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Implementing and sustaining evidence-based practice in health care: The Bridge Model experience

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Abstract

This qualitative study analyzed the experience of community-based organizations (CBOs) implementing and sustaining the Bridge Model of Transitional Care, a social work-based health service intervention for reducing hospital readmissions. We conducted semi-structured interviews with clinical supervisors from 13 CBOs that received Bridge Model training between 2012 and 2015. CBOs faced significant challenges implementing and sustaining transitional care programs, particularly related to building effective and sustainable partnerships with hospitals. Additional barriers to program implementation and sustainability included financial barriers and staff turnover. Facilitators to implementation and sustainability included organizational champions, organizational culture, and value of evidence. Recommendations for CBOs to implement health service interventions include gaining early buy-in from hospital partners, creating a contractual arrangement with the hospital partner, understanding changes in health-care payment models, diversifying funding sources, developing an evaluation plan, and nurturing organizational champions.

Keywords

Transitional care; implementation; hospital–community partnership

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Declaration of interest

X.X. volunteers (unpaid) as the “head of research” for the Bridge Model National Office (BMNO, a collaborative that is charged with disseminating and implementing the Bridge Model). W.R. is the Head of Quality Improvement at BMNO. R.A. is the Head of Strategic Development of BMNO.

Introduction

Transitions from hospital to home are vulnerable exchange points prone to patient safety risks and stressful for patients and their caregivers. Nearly one in five Medicare beneficiaries discharged from the hospital are readmitted within 30 days, and over one-third are readmitted within 90 days (Jencks, Williams, & Coleman, 2009), costing Medicare over \$26 billion annually (Goodman, Fisher, & Chang, 2011). Approximately, three-quarters of these readmissions may be preventable if patients received appropriate care before transitioning out of the hospital (Medicare Payment Advisory Commission, 2009). Poor transitions from hospital to home contribute to nursing home placement and functional decline, as well as to an increased burden and cost on the individuals, health-care providers, and public funding sources (Jencks et al., 2009). Reducing readmissions by improving care transitions is fundamental to the triple aim of improving care, improving health, and reducing costs; reducing readmissions has emerged as a high priority within United States health-care reform (Kocher & Adashi, 2011; Ouslander & Maslow, 2012). Section 3026 of the Affordable Care Act created the Community-Based Care Transitions Programs (CCTP) that provided \$300 million for community-based organizations (CBOs) to implement and evaluate models for care transitions from the hospital to other settings. In addition, Section 3025 of the Affordable Care Act established the Hospital Readmission Reduction Program, a permanent component of Medicare's inpatient hospital payment system that requires Centers for Medicare and Medicaid Services (CMS) to impose financial penalties on hospitals with excessive readmission rates beginning in late 2012.

A variety of evidence-based transitional care programs have been shown to decrease hospital readmissions in randomized controlled trials (Coleman, Parry, Chalmers, & Min, 2006; Hansen et al., 2013; Jack et al., 2009; Naylor et al., 2004). The implementation of these evidence-based transitional care programs in real-world practice has been slow, in part due to a lack of knowledge concerning necessary strategies to take these programs to scale (Naylor et al., 2013). Sustainability of these programs is another issue rarely addressed in the literature. Additionally, efforts regarding the implementation of transitional care programs have focused on the traditional health-care settings, primarily the inpatient department of general hospitals. The perspectives from CBOs are missing.

This study begins to fill the research gap about how to implement and to sustain transitional care programs that connect community-based, post-acute, and acute care settings. We examined the experience of CBOs implementing the Bridge Model of Transitional Care (i.e., the Bridge Model), an emerging evidence-based transitional care program recognized by the Administration on Community Living and the Agency for Healthcare Research and Quality. This study adds a unique perspective from CBOs on what facilitates and blocks implementing and sustaining a transitional care program connecting the hospital and the community.

The Bridge Model

The Bridge Model uses master-prepared social workers as transitional care staff called Bridge Care Coordinators to help individuals transition from the inpatient setting to their homes and communities. The Bridge Model addresses psychosocial causes of readmissions

such as low health literacy, lack of social support, living alone, inadequate access to community long-term care, and unstable or unsafe home environment that are beyond the influence of clinical care and physiological parameters of medical conditions (Burke et al., 2016; Hu, Gonsahn, & Nerenz, 2014; Kansagara et al., 2011). The focus on addressing psychosocial determinants of readmissions distinguishes the Bridge Model from other well-described transitional care models targeting the specific processes of care and disease self-management (Arbaje et al., 2010; Coleman et al., 2006; Hansen et al., 2013; Jack et al., 2009; Naylor et al., 2004).

