Developing inter-agency collaboration for older patients needing rehabilitation

Geoffrey Bloor

Abstract

Inter-agency collaboration is becoming increasingly important in delivering services to elderly people. Collaboration is not easy and careful attention needs to be paid to developing and sustaining the necessary working relations. This paper presents an analysis of what worked in a successful rehabilitation program involving collaboration among a number of acute public hospitals and aged care service providers.

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What is known about the topic?

Inter-agency collaboration to facilitate continuing care for clients is important, but not easy to achieve.

What does this paper add?

This paper outlines the views of stakeholders of the Acute Transition Alliance–Home Rehabilitation and Support Service (ATA–HRSS),[1] which provides rehabilitation and support for elderly people following an acute hospital stay, on aspects of collaboration.

What are the implications for practitioners?

The study suggests that shared vision, flexibility in implementation, top-down support, building understanding and trust, joint learning and development of a rehabilitative culture were key to the success of this program. ◆

IMPROVING THE INTERFACE between the acute and aged care sectors has become a priority in recent years.[2] The fact that these sectors, although serving essentially similar client populations, have developed largely independently of each other presents considerable challenges in developing cooperation between individuals and organisations both across and within these sectors.

The Acute Transition Alliance–Home Rehabilitation and Support Service (ATA–HRSS)[1] provides rehabilitation and support for elderly people following an acute hospital stay. Its success has depended upon a high degree of collaboration between the 21 public hospitals and 18 aged care providers involved, and upon the ability of aged care organisations to adopt a rehabilitative approach to aged care. This paper presents an analysis of the methods used in this program to enhance collaboration and inter-organisational learning. A brief background to the program is given. This is followed by a summary of what is already known about collaboration, and an overview of the research. The paper then moves to key themes that were identified in the research and a discussion of what worked for the ATA–HRSS.

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Background

In 2000–2001 the South Australian health system faced a crisis because of high numbers of elderly people waiting in public hospitals for residential care beds. The press and the hospitals blamed the aged care sector as, for a variety of reasons, there were temporarily insufficient places to meet the demand. Consequently, the South Australian Government funded a pilot program whereby elderly people identified in hospital as needing residential aged care placement but who might benefit from rehabilitation were given this opportunity through the use of unlicensed places within the aged care sector. The success of this pilot encouraged the Commonwealth and state governments to jointly fund the ATA–HRSS as part of the Innovative Care and Rehabilitation Services program.

There were many stakeholders to this program. The public hospitals wanted early discharge of patients and reduced length of stay. The aged care providers believed they could assist using existing services and saw the opportunity to expand their roles in a pilot environment. They believed many people were being admitted inappropriately to residential care as the only available option apart from hospital. The state government was concerned to stop the "bed blocking" in the public hospitals, thereby reducing hospital waiting lists and the associated political problems. The Commonwealth government wished to ensure that elderly people were not admitted prematurely to permanent residential aged care. Collaboration was required to address these different agendas for the program.

The research

The author was a participant observer and member of the Steering Committee and researched:

- What factors facilitated collaboration between the many stakeholders?
- How did participation in the program affect the way workers in the two sectors interacted with each other?
- What impact did participation have on the way workers interacted with elderly clients?

The methodology included interviews and focus groups with a range of key stakeholders and workers in the program, and analysis of minutes and documents connected with the program. These different methods enabled triangulation of data collected, and contributed to a broader and deeper understanding of interagency collaboration and of participants' experiences of collaborating with other agencies.

Facilitating collaboration

Collaboration is a process whereby parties who see different aspects of a problem can jointly explore these perspectives and search for solutions that go beyond their own limited vision of what is possible.[3] Such solutions may require resources greater than those accessible to any one party but which may be possible if parties pool resources and expertise. Out of their interactions regarding possible solutions the stakeholders reach agreements which may include rules governing interactions among parties, the contribution and sharing of resources, redesign of their respective roles and responsibilities, or recommendations to policy makers about the domain.[4] Collaboration occurs when organisations develop means for bridging organisational and interpersonal differences, and jointly reach outcomes they value.[5]

