individual programs or departments play a role will help staff craft and consistently deliver the message with internal and external stakeholders. A critical part of framing the message will be clearly stating the potential positive outcomes for consumers, families, and partners.

Messaging Strategies and Promoting Your Partnership

When first approaching hospital leadership, it will be helpful to know information about the organization. Doing some research about your potential partner can help you uncover potential selling points for your initiative.

Resource

- Developing Care Transition Partnership Messages (PDF)

Highlight the hospital's mission. Many hospitals have an explicit mission to improve the health of the surrounding community. A well conceived care transitions program may fit the hospital mission. Noting any concordance between the initiative and the hospital's mission may be an effective selling point. Many hospitals post their mission statements on a public website.

Consider the community benefit. Not-for-profit hospitals must provide a community benefit to justify their tax-exempt status. Recently, payers and policymakers have placed an increased emphasis on monitoring community benefit. The need to provide and document community benefit may be a motivating factor for the hospital, especially in States where community benefit has been a public issue.

Align common interest and expertise. Individuals at risk for multiple rehospitalizations are frequently already connected to the Aging Network, or are within the target population served by your organization. Present hospitals with convincing data that illustrate the overlap in your collective expertise. Such data could include

consumer demographics, program outcomes, previous funding awards in related efforts, etc.

Speak about reducing rehospitalizations. Beginning in 2012, hospitals will be financially penalized for potentially preventable Medicare readmissions within 30 days, regardless of which hospital an individual is readmitted to.[9] Raise awareness of the clinical and economic outcomes your partnership and program can address.

Share feedback. Once a patient leaves the hospital, discharge planners often do not know the outcome of the transition home. Providing feedback to the discharge team regarding the type of support and services the individual will receive and the outcome of the transition not only enhances the relationship but also demonstrates the role and value of your organization within the discharge process. You can pique the hospital's interest by sharing the results of data collected from your initiative.

Address patient satisfaction and quality. Hospitals routinely measure patient satisfaction with hospital services, and many hospitals make patient satisfaction an important part of their quality improvement and marketing strategies. Additionally, under the Hospital Value-Based Purchasing program, hospitals that do not provide high-quality care to Medicare beneficiaries as indicated by their performance on certain measures will be financially penalized.[10] Your initiative may be a way to improve patient satisfaction by providing extra assistance and consultation to patients and their families.

Resources

- MD Link: Partnering with Physicians and Community Organizations

9 Patient Protection and Affordable Care Act, Public Law. No 111-148, § 3025, 763-776 (2010) http://www.healthcare.gov/center/authorities/patient_protection_affordable_care_act_as_passed.pdf

10 Patient Protection and Affordable Care Act, Public Law. No 111-148, § 3001, 613-642 (2010) http://www.healthcare.gov/center/authorities/patient_protection_affordable_care_act_as_passed.pdf

Formalizing Agreements

Care transitions partnerships should consider developing formal agreements. A comprehensive agreement clearly addresses each partner's roles and responsibilities as well as many of the elements needed for the partnership to run smoothly. While agreements can and should be reviewed and revised over time, a strong agreement forged early in the partnership lays the foundation for a strong and sustainable collaboration.

A partnership agreement between hospitals and community based providers contains critical information and clarifying details. Agreements include some standard legal sections, but the language used often sets the tone for a "partnership spirit." Agreements vary, reflecting the uniqueness of the partnership and can take on varying degrees of formality ranging from letters of support, to memoranda of understanding, to formal legal agreements. Common elements often include the following (though not every item need be addressed):

- General information
- Partnership services
- Fiscal and other resources
- Systems
  - » Planning and decision making
  - » Communications
  - » Oversight
  - » Recordkeeping and documentation
- General administrative elements

Resources

- Guide to Memorandum of Understanding Negotiation and Development
- Maximizing Program Services Through Private Sector Partnerships and Relationships
- Sample Agreements (Zip)

Special Considerations: Institutional Review Boards

An Institutional Review Board (IRB) reviews research involving human subjects including all projects involving the hospital's patients or personnel, regardless of sponsor. Protecting human subjects, during research activities is critical and has been at the forefront of U.S. Department of Health and Human Services (DHHS) activities for decades. In addition, the DHHS is committed to taking every appropriate opportunity to measure and improve the quality of care for patients. These two important goals typically do not intersect, since most quality improvement efforts are not research subject to the DHHS regulations dealing with the protection of human subjects. However, in some cases quality improvement activities are designed to accomplish a research purpose as well as the purpose of improving the quality of care, and in these cases the regulations for the protection of subjects in research (45 CFR part 46) may apply.