The core components of the Bridge Model are (a) a thorough biopsychosocial needs assessment, (b) the integration of psychotherapeutic methods (e.g., motivational interviewing and behavioral activation) into care coordination and case management activities for increased patient engagement, and (c) a standardized approach to hospital–community-aging services network collaboration to ensure a seamless continuum of care and information exchange. Specifically, BCCs meet with an eligible patient and his or her caregivers face to face at the hospital bedside before discharge to develop rapport and to understand the patient's goals and preferences. Within 3 days of discharge, BCCs conduct a comprehensive needs assessment and develop a care plan with input from the patient and caregivers. Over the course of the 30 days following discharge, BCCs manage care coordination tasks, collaborate with other health professionals and social service providers, advocate for patients, provide brief counseling, and arrange services and follow-ups. These tasks are performed either in person or over the telephone. When delivered telephonically, BCCs conduct 20–25 telephone calls on average to each patient in the 30 days after discharge.

The focus on addressing psychosocial determinants of readmissions with a holistic approach to health and health care resonates with CBOs. The intervention approach of the Bridge Model also aligns with the services that many CBOs already provide, such as case management and linkages to community resources. These features of the Bridge Model have made it particularly appealing to CBOs. To date, nearly 70 agencies have been trained by the developers of the Bridge Model to implement this intervention. Nearly half of these sites are CBOs, such as Area Agencies on Aging, regional planning organizations, senior centers, and other social service agencies. Unlike hospitals which can implement the intervention directly, CBOs implementing the Bridge Model require a hospital partner for referrals and as a result, CBOs not only face unique challenges implementing and sustaining the Bridge Model but also possess unique opportunities.

Conceptual framework

The purpose of this study is to identify the facilitators and barriers associated with implementing and sustaining the Bridge Model at CBOs. This study provides the first systematic assessment of CBOs' experience implementing and sustaining a transitional care program. As shown in Figure 1, the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Kitson et al., 2008) guided our inquiry. The PARIHS framework proposes that successful implementation of research in practice is a function of (a) evidence, the nature and strength of research evidence, practitioner expertise and

experience, and patient experience; (b) context, the environment in which the proposed changes are to be implemented. Core elements of the context include organizational culture, leadership roles, and the organization's approach to evaluation; and (c) facilitation, the type of support, guidance, learning, and coaching needed to help people change their attitudes and ways of thinking and working.

Methods

A qualitative case study approach was used to complete process tracing and cross-case analysis. To this end, clinical supervisors, or program coordinators, were recruited from agencies trained in the Bridge Model between 2012 through 2015. Initial informational interviews determined clinical supervisors or program coordinators to be the best key informants given their knowledge on both the day-to-day model operations as well as about the larger organizational structure. The Bridge Model National Office provided a list of agencies trained between 2012 and 2015. We identified 31 unduplicated CBOs from the list. A trained site was identified as a CBO if it was not a part of a hospital system or an academic medical center. The research team contacted these agencies by email or telephone to recruit participants and to schedule interviews. We determined the eligibility of a potential informant by asking about their title and position as well as their role in relation to the implementation of the Bridge Model. Each informant provided verbal consent and received a \$40 gift card for full participation. After the study protocol was reviewed by the Northwestern University Institutional Review Board, it was determined that this study is not regulated as human subjects research.

A semi-structured interview guide covered the three domains of successful implementation according to the PARIHS framework (see Appendix for a complete list of questions). The first author conducted pilot testing of the interview guide with a clinical supervisor and trainer of the Bridge Model at an academic medical center. Response to the pilot testing of the interview guide was not included in the analysis because the informant was not based at a CBO. Following pilot testing of the interview guide, the first author conducted one-on-one telephone interviews with all informants in early 2017. The timing of these interviews was significant because CCTP funding—the primary funding source for many CBOs to implement transitional care programs—had ended by the end of 2016. A third-party service transcribed the audio-recorded interviews. Guided by the PARIHS framework, our analysis consisted of reviewing the transcripts, assigning codes to text, categorizing codes, and extracting themes that emerged (Graham, 2007). The process of coding involved both preset and open codes. Preset codes were developed based on the PARIHS framework, such as “evidence,” “receptive context,” “leadership,” “evaluation,” and “facilitation.” Emergent codes were assigned to concepts and ideas in the data that were different than the preset codes. Themes were extracted from these codes and further categorized into “barriers” and “facilitators.”