Collaboration may occur for a number of reasons. These include altruism and improving the capacity of organisations to achieve intended results,[6] resource dependency, such that some participants are dependent upon others for the resources they need to achieve their own goals,[7] or the need to respond to a changing environment in a new way.[8] By collaborating, organisations can take advantage of differences among them — in terms of knowledge, skills, and resources — to develop innovative, synergistic solutions to complex problems they cannot remedy on their own.[4,9,10]

Successful collaboration depends on organisations recognising the need to work jointly to address an issue, communicating well with each other, and having the capacity and working relations to undertake and sustain the intended action.[11] It is generally assumed that to collaborate partners need to share visions and goals,[5,12] however this is not necessarily the case.[13] Partners may not share the same vision or goals, but because of resource dependency agree to work with each other towards some compromise which may not fully satisfy any, but which each sees as a step towards an outcome they want.

Trust is identified by many writers as a key factor in successful inter-organisational relationships.[14-16] It has been suggested that collaborative relationships cannot be formed and function without a degree of trust between organisations and individuals.[17] Trust serves two purposes: firstly, it is a substitute for formal control systems, and secondly, it is an enabling condition to facilitate the formation of ongoing networks.[18] The longer a collaborative relationship endures, the better participants will get to know each other and the more likely it is that trust in personal goodwill rather than formal role

performance will become the basis of the relationship.[15] Tesoriero, however, suggests that it is the balance of trust/mistrust that is important, and that this is related to knowledge about partners and the predictability of their actions.[19] Where there is trust, people are automatically expected to do the right things; where there is mistrust, formal mechanisms are used to make people accountable for their actions. Collaborative relationships may develop formal rules, but often expectations regarding consultation, joint decision-making, consensus, fairness, accommodation, and confidentiality are tacit rather than articulated, except when they have been breached. The requirement for public accountability often requires formal agreements, but the existence of such agreements can hinder the development of trust if one partner is seen to have too much power in the relationship. The balance between trust and formal safeguards of the terms of inter-organisational relationships is important. Excessive formalisation and monitoring can lead to conflict and distrust among parties and the dissolution of collaboration;[20] excessive trust can lead to groupthink and the inability to see problems that cause failure.

Learning is important to any collaborative effort. The literature suggests there are three levels of learning (individual, group, and organisational) linked by social and psychological processes.[21] At the first level, intuition allows individuals to recognise patterns and opportunities within situations and experiences. This tacit knowledge requires interpretation before it can be enacted. This is done by reference to values, past experiences and assumptions about how things are or ought to be. Sharing this learning with others allows negotiation and mutual adjustment so that it can be integrated into group practice. Finally, this learning becomes taken for granted and embedded into the organisation's structures, routines and procedures.

Organisational culture is important in this process. It provides the tools by which individuals can apprehend and make sense of experiences.[22,23] Organisational culture also provides the language (jargon and metaphors) to communicate learning to others and influences how groups negotiate and make mutual adjustments so that learning is integrated into group practice. New learning and practices are artefacts which may come to symbolise wider assumptions about the organisation, its purposes and its environment.[22,23]

Given their boundary-spanning roles, managers and other leaders are often at the forefront in introducing learning from other organisations and helping organisational members make sense of the collaborative experience.[24] They are also important in diffusing learning throughout the organisation and institutionalising it into the organisation's structures, routines and procedures.

Collaborating in the ATA–HRSS

Interviews and focus groups with key hospital and aged care staff involved in the ATA–HRSS indicated that they found the experience of collaboration to be rewarding. Hospital staff reported that they had a better appreciation of what could be achieved by aged care providers working either in residential or community age care. Similarly, aged care workers had a better understanding of the pressures hospital staff faced, and particularly their need for early discharge planning for patients. As one community aged care provider commented about the changed relationship:

> Clearly the hospitals' understanding of what community care was was different to what our understanding was so there was a fair amount of frustration around that. Over time things got a lot better. I think as the program is better known and more established in hospitals, they are getting a better understanding of what is achievable in the community … you actually need to understand the hospital system in order to get information you need and you need to be really clear about your role in the community … I think it's given our staff better insight into hospitals and vice versa.

