Clinic-community partnerships: A tool to maximize their impact

2008 Diabetes Translation Conference

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Learning objectives

• To understand how clinic-community partnerships move from development to the achievement of outcomes

• To learn about the development of a new tool to help clinic-community partners assess their progress and identify potential opportunities for improvement
Chronic Care Model

Community
- Resources and Policies

Health System
- Organization of Health Care
  - Self-Management Support
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient
- Prepared, Proactive Practice Team

Productive Interactions

Functional and Clinical Outcomes
Demonstrating and evaluating programs to promote self management of diabetes through clinic-community partnerships
Tools for building clinic-community partnerships to support chronic disease control and prevention

- Framework
- Checklists
  - Partnership
  - Organizational capacity
  - Intermediate outcomes
  - Long term outcomes
- Taking Action-Making Improvements
The Framework

• Created to explore the “value added” of partnerships to diabetes (or other chronic disease) self management outcomes

• Created by a workgroup consisting of BCS grantees, program staff and expert consultant

• Created through group processes over life of BCS project (Grantees funded 2003-2006)
Framework for Building Clinic-Community Partnerships to Support Chronic Disease Control and Prevention

Partnership Attributes

Function:
- Leadership and management
- Collaboration
- Synergy

Infrastructure:
- Leadership
- Partnership resources

Organizational Capacity

Your Organization:
- Recognition of the benefit of collaboration
- Improved capacity to respond to demands
- Increased information and resources
- Increased community input
- Greater utilization of services

Between Organizations:
- Connection to the community
- Creation of a shared vision
- Focus on issues/needs of the community rather than only on accountability to the agency
- Enhanced referral services
- Share information and resources

Intermediate Outcomes

Individual Level:
- Improved self-management
- Better clinical outcomes
- More willing to talk about health concerns
- Better access to community resources
- Opportunities for personal and professional growth

Organizational Level:
- Improved services
- Increased capacity for outreach
- Improved treatment protocols
- Increased awareness and demand for organizational expertise
- Improved data systems

Partnership Level:
- Improved partnership functioning
- More stable partnership structure
- Strategic expansion of networks
- Increased collaboration among partners
- Improved ability to leverage resources

Community Level:
- Increased resources and/or increased access to resources
- Increased community awareness of health issue
- Data that can be used by other agencies to garner additional resources
- Increased community engagement in health
- Increased advocacy and consumer demands

Long-term Outcomes

Decreased morbidity/mortality
Improved quality of life
The Checklists

- Relate to phases of partnership development depicted on framework

- History
  - Literature review
  - Focus groups
  - One on one interviews
  - Pilot test
The Checklists

• Purpose
  – Assess where the partnership is
  – Identify how the partnership can move forward

• Structure
  – Perception
  – Extent of agreement
  – Satisfaction
FRAMEWORK FOR BUILDING CLINIC-COMMUNITY PARTNERSHIPS TO SUPPORT CHRONIC DISEASE CONTROL AND PREVENTION

PARTNERSHIP ATTRIBUTES

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LONG-TERM OUTCOMES

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Improved quality of life
Checklists – Partnership Attributes

• Partnership function
  – Leadership and management
    • Communication methods
    • Well coordinated activities
    • An environment that fosters respect and trust
  – Collaboration
    • Processes to establish common goals and objectives
    • Processes that allow all partners to participate and influence decision-making
  – Synergy
    • Working together
Checklists – Partnership Attributes

- Partnership infrastructure
  - Leadership
    - Formal with defined roles and responsibilities
    - Leadership is shared
  - Partnership resources
    - Dedicated staff
    - Tangible and intangible resources
    - All partners are able to use resources
# Framework for Building Clinic-Community Partnerships to Support Chronic Disease Control and Prevention

## Partnership Attributes

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*Diabetes Initiative*

A National Program of the Robert Wood Johnson Foundation

*Washington University in St. Louis School of Medicine*

Robert Wood Johnson Foundation
Checklists – Organizational capacity

• Your organization’s capacity
  – Benefit
  – Enhance abilities and skills
  – Increase referrals and services

• Capacity between partner organizations
  – Increase connectedness to community
  – Shared vision
  – Formalized systems
FRAMEWORK FOR BUILDING CLINIC-COMMUNITY PARTNERSHIPS TO SUPPORT CHRONIC DISEASE CONTROL AND PREVENTION

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**LONG-TERM OUTCOMES**

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Checklists – Intermediate Outcomes

• Individual level outcomes
  – Improved behaviors
  – Improved outcomes
  – Improved knowledge

• Organizational level outcomes
  – Increased organizational support
  – Increased access to services
  – Improved treatment protocols
Checklists – Intermediate Outcomes

- Partnership level outcomes
  - Increased trust
  - Improved conflict resolution
  - Increased likelihood partnership sustainability

- Community level outcomes
  - More information, services and programs
  - Access to data
  - Increased access to environments that support healthy behaviors
  - Creation of local and state policies
Taking Action – Making Improvements

- Program improvement
- Helps ensure consensus on issue of focus for improvement
- Promotes accountability
Conclusions

• Clinic-community partnership have the potential to enhance resources and supports for chronic disease prevention and care

• The tools can help
  – provide a way to assess partnership progress
  – help identify opportunities to work together to improve programs and services
  – increase the ability of the partnership to affect positive changes in health
Available at
http://diabetesinitiative.org/lessons/tools.html
The 14 Sites of the RWJF Diabetes Initiative