Results

A total of 13 informants, each representing a CBO, agreed to participate in our study, yielding a response rate of 41.9%. These CBOs were located in seven states across the

United States, including Washington ($n = 2$), Texas ($n = 3$), Georgia ($n = 2$), Michigan ($n = 1$), Illinois ($n = 3$), North Dakota ($n = 1$), and New York ($n = 1$). Five informants worked at Area Agencies on Aging, four worked at regional planning organizations, and four were from other social service agencies. Most informants had worked in the field of aging for over 10 years and some possessed over 20 years of experience. The number of years informants worked in transitional care specifically was much shorter, ranging from 1 to 6 years. All informants were female except one.

Average length of interviews was 35 min. CBOs first received training on the Bridge Model between 2012 and 2015 ($n = 4$ in 2015; $n = 3$ in 2014; $n = 3$ in 2013; $n = 3$ in 2012). At the time of interview, five CBOs had implemented the Bridge Model and were actively running the program (referred to as “active sites” hereafter), seven implemented previously but now had stopped (referred to as “inactive sites” hereafter), and one had not implemented the program yet (referred to as “dormant site” hereafter). Out of the five active sites, two received training in 2012, one in 2013, and two in 2015. The majority of the sites had one to two BCCs at the time of implementation.

Six themes were identified as barriers and facilitators to the implementation and sustainability of the Bridge Model. Themes related to barriers were voiced more often by inactive sites, whereas themes related to facilitators emerged from active sites.

Overall experience

Informants shared positive experiences with the Bridge Model—particularly its social focus and user friendliness. All informants with experiences implementing the intervention agreed that the Bridge Model is “a good program.” As one informant aptly summarized: “Bridge is a good social model that is person centered and provides excellent tools and is user friendly.” Another informant expressed, “It’s a great social work model and incorporates all of those techniques that social workers know how to use.” In fact, when comparing the Bridge Model to other similar program initiatives, the incorporation of social work skills and values to program outcomes was noted as a major program advantage. Another informant noted:

It worked better than [some other models].... It allowed us to provide services, medical and non-medical services joined together and the other model does not allow that. [The other models] just have the medical component to it and didn’t want the social fact to it. Bridge allowed both to come together to support the whole ... (person) ... in the home.

Informants shared that patients were generally receptive to the intervention. For several CBOs, an important motivation for training was to become a part of the post-acute care network of local hospitals, creating pathways for future funding via new payment models. These features of the intervention attracted the CBOs to seek out training on the Bridge Model.

Implementation barriers

The lack of effective partnerships with hospitals was unanimously identified by inactive and dormant sites as a significant barrier for implementation. When asked if CBOs had a contract or a strong partnership with hospitals, none of the inactive or dormant sites responded yes, while all active sites responded yes. Not having a hospital partner was the primary reason the dormant site described had not yet implemented the Bridge Model. Furthermore, informants from inactive sites commented that not having a formal contract with a hospital partner was “what made everything fell apart” and was a “stumbling block” for them to sustain the program. An informant from an inactive site pointed out the unique challenge of sustaining a transitional care program from other evidence-based programs:

We had success with evidence-based programs like fall prevention program and chronic disease self-management program. So it isn't that we haven't had experiences that can help us with [the Bridge Model]. It's the matter of just finding the way to get a contract (from hospital) to work.

Several informants felt that hospitals preferred to provide transitional care service in-house rather than contracting those services with CBOs:

The hospitals wanted to hire their own because they had more control and they wanted to go more medical ... and we weren't able to say, okay, I am going to send the ambulance out there every time somebody goes to the hospital ... [Hospital staff] believed [causes of readmissions] were medical ... [I believe] it was their environment and habits that were causing all these readmissions. [Hospitals] didn't think they would change habits and just wanted to do immediate medical procedures to make them not be back in the hospital each time it occurred.

Providing transitional care services in-house gives hospitals “better control” on operations and reduces costs, putting CBOs at disadvantages in the process of sustaining transitional care programs.