Where previously workers in aged care felt that in their relationships with hospital staff "somehow we were made to feel inferior", this was changing to a more collegial relationship:

> Programs like the ATA are having an impact in as much as they are breaking down those

> barriers … with the ATA there are more definite goals so everyone is striving for those goals … I think when we first started with the ATA, they had no idea what we were doing at all and they were very uncooperative.

> Attitudes are changing … some of the doctors respect our opinion. They talk to us about the person's condition, medication. If we say, look you know, we have an opinion on someone's medication, then we are open and say it. What about trying this? And we discuss it as professionals together.

Both hospital staff and aged care workers spoke of the insights gained from each other, which allowed them to implement the program to best fit their agencies and clients. This was important in gaining commitment from staff and accords with the literature on the diffusion of innovation which says that compatibility, flexibility and reversibility are key factors in the take-up of new ideas and practices.[25]

Aged care workers also reported an improved relationship between the community and residential providers. In the past, elderly people usually moved from community-based aged care to residential aged care, but movement in the other direction was rare. With this program the aim has been, where possible, to enable people to return to community living. Consequently, residential aged care providers have made referrals to community agencies and thus have formed a different working relationship with them.

A recurring comment from aged care staff working in the program was that they thought that what they were doing was important and valued by their organisations. Self esteem among these staff was very high, particularly among those in coordination roles with contact with colleagues in other agencies. A number of Chief Exceutive Officers (CEOs) of aged care organisations commented upon the fact that the success of this project had given them confidence to consider further collaborative ventures.

Finally, the impact of the program was not felt just by the staff and clients directly involved. In some agencies, especially in residential aged care, there appears to have been a wider effect. Some managers reported that because of the new practices introduced in this program, other staff also became more likely to encourage independence of clients. Indeed, several care workers complained that other clients should be given access to the ATA–HRSS program because it would provide greater flexibility in the way they could deliver services to them. Some managers think these changes may reflect the beginnings of a significant shift in the culture of aged care. Likewise, in some facilities the program has also affected the perceptions of other residents so that they also changed their views about residential aged care being "the end of the road" for them. As one Director of Nursing observed of the impact of having ATA–HRSS clients in her facility:

> Others see these people come and go and I would now have more people — residents — talking about the possibility of going home than I've ever had before, and I suppose because of our changing knowledge and our attitude, not so much the care or the rehabilitation, but to setting goals and saying well it seems impossible, but maybe it's not, and I think that's what's changed.

Themes from the research

Two linked themes were frequently raised in interviews and focus groups: learning about collaboration and learning about rehabilitation. Stakeholders tended to refer to collaboration occurring at two levels. CEOs and government stakeholders tended to talk about collaboration at a macro-level referring to the ATA–HRSS program; workers at the coalface tended to speak more about collaboration with only a few other agencies (usually one or two referring hospitals, a residential aged care provider and one or two community providers). It became apparent from this that while the program was successful overall, there was variation in the extent to which collaboration had succeeded within sub-groups within the alliance.

A further analysis of the data revealed that an iterative process involving assessment, commitment and learning about collaboration underlay the decisions of care providers about participating in the program. In the case of the hospitals, this same cycle was important in determining the extent of

their ongoing commitment to the program, although the decision to participate was made at state level. This process was influenced and aided by decisions and actions taken at the macro level, but micro-level success was of primary importance.

In deciding whether or not to join the initial ATA pilot project, CEO's considered a range of factors. These included the capacity of their organisation to provide rehabilitation for older people, the resources they could commit; their expectations and the expectations of other partners, the likely impact that participation might have on their organisation, and other likely benefits or risks. Hospitals considered similar factors, including the likely impact of the program on their ability to discharge elderly people from hospital, when deciding how to participate in the program.

As the pilot program progressed, organisations learned more about what was required to undertake the task of providing rehabilitation, and developed skills in providing rehabilitation and collaboration. Over time the partners learned more about the task, processes, skills required and goals of the project, and what they could realistically expect from each other. This engendered not only trust in the goodwill of the partners but also increasingly in their competence. Thus it was unnecessary for the ATA to impose many controls upon the partner organisations to achieve the goals. Individual partners learned what was expected of them and made decisions about how or if they could meet them, which led to both hospitals and aged care providers changing some of their individual organisational routines to improve the efficiency and effectiveness of the collaboration. At the end of the pilot program, all partners decided to remain in the alliance and participate in the ATA–HRSS, although some adjusted the resources they were prepared to commit and others developed different structures and systems to provide the service.

