









# Clinic-community partnerships: A tool to maximize their impact

**2008 Diabetes Translation Conference** 

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# Learning objectives

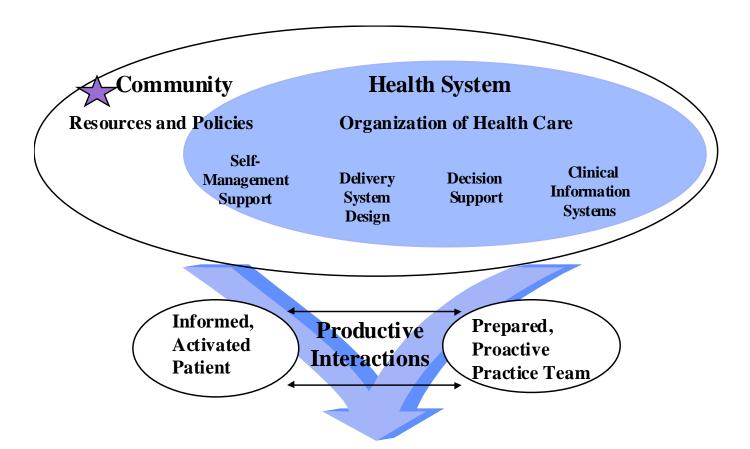
 To understand how clinic-community partnerships move from development to the achievement of outcomes

 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



### **Functional and Clinical Outcomes**









# Building Community Supports for Diabetes Care



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







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# 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







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- Increased community engagement in health
- Increased advocacy and consumer demands

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# 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







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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







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www.diabetesinitiative.org

# Available at

http://diabetesinitiative.org/lessons/tools.html









# The 14 Sites of the RWJF Diabetes Initiative