The lack of funding was another barrier to the implementation of and more importantly, to the sustainability of the program. Some CBOs utilized funding from multiple sources such as the Older Americans Act, private foundation grants, and state funding to support the initial implementation of the Bridge Model. For other CBOs, CCTP funding was the sole funding source for obtaining training and implementing the Bridge Model. After CCTP funding ended, these agencies were not able to continue the program. An informant described this challenge of having funding initially but not being able to sustain the program:

We were using some of the aging funding on helping caregivers and ... some of the extra funding that we had here at the Area Agency on Aging (to operate the Bridge Model initially), but we couldn't continue it without backing from the private sector out in the community.

The financial barriers are closely tied to a lack of effective partnerships with hospitals. For instance, even though the CBOs that received CCTP funding had hospital partners as part of the CCTP, these partnerships did not remain after external funding ended. The ideal scenario

where hospital partners would pay for the CBOs to continue running the program did not happen.

Four informants from inactive sites named staff turnover as another barrier for sustaining the program. Turnover of key program staff could add financial burden to program operations because new staff are required to be trained by Bridge trainers to maintain implementation fidelity. This cost is in addition to the costs already associated with recruiting and training new hires. Staff turnover also leads to the weakening or even the loss of relationships between organizations. Often, partnerships between a hospital and a CBO are built and maintained by one or two key persons. One informant described the weakening of partnership due to staff turnover within both organizations: “We had a lot of turnover ... hospitals were merging ... larger hospitals took over the smaller hospitals ... (This) has made us not have strong connections.” Turnover in key staff or contact persons in either the hospital or the CBO could adversely affect the strength of the partnerships between the two, creating a significant barrier for program suitability.

Implementation facilitators

Informants identified several implementation facilitators. Active sites that reported doing well shared an organizational culture that encourages creativity, flexibility, and adaptability. At one active site, program staff identified a service gap and they targeted patients who refused home visits and were thus deemed ineligible to receive the transitional care services provided by the hospital but eligible for the Bridge Model:

Our hospital partner is using [another transitional care intervention], which requires home visits. When a patient does not want home visit, then we get a referral [from our hospital partner] for Bridge and we can do the Bridge intervention over the phone if the patient will not allow us to come into their house. So at least they have something. Sometimes, we can build rapport and then still be able to get into the home.... We have both the coaching model and the Bridge Model.

Because the Bridge Model addressed the challenges of a high-need patient population whose needs cannot be satisfied by the hospital, the hospital was encouraged to collaborate with the CBO to implement the Bridge Model. Another active site expanded their service settings to include skilled nursing facilities (SNFs):

When we first started the program, we were just working with the hospital.... We found more than half of the people went to skilled nursing facilities prior to going home. We had to see patients in the skilled nursing facilities once their conditions stabilize.... At this point, we are just seeing COPD and pneumonia patients based on what the hospital wanted us to do with its funding.... So we had to reach out to the skilled nursing facilities and say, hey, you know, it's been great to partner with you but we can no longer be doing this for you for free and seeing the same amount of people. So there was one skilled nursing facility at that time that jumped on board and said, yeah, we will pay for you to do this and then now about a year later another one is looking to jump on board as well. It's actually the perfect time for the skilled nursing facilities because CMS is already starting to talk about readmission penalties for the skilled nursing facilities and they know that's going to

be like the next thing on their plates. They are looking to have a readmission program just like the hospitals do.

A provision of the Protecting Access to Medicare Act that goes into effect in 2018 will penalize both SNFs and general hospitals for readmissions. As a result, SNFs are increasingly investing time and resources in methods to reduce readmissions. Seeing this need, the active site, which was providing the Bridge Model for general hospitals at the time, reached out to SNFs and started serving patients from SNFs as well. The informant from this site commented that the health-care industry “is continuously changing” and, therefore, CBOs have “to go with the flow” and “try to keep up with the hospital” to work effectively with them; and that informant said that CBOs need “treat hospitals and SNFs as clients ... and make sure that they are happy with the services.”

Another facilitator of implementation and sustainability is organizational champions. When asked to summarize the key lessons that made CBO–hospital partnerships work, one informant said, “Obviously, there needs to be a champion at the hospital or skilled nursing facility.” Another informant responded enthusiastically:

I can tell you exactly why we have been able to keep it going. It’s because of there is one person at the hospital who is highly passionate about the [another model] and, I on this side am passionate about Bridge and partnering with the hospital and preventing those readmissions. So we just keep going forward with it and no matter what happens, you know, when it becomes difficult, we just keep moving that forward.