The need for flexibility in program implementation was carried from the ATA pilot project into the ATA–HRSS. It was recognised that to effectively promote a rehabilitative approach among the newer partners opportunities should be provided for staff to learn from the experience of the others. Consequently, workshops were held to share experiences in using assessment tools, in defining the tasks and goals of the program, and in planning rehabilitation for clients. Opportunities were also given at advisory and steering committee meetings for sharing experiences and reporting back on outcomes and lessons learned. At the end of the ATA–HRSS program all aged care providers involved indicated that they would wish to participate in a collaboration to provide transitional care under the new arrangement being negotiated between the Commonwealth and state governments.

Practical considerations for success

A number of practical measures were important to the success of the ATA–HRSS.

A shared vision with flexibility in implementation

A vision of providing rehabilitation and client-focussed support services to elderly people who would otherwise require permanent residential aged care was enough to galvanise the stakeholders to action despite their own different agendas. The stakeholders remained committed to the shared vision and recognised that there had to be flexibility in the resources and methods used by each partner to deliver services. Consequently, apart from procedures to ensure efficient referrals of patients from hospitals to aged care providers, and to monitor patient outcomes and the expenditure of funds, few system-wide rules developed. Each aged care provider was free to implement the program in a manner that best fitted their organisation and needs of their clients.

Top-down support

Because the original project was founded in response to a crisis, it was set up and running quickly with little time for negotiation between stakeholders. Although there was one auspicing agency which hired two triage staff (to coordinate referrals, coordinate information and data collection and sharing, and funds dispersal), the project was envisioned and remained a collaborative effort between aged care providers, hospitals, and South Australian and Commonwealth governments. An

Advisory Committee initially consisting of CEOs of the aged care agencies, hospital representatives and representatives from the two levels of government was established to oversee the development of the project. This initially met monthly and then quarterly to discuss broad directions for the program. A smaller Steering Committee was added to handle implementation issues and evaluation of the project. The involvement of the CEOs in the initial stages was symbolically important in giving lower level staff permission to experiment in collaborative service delivery. As stated by one program coordinator,

> . . . the collaboration started at the top initially. When the project started, that's where all the collaboration was, but I think where the collaboration is the strongest, is where it needs to be and that is at the coal face, because that is where you will have the providers who have a real interest in outcomes for older people and they really look for ways to actually ensure that they can achieve, and so we are finding that we have got a collaboration between providers, for example, which would not have necessarily existed before.

Building understanding and trust

Before the formation of the ATA, the aged care organisations were used to being competitors in tendering for funds and grants from the Commonwealth and state governments. Their CEOs had had some experience in working together as advocates within a policy network. Consequently there was a degree of goodwill trust between them which facilitated their joining an alliance.

These organisations had only a limited understanding of each other's capacities to provide rehabilitation. They did, however, have some knowledge of each other's abilities in residential aged care and home and community care, and so had some expectations about performance and behaviour within the alliance. Similarly, there was limited knowledge of each other's routines and capabilities, and there was a degree of scepticism about each others' capacity and motives in the alliance. The hospitals were unsure about the ability of the aged care sector to provide rehabilitative services, previously seen as the exclusive domain of the health services. This resulted in some referrals for ongoing support only, rather than for rehabilitation. However, as feedback demonstrated the success of the program, more appropriate referrals occurred and the program became embedded in hospital discharge planning.

It was quickly recognised that developing trust between partners required improving knowledge of each other's capacity to collaborate within the program.[10] Steering and Advisory Committee meetings occurred in different agencies so that members could get a feel for each other's agencies. Committee members regularly reported back on how the program was operating and any new developments within their agencies. Each agency designated a few staff specifically for the program so that they would become known to staff working in the program in other agencies. In most hospitals the program was coordinated through the social work department because social workers generally had more understanding of aged care services (especially in a residential setting). Aged care providers appointed program coordinators but used existing staff to deliver services. Later it was realised that other hospital staff also needed to understand more about aged care services and that aged care workers needed to understand the pressures facing the hospitals. Consequently, experienced aged care staff were appointed as liaison officers based within some hospitals to help identify potential clients for this program and other aged care services. They also mediated between the hospitals and aged care providers when misunderstandings or uncertainties arose.