To determine whether these regulations apply to a particular quality improvement activity, the following questions should be addressed in order:

1. Does the activity involve research? (45 CFR 46.102(d))
2. Does the research activity involve human subjects? (45 CFR 46.102(f))
3. Does the human subjects research qualify for an exemption (45 CFR 46.101(b))
4. Is the non-exempt human subjects research conducted or supported by HHS or otherwise covered by an applicable FWA approved by Office for Human Research Protections (OHRP)

For those quality improvement activities that are subject to these regulations, the regulations provide great flexibility in how the regulated community can comply. Other laws or regulations may apply to quality improvement activities independent of whether the DHHS regulations for the protection of human subjects in research apply. It is important for you to consult with all of your hospital partners regarding state and internal policies for institutional review. It will require additional consideration to establish the memorandum of understanding (MOU) and timeline for program development.

For more information, visit: http://privacyruleandresearch.nih.gov/irbandprivacyrule.asp.

The Road to Partnership—A Case Study

It takes time for new partners engaging in care transitions work to build effective and mutually beneficial relationships. It will also take many strategies, stakeholder champions, and continuous education to get you there. This case study from Missouri's Hospital Discharge Planning Grant discusses the back and forth journey to developing and engaging their hospital partnership.

A portion of the first year of planning was spent educating hospital discharge upper management of the partnering hospital on the goals of the grant and how the involvement of their staff would be a great benefit to the project. Part of the education was to relieve any doubt that this project would replace their system, but rather enhance it and provide a valuable community resource to hospital discharge planners. A meeting with executive leadership of

the medical center and the two other partnering hospitals was held late in the second planning year. Employing educational presentations on the desired outcomes of the project, how it would help hospitals deal with readmission, and the new CMS reimbursement regulations was very effective. We developed message strategies to reassure that the intent was neither to shut down nursing facilities nor supplant hospital dischargers or home health nurses or aides. The overwhelmingly positive response on the part of executive leadership greatly helped to solidify relationships and further impacted relations with upper management. In hindsight, it would have been better to have built relationships with these organizations with a "top-down" fashion, securing first the support of executive leadership and key management.

Missouri Department of Health and Senior Services Division of Senior and Disability Services Hospital Discharge Planning Grant

Questions to Consider and Practical Advice from the Field

Q: How did you initially get started in your partnership development?

Participation needs to further the goals of each partner's organization, making successful completion a "win" for everyone. Orientation on project goals and benefits was provided to all partners and reviewed often. To be respectful of everyone's time, we aimed for short, productive meetings and set aside time for monthly conference calls. Face-to-face meetings helped partners get to know each other. We developed an online collaboration portal to provide a platform for communication and information sharing. *South Carolina Bureau of Senior Services, Hospital Discharge Planning Grant*

We had staff outside of the immediate project at the State level interview each partner separately so that we could better understand where there might be "history" between partners that could affect our working together. We met regularly as the Care Transitions Task Force to complete the design work for the hospital model. We used a "safe table" agreement that covered the need for confidentiality and the ability to share de-identified client data for quality improvement purposes. *Oregon Seniors and People with Disabilities, Hospital Discharge Planning Grant*

We have found that each hospital has its own unique hierarchy and decision-making system. This is particularly true in the area of discharge planning; some systems use a nurse case manager to drive the discharges, others use a social service system. Before seeking partnership, it is critical to understand the hospital system. Identifying a champion for the project is a second key element in forming the partnership; your champion can help in understanding the system and in gaining access to higher level decision makers. In our experience it was most helpful to begin where we had an existing interface with the hospital system; for us this was the social service department. We started as a guest working with social services and had the ultimate vision of integrating our staff within all levels of the hospital system. I would encourage new projects to work toward

having access to the hospital executives in order to achieve a true partnership. Lastly, in choosing a hospital partner it is important to look at values: Do you respect each other? Is this a system that is open to change? Evaluate the size of the institution and your program's ability to meet the needs of the patient population. *Aging Care Connections, ADRC Evidence-Based Care Transitions Program*

We developed a simple online survey designed for key line staff from all partners who worked on the program (e.g., case managers, discharge planners, nurses). This helped us with the development of protocols, identified key staff for focus groups, and identified leaders to rally participation. *Kansas Department on Aging, Hospital Discharge Planning Grant*

We've very much focused on our board development over the years. Our AAA has a large board of directors —29 members—that has gone from a business focus to a medical one. It now includes two to three CEOs from hospitals, a chief medical officer (a geriatrician), a hospice physician, a family practice physician, etc., so that half of all members are in medical or health fields. We needed to get buy-in from this broader group to improve coordination between medical and long-term care systems and expand the home and community based services system. *Area Agency on Aging 10B, Inc., Uniontown, Ohio*