The presence of individuals within both organizations who were committed to program development and expansion made a significant difference in successful program implementation and sustainment.

Both active and inactive sites spoke to the value of evidence in supporting the implementation and sustainability of the Bridge Model. An informant from an inactive site believed that “to show that ... the evidence based programs that were in place do work and ... have long term effects and outcomes” would help revive their operation of the Bridge Model. An informant from the dormant site asked for “national statistics” supporting the effectiveness of the Bridge Model and believed that “showing the numbers” would help potential hospital partners to come on board. Active sites developed a practice of periodic internal evaluations. Through a periodic evaluation, one active site found that higher numbers of patient served correlated with lower rates of readmissions and communicated this finding to their hospital partner. Satisfied with the evaluation result, the leadership at the hospital became more invested in the program and wanted to “make sure this program succeeds.” An informant from another active site detailed the need to have a tracking system to demonstrate value of services and spoke to the unique value of CBOs in providing transitional care services:

There has to be some kind of tracking in place so the manager knows how many people they are seeing and what kind of services they need, so we can show to the hospital like not only, you know, that we are helping with transitions but we are able to connect them to home delivered meals, transportation, emergency home

response ... and then you have to have access to (data on) readmissions because ... if you can't speak the hospitals' language, you know, tell them that you reduce readmission by X, Y and Z and otherwise it may not be sustainable ... because some (hospital) administrators ... are very down to the line like how much money is saving, you know, how much is the saving if we have this versus them doing it themselves.... For us it's really like we are the expert and we see them in the community and we do home visits which is something that a skilled nursing facility will never do. So why not use the community based organization that has all that knowledge?

Informants believed that being able to cite evidence, particularly "numbers" using their program's data, demonstrating the effectiveness and cost savings of the Bridge Model was critical to building and maintaining partnerships with hospitals.

Discussion

By examining the experiences of CBOs using the Bridge Model, this qualitative study adds to what little literature exists on the implementation of transitional care programs that connect community-based, post-acute, and acute care settings. CBOs serve a client population who frequently interface with the traditional health-care sector and thus, those CBOs are in the position to play an important role in improving care transitions, coordination, quality, and outcomes. CBOs are more closely linked with community services and providers, which the traditional health-care sector cannot replicate easily. Financial incentives through changes in reimbursement have created opportunities for CBOs and hospitals to forge partnerships, particularly in the context of care transitions; however, CBOs face significant challenges implementing and sustaining transitional care programs.

The most significant challenge was building effective partnerships with hospitals to acquire patient referrals and generating sustainable sources of funding. This finding is not unexpected as a multidisciplinary approach to the provision of transitional care services both within the hospital and between the hospital and community was identified as a key feature of effective transitional care programs in a systematic review (Laugaland, Aase, & Barach, 2012). Parrish, O'malley, Adams, Adams, and Coleman (2009) also concluded that organizations interested in improving care transitions need to develop collaborative hospital-community partnership. Very few transitional care interventions have adopted a multidisciplinary approach and provided interventions across the hospital-community care continuum (Laugaland et al., 2012; Shepperd et al., 2013). Developing and sustaining hospital-community partnerships to improve care transitions can be challenging due to limited funding, widely different organizational cultures and priorities, and varying systems for data collection and storage. Informants in this study frequently experienced these challenges. Given the limited scope of our study, we did not probe in-depth into the process of building partnerships with hospitals; nevertheless, the experience of informants at active sites suggests that perseverance, an adaptive organizational culture, and the presence of champions and key contacts go a long way to facilitate the formation and sustainability of partnerships with hospitals.

Staff turnover also impeded program implementation and sustainability. Studies link staff turnover in human service agencies to reduced productivity, financial stress in the organization, weakened relationship with clients and providers, and poor implementation outcomes when implementing evidence-based practices (Aarons & Sawitzky, 2006; Woltmann et al., 2008). In this study, staff turnover at CBOs weakened relationship with hospital partners, making it difficult for the CBOs to maintain a source of referral to continue providing transitional care services.