Aged care providers were also initially reluctant to accept that hospital staff could identify patients who would benefit from the program. Accordingly, it was agreed that each agency would assess patients referred to them before accepting them for rehabilitation. Over time this mistrust of the hospitals diminished but the procedure was maintained because it promoted contact between the two groups of staff.

Joint learning about rehabilitation

Steps were taken to assist aged care providers develop a rehabilitative focus. Coordinators pre-

sented case studies at Steering and Advisory Committee meetings both as examples of what had worked in their agency and to elicit comments and advice. This helped diffuse successful ideas and information throughout the alliance. Regular summaries of program outcomes were given to all stakeholders. Where multiple agencies were involved in providing services for a client (eg, when a client graduated from residential to community-based services) feedback was given to each agency about progress and outcomes. When common issues were identified (eg, care planning for patients, clarifying what was meant by rehabilitation, etc) workshops were developed (sometimes using external experts, hospital staff or aged care providers who were seen as leaders in the area) which were open to all stakeholders.

Developing a rehabilitative culture

Adopting a rehabilitative focus was not always easy, particularly in residential care due to the influence of Commonwealth funding arrangements. Higher funding is given when a resident requires greater amounts of nursing care. Consequently a culture often developed of "doing things for residents" rather than encouraging them to do things for themselves, reinforcing dependency. Also, because staff were busy, there was pressure to complete tasks quickly, and as one staff member commented: "It takes a lot longer to encourage a resident to shower and dress herself that it does to do it for her." Staff working with ATA–HRSS clients were seen by some colleagues as having an unfairly easier workload. Providers adopted different methods to address this problem. Some employed staff specifically to provide ATA–HRSS services; others undertook staff development. Leadership by program coordinators and triage staff in justifying and interpreting practices in relation to the ability of elderly people to regain independence after an acute hospital stay supported the changed focus and diffused a rehabilitative focus throughout the alliance. The comments from one community-based coordinator encapsulate this well:

> … the change with this rehab program was about education of care staff and coordinators … that, at the end of the day, we could actually discharge people to nothing. That was actually a really difficult part of this whole understanding about rehab … if you give something a label of rehab it just emphasises a part of what you are already doing … if you are actually talking about rehab it keeps it in the top of peoples' minds, that you don't do things for people, you are doing them with them, and trying to actually get them to do them on their own. So, it has been a little bit about us just changing the mindset and about being more mindful that this person may actually need to manage on their own, rather than have the worker come back week in and week out. So that's been the biggest challenge in it. That's our understanding of rehab, it's really you know, promoting strength.

Conclusions

This study showed that those involved in the program believed that collaboration has enhanced services to clients. Not only has it led to earlier discharge of elderly patients from hospital, but it has ensured that a higher proportion are able to return to living in the community. Inter-agency collaboration has also been seen to enhance discharge planning by making hospital staff aware of the capacities of aged care agencies to provide services "downstream" and to think about the information needed by these agencies to provide the services.

The understanding of collaboration also focuses attention on learning within and between organisations. Lessons learnt about collaboration and the diffusion of innovative practices demonstrate the value of a flexible approach to cross-agency program implementation, especially in gaining the commitment of staff. This project also demonstrates that collaboration does not necessarily require detailed planning in the early stages, but rather a commitment to the vision and goal of the collaborative effort. Commitment by managers and other leaders to the program, especially in promoting new practices in terms of values and assumptions about the ability of elderly people to gain independence, helped the rehabilitation of elderly people. Openness and a willingness to share information about both successful and unsuccessful outcomes

and to address relationship problems as they occurred were important in developing the credibility and trust necessary to operate a collaborative program with as much flexibility in approaches to implementation as this one. These lessons are relevant not just to this case but also to other collaborative efforts.

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Competing interests

Geoffrey Bloor is employed by Repatriation General Hospital which is one of the collaborating hospitals.

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