Our motto, which has been our motto within our care management system, and continues to be our motto with care transitions, and which resonated very well with the hospitals and health plans, is to make sure that older adults receive the right care at the right time, in the right setting, and at the right cost. Our goal was to communicate our value to hospitals and health plans, to be seen as a good community partner, and to identify mutual goals and interests, and to understand their priorities and interests. We explained to them all that we do and the value and services that we bring to the community. We were surprised that most of the hospital executives had very limited knowledge of community based, long-term services and support, and were also unaware of the unbiased nature of our Area Agency on Aging. Many of the hospitals told us that they had limited knowledge of services that are available outside of the hospital walls. When we talked to hospitals and health plans, we made sure that we distinguished ourselves from vendors that they're frequently hearing from. We told them, "We're not here to sell anything. We also aren't just doing care transitions. We are providing long-term care consultations. We're options counseling to make sure that the patient understands all of their options." *Council on Aging of Southwestern Ohio, Cincinnati, Ohio*

Q: What strategies did you use to encourage partnership buy-in?

It really helped having buy-in from the top level within our own network. Our secretary of aging met with administrators of each hospital to explain the project, emphasize its importance, and ask that administrative point people be assigned to our development team. *Kansas Department on Aging, Hospital Discharge Planning Grant*

Due to disparate resources of our participating hospitals, as well as the severe budget cuts many of them are contending with, our project aimed to integrate the meaningful use of options counselors in discharge planning, rather than attempting to design the project that would entail major changes in procedures and staffing within the hospital. This was an effective strategy for obtaining buy-in and solidified our option counselor's role in the discharge planning process. *Missouri Department of Health and Senior Services, Division of Senior and Disability Services, Hospital Discharge Planning Grant*

Our program gained hospital buy-in for their care transitions program through personal networking. The AAA/ADRC planning staff went to hospital administrators and asked them to support the project. Gaining buy-in was easy once we explained our vision

for the program. The chief operating officer of two hospitals now involved in the program connected us with the state hospital association, which also supported the project and brought in more partners. *West Virginia Bureau of Senior Services, Community Living Program*

We worked with the director of case management, then with the managers of the case managers, and the case managers themselves to get buy-in for the program. We met frequently and offered financial incentives for participation. Initially we did not work with doctors, preferring to keep it contained to the discharge process. However, training and education about the program has begun with physicians. *AAA of Central Texas, ADRC Evidence-Based Care Transitions Program*

If I was to frame this in a large aspect, we are kind of the beta site for the AAA, before they spread to other hospital systems in the region. How did we first begin? We got together in a room and it was kind of like, "Hi, what's your name, what's your major ... " And we just started dating from there. I now sit as the chief medical officer for the Area Agency on Aging Board. I think that's important because, as a geriatrician, I have the ability to "span boundaries" between the hospital and long-term care and the community. As we went along we would communicate together with the AAA and trust each other and have a kind of mutually aligned vision. We have always addressed each other's threats and concerns and conflicts openly. We built trust and identified major gaps in the continuum of care for each partner in communication and processes. We wanted to integrate the AAA programs across a hospital based geriatric program and the Aging Network to gain improvements. We saw a real need, and although this may not be aligned with hospital admission targets at the time, I was focused on reducing readmissions for at risk and vulnerable elders—that is what we were doing. While we saw vulnerable populations being admitted to our Acute Care for Elders (ACE) unit, they would get skilled home care on discharge, but their social determinants and other needs wouldn't be met. So we wanted to expedite that referral to community based long-term care services and we began by identifying the need proactively at the time of hospitalization. *Dr. Kyle Allen, Medical Director of Post Acute and Senior Services, Program Director of the Geriatric Medicine Fellowship Program, and Chief of the Division of Geriatric Medicine Summa Health System, Akron, Ohio*

Q: What were some milestones in establishing your collaborations and partnerships?

A primary milestone in establishing the collaboration and partnership is executing a written agreement between the partners. We started with a simple memorandum of understanding; this should be in place prior to the start of the project. Having such an agreement is valuable in eliminating challenges that can arise due to changes in leadership or personnel within either partner organization. Ultimately, to have an enduring partnership, a legal partnership agreement is essential. This agreement should address essential elements such as liability, data sharing, and confidentiality. The memorandum or legal agreement should also clearly define the service provision and the responsibilities of each partner. Training of social work and nursing staff is another essential milestone in gaining acceptance for the project and cooperation. *Aging Care Connections, ADRC Evidence-Based Care Transitions Program*

Additional Resources

- Community Partnership for Older Adults: Partnership Evolution http://www.partnershipsforolderadults.org/resources/levelone.aspx?sectionGUID=e51f8945-eb69-4567-af0e-057fdb6df753

Tools

- Developing Care Transitions Partnership Messages
- OAA and Care Transitions Crosswalk
- What is the Aging Network