Consistent with organizational theories and literature, organizational culture and champions both played vital roles in sustaining the Bridge Model. Organizational champions are those individuals who emerge spontaneously and informally within an organization and enthusiastically promote change to others for the good of the organization (Howell & Sheab, 2001). Some champions are associated with a specific project and some lead change for the entire organizations (Shaw et al., 2012). Although the presence of champions does not guarantee program success, they do play an important role in the successful implementation and sustainment of organizational change and innovations. The importance of the presence of project champions was evident from our interviews. Informants from three of the active sites showed clear enthusiasm and commitment to the success of the Bridge Model at their organizations whereas only one informant from inactive site clearly expressed passion for the model. These project champions actively pursued partnerships with the hospitals and SNFs, took on a sense of ownership and responsibility for the transitional care program, and conducted ongoing evaluation of the program.

Understanding the experience of CBOs collaborating with the traditional health-care delivery system has important implications for population health in the context of health-care delivery system and payment reform. New delivery systems (e.g., accountable care organization) and payment models (e.g., bundled payment) gave impetus for hospital systems to work with CBOs in caring for patients. Despite uncertainty over the Affordable Care Act, the trend for value-based care models is likely to continue (DeVore, 2017). The incentive for hospitals to collaborate with CBOs to improve quality and value of care continues in health care in general and in transitional care specifically. For example, the Skilled Nursing Facility Value-Based Purchasing Program, scheduled to start in 2019, provides incentive payments to SNFs based on their all-cause and potentially preventable readmissions. Given this policy context, we summarized lessons learned and recommendations for CBOs interested in implementing transitional care programs:

1. Identify potential hospital partners and champions of the model on the hospital side and acquire early buy-in. CBOs could self-assess if their organizations are ready for implementation using the readiness assessment developed by the Bridge trainers.

1. Create a contractual arrangement with the hospital partner. A contract or business agreement will cover key aspects such as expected deliverables and the responsibilities of each party. Importantly, formal contracts will prevent staff turnover from damaging operations because arrangements were informal between individuals.

2. Understand changes in health-care payment models, including the numerous incentives for hospital–community collaboration represented by accountable care organizations, shared savings, and bundled payment programs. Knowing how these payment models impact transitional care service can help CBOs better understand the incentives of hospital partners and also can help develop strategies for building partnerships. Furthermore, keeping up with reimbursement and policy changes can help CBOs identify new partners (e.g., SNFs and managed care organizations).
3. Diversify funding sources. Having a hospital partner willing to refer patients does not necessarily lead to a contract or financial arrangement between the hospital and the CBO. It may take a while before a hospital partner is willing to share the expenses and revenues of transitional care service provision. In addition to program grants, several CBO informants interviewed in this study integrated the Bridge Model into long-standing programs supported by more sustainable funding. For example, one active site integrated the Bridge Model into their care coordination services under Medicaid and was able to sustain the program through reimbursement.
4. Develop a plan for evaluation and quality improvement from the start. Accurate documentation of services provided, a robust data tracking system, and periodic evaluation protocols are essential elements of a good evaluation plan. Program staff should also develop a plan to communicate the findings of all evaluations to the stakeholders involved and explain how the findings will be used for improving their program operations.
5. Develop and nurture organizational champions. CBO leadership can identify individuals among their staff who possess leadership skills, perseverance, and passion for the Bridge Model. Champions will lead the implementation effort, and leadership should empower them with support and provide them with tools and resources.

Limitations to this study included small sample size. Several factors limit the representativeness of the study sample: (a) staff turnover in the CBOs may have reduced participation since agencies could have first received training on the Bridge Model in 2012; and (b) inactive sites may have been reluctant to participate due to concerns that their experiences would not offer much value. Given the limited scope of the study, only one informant from each organization was interviewed. Although we believe that clinical supervisors or program coordinators made the best all-around informants, perspectives from other program staff and agency leadership would have allowed a more in-depth examination of CBOs' experiences implementing and sustaining transitional care programs. In addition, we did not collect detailed information on the implementation process because a few years had passed since CBOs first implemented the program, thus information obtained in this study is more pertinent to program sustainability rather than the initial implementation process.

Effective partnership with hospitals and other health-care providers is key for CBOs to successfully implement and sustain transitional care programs. Successful implementations

of stand-alone evidence-based programs by CBOs cannot be translated into implementations of health interventions that require close hospital–community partnerships. Future research should examine the process of community–hospital partnerships building on the perspectives of both CBOs and hospitals and identify strategies for sustaining partnerships from both sides.

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Figure 1.
PARiHS (adapted from Kitson et al., 2008).