

Organizing Communities Around Care Transitions: The Community Connections Experience

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The Community Connections initiative provides an example of building collaboration and partnerships across traditional boundaries—public-private, medical home, and community-based services—to improve care transitions and support for older adults and adults with disabilities. This approach was inspired by the self-governance and community engagement model, with the knowledge, experience, and participation of community stakeholders.

The community leaders and stakeholders in Chatham and Orange Counties who enacted the Community Connections initiative may not have used, or even heard of, the terms “wicked problems,” “complexity theory,” and “collective impact.” However, they knew that the old approach of taking a problem apart and trying to fix one piece at a time, using classical, “scientific” methods, had not really worked in finding a way to provide adequate community supports and services for older adults and adults with disabilities—especially at times of transition. They knew that organizations cannot work in isolation, that neither medical nor social service providers can develop solutions alone, and that both private and public entities have roles and responsibilities. The Community Connections project, which champions collaboration, embodies aspects of those 3 theoretical concepts—wicked problems, complexity theory, and collective impact—and it provides a dynamic example, not a rigid model, of how diverse community organizations and interests, with varied ideas and approaches, can come together to begin to find answers.

This initiative, which was funded by The Duke Endowment and was facilitated by funding recipient Carol Woods (a not-for-profit continuing care retirement community in Chapel Hill), sought 6 key outcomes: to improve transitional care through increased community coordination, to use technology to support transitions, to create new health care partnerships, to support health care delivery in nontraditional settings, to decrease avoidable emergency department visits and rehospitalizations, and to increase individuals’ ability to remain in their homes. These outcomes emerged from 2 different planning processes held in Orange County, but they also reflected the thinking of aging stakeholders in neigh-

boring Chatham County. In fact, they might well have been identified by any stakeholder in the aging or disability communities anywhere. The lack of coordinated, adequate, and accessible supports for people moving between health and social support settings (hospital, home, and long-term care facilities) met the criteria for wicked problems, as defined by Churchman: complex interdependencies, incomplete information, and uncertainty about the effectiveness of potential solutions [1]. Different thinking was called for.

Leaders from the 2 counties, brought together by the project staff at Carol Woods, decided to pursue 2 courses of action simultaneously. The first was to take advantage of a call from the North Carolina Department of Health and Human Services to become a community resource connection (CRC; also called Aging and Disability Resource Centers or ADRCs nationally) for the aging and disability communities [2]. The second was to enlist the Center for Aging Research and Educational Services (CARES), of the Jordan Institute for Families, School of Social Work, University of North Carolina-Chapel Hill, to lead the community-engagement self-governance process developed by Nelson [3]. This process, which has been used in child welfare and in the development of the first CRCs, was championed by Community Connections and adopted by the North Carolina Division of Aging and Adult Services, to launch numerous additional community meetings.

The community engagement event facilitated by CARES, inspired in part by the complexity-theory work of Wheatley [4] and Holland [5], emphasized that there is not a single way of “knowing” and that the process of knowing is itself a dynamic, emergent process of discovery and creation. Valuable knowledge is gained from research and from the application of evidence-based practice. Equally compelling knowledge is gained from practice-based evidence—the accumulated life experiences of hands-on health and social

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service providers and observant and highly motivated family caregivers. Both of these sources of knowledge are in service to a third source, the shared values and collective impacts or outcomes sought by older adults and adults with disabilities, themselves [6, 7].

Using the community engagement framework (a change process that informs how complex problems are overcome), and piggybacking on the collaboration building that is required for CRCs, Community Connections began to work toward 4 of the 5 conditions identified by Kania and Kramer [8] for successful collective impact: a backbone support organization, a common agenda, mutually reinforcing activities, and continuous communication. One of the 5 conditions, shared measurement systems, remains to be further specified and developed.

Backbone Support Organization

One condition of success in collective impact is a backbone support organization, defined as “a dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly” [8]. To a large degree, Carol Woods served in this capacity, particularly excelling in communication, facilitation, and logistics. A second grant, from The Duke Endowment, is allowing them to continue to develop in this role.

A Common Agenda

As Kania and Kramer point out, organizations that believe they are working on the same social issue often have slightly but meaningfully different perceptions of both the problem and the solution [8]. Members of the initiative understood this reality. Their first step toward creating a common agenda was to begin to understand and make more explicit the goals of all of these interested stakeholders. For example, AccessCare of Central Carolina’s (the local Community Care of North Carolina affiliate) and Piedmont Health Services’ community health centers were focused on preventing unnecessary hospitalizations and rehospitalizations. Initiatives at University of North Carolina Hospitals were aimed at preventing readmissions and unnecessary returns to the emergency department. Most of the community-based service organizations participating in the CRC were interested in improving quality of life and independence for older adults as well as younger adults with disabilities, and most of these organizations operated on the reasonable but not yet proven assumption that their services prevent or delay placement in residential facilities. Thus, the overlapping parts of their agendas appear to be reducing the number of transitions from home to any other setting, and they also appear to be supporting people at times of transition, when they are most vulnerable to repeated or cycling additional transitions.

Mutually Reinforcing Activities

Working toward alignment among these stakeholders, Community Connections provided some combination of participation, leadership, and financial support to a number of these organizations’ initiatives that held promise of reinforcing the overall efforts to support people in transition and to reduce unnecessary transitions.

Community Connections has continued to provide financial support and participation in the leadership of the Chatham-Orange CRC, which has grown and expanded. At present, there are 25 organizations in the 2 counties that have signed memoranda of agreement.

The CRC, in turn, was chosen to participate in the North Carolina implementation of a federal person-centered hospital-discharge planning grant that brings together hospitals and community resources to reduce preventable readmissions.

A transitions performance team that grew directly out of the community-engagement/self-governance event facilitated by CARES developed 2 active subcommittees: the patient advocacy at transitions committee and the outreach network. The former collaborates with University of North Carolina Hospitals, recommending ways to improve the emergency department and hospital discharge experience; the latter focuses on educating the community about available resources.

With the understanding that falls are often a first step in a downward spiral for older adults, the initiative funded a physical therapist to expand falls-prevention programs. This led to balance and falls workshops, health-fair balance classes, and balance and falls in-service education for health and fitness providers and their students, as well as materials developed for use by providers in the community.

The Community Connections grant also funded and assisted University of North Carolina emergency and geriatrics staff in designing a small, randomized, controlled trial ($n = 121$) at University of North Carolina Hospitals to study the impact of a phone call follow-up with elderly patients about their understanding of and compliance with discharge instructions after an emergency department visit.

Community Connections and Carol Woods staff members received training to become certified lay leaders for the evidence-based Living Healthy Chronic Disease Self-Management Program, developed by Stanford University and funded by the Administration on Aging. This national program has achieved fewer days in the hospital and a trend toward fewer outpatient visits and hospitalizations for participants [9].

Through support from the Community Connections grant, Piedmont Health Services was able to extend the service area of its Program for All-Inclusive Care for the Elderly (PACE) site into Orange County. This change provides a new community-based, long-term care option for people who are eligible for nursing home placement.

Recognizing that transportation to primary care services is a major obstacle for some vulnerable adults, particularly those in rural areas, Community Connections sponsored project health rides in Chatham County, to provide 2,748 rides to medical appointments and health screenings. Funds were used both for rides and as local matches to bring in \$260,000 in additional state and federal monies.

Piedmont Health Services, Roanoke Chowan Community Health Center, and Community Connections partnered to develop a telehealth program at Piedmont Health Services for older adults with cardiovascular disease. Community Connections provided the funding, and Roanoke Chowan Community Health Center provided the equipment, training, and initial monitoring for the project, on the basis of their previous successful pilots.

With the identification of adult day health care as a service needed both to delay residential placement and to help with transitions from hospital to community, Carol Woods and Community Connections helped to support the construction and the program development of a new site of the Central Orange Adult Day Health Program (recently renamed Florence Soltys Adult Day Health Program). They also ensured that program staff participated in networking groups in the 2 counties.

In addition to encouraging the expansion and coordination of services and supports, Community Connections contributed to the development of the workforce, to meet the growing needs in aging and long-term care services. To that end, they (1) helped fund A Helping Hand's prehealth/service learning internship program for university students; (2) helped Chatham County Council on Aging fund a scholarship program for nurse aide students at Central Carolina Community College and supported their certification examination expenses; and (3) collaborated with Carol Woods, Theater Delta, and University of North Carolina's Institute on Aging to create and deliver interactive theater performances for middle and high school students that were designed to facilitate positive relationships between young and old people.

Continuous Communication

Networking and facilitating communication between parties have been the crowning strengths of the Community Connections initiative. Of the 36 stakeholder agencies in the 2 counties that responded to a survey conducted by CARES, a large majority reported that, through the Community Connections initiatives, they had learned about new programs or services (89%) and had increased their connections with their colleagues in other agencies (94%). In addition, a substantial minority—more than 40%—had taken further steps toward formalized collaboration by partnering with another agency to seek additional funding for a program or services. More than half had begun cross-training with other agencies. A total of 64% increased focus on transitions, and 66% increased partnerships to support transitions.

Next Steps

The fifth condition for successful collective impact—shared measurement systems—has been more challenging. To make and demonstrate a collective impact on avoidable transitions, not only must the group complete the work of determining a common agenda, but it must also find a common way to measure the effect of their consolidated efforts. The specific “mutually reinforcing activities” might not each be measured, but there must be an agreed-on measure for the success of this effort as a whole. Finding this shared agenda and measurement is the only way to consolidate funding to achieve the scale of work that can really provide the evidence needed to change the face of transitional care in Orange and Chatham Counties.

University of North Carolina Hospitals' program of emergency department phone follow-up produced some statistically significant improvements. The patients in the intervention group were significantly more likely to follow up with a physician within 5 days after ED visit and had significantly improved comprehension of discharge instructions. They also were more likely (though not significantly) to understand medication instructions and manage their medications correctly (B. McCall, unpublished data). Other efforts focused on outputs (eg, clients served, resources obtained). Neither had a sufficient sample size with which to measure the impact on hospital admissions/readmissions or other transitions, but the programs provided the building blocks for other successful efforts.

Conclusion

Community Connections has brought together stakeholders, has stimulated a number of pilot efforts to solve pieces of the transitions problem, and has begun to set the stage for a continuing collaboration that could have enormous collective impact on this vital issue for older adults and adults with disabilities. This is only a beginning, but it is a beginning that promises great things for the 2 counties and for the state. **NCMJ**

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