Tools for Building Clinic-Community Partnerships to Support Chronic Disease Control and Prevention

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The development team was led by Carol Brownson and Gowri Shetty from the *Diabetes Initiative* National Program Office at Washington University in St. Louis with consultation and assistance from Elizabeth Baker and Ellen Barnidge from the Saint Louis University School of Public Health. The team gratefully acknowledges the Building Community Supports for Diabetes Care grantees of the *Diabetes Initiative* for sharing their partnership experiences to shape the content of the framework and checklists and for reviewing and pilot testing the tools. We also thank Candice Graham of the National Program Office for administrative support and Elisa Weiss of the Memorial Sloan-Kettering Cancer Center for her collaboration and contributions to the final draft.

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The following tools are organized around the FRAMEWORK FOR BUILDING CLINIC-COMMUNITY PARTNERSHIPS TO SUPPORT CHRONIC DISEASE CONTROL AND PREVENTION developed by the Building Community Supports for Diabetes Care (BCS) Program of the Robert Wood Johnson Foundation *Diabetes Initiative* (www.diabetesinitiative.org). One of two programs in the *Diabetes Initiative*, the BCS program required that grantees work in clinic-community partnerships to enhance community supports for diabetes care. The BCS projects demonstrated how clinic-community partnerships of various types can promote self management more comprehensively and seamlessly than any partner could do alone.[1]

While the literature about partnerships, collaborations and community coalitions is vast, there is less written evaluating the contributions of partnerships to outcomes of coalition work. To respond to this gap, a workgroup of BCS grantees, expert consultants and *Diabetes Initiative* staff developed a framework to reflect the phases of their partnerships' work. Using the framework as a guide, a series of self-assessment checklists was developed to help partnerships evaluate their progress and identify areas that, if improved, would strengthen the partnership and support achievement of their stated goals. Finally, a tool was developed to help partnerships plan changes in areas identified for improvement. Although developed with diabetes in mind, the tools are applicable to a range of chronic diseases.

The Framework

The FRAMEWORK FOR BUILDING CLINIC-COMMUNITY PARTNERSHIPS TO SUPPORT CHRONIC DISEASE CONTROL AND PREVENTION (Figure 1) suggests that partnerships, specifically clinic-community partnerships, are key to building community support for chronic disease care and management. The framework outlines how essential partnership characteristics build capacity necessary to achieve specified intermediate and long term outcomes. The partnership characteristics and capacities within and between organizations are deeply rooted in the literature (see references). The intermediate outcomes were identified by BCS partners through a nominal group process and qualitative interviews.

The Checklists

The TOOLS FOR BUILDING CLINIC-COMMUNITY PARTNERSHIPS TO SUPPORT CHRONIC DISEASE CONTROL AND PREVENTION includes three evaluation checklists that correspond to the first three phases of the framework. The checklists are intended for use by partnerships

[1] Brownson CA, O'Toole ML, Shetty G, Anwuri VA, Fisher EB. Clinic-Community Partnerships: A Foundation for Providing Community Supports for Diabetes Care and Self Management. *Diabetes Spectrum.* 2007: 20 (4): 209-214.

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interested in improving the efficiency and effectiveness of their partnership. They can be used sequentially according the phase of the partnership and periodically to assess changes. The checklists are designed to help partnerships track the progression of their work, facilitate discussion among partners, and identify areas for improvement. These checklists also may be used in the planning stages of a new partnership or initiative, or as a tool to orient new partners to the work of the partnership.

It is recommended that each organizational representative in the partnership fill out the self- assessment checklist(s) independently prior to group discussion. Alternately, the partnership may elect to discuss and respond to the checklist(s) as a group.

1. Partnership Attributes Checklist

The purpose of the PARTNERSHIP ATTRIBUTES checklist is to informally evaluate the partnership's function and structure. It is important to note that partnerships are diverse. They may be formal or informal, large or small, or include different types of partners (community, clinical, academic, etc.). The checklist will help determine the partners' perceptions about the presence and adequacy of characteristics such as leadership, decision making power and resources.

Respondents are asked to indicate: 1) to what extent they agree with the statements on the checklist, and 2) how satisfied they are with the structure and function of the partnership.

2. Organizational Capacity Checklist

The ORGANIZATIONAL CAPACITY checklist is divided into two sections. YOUR ORGANIZATION'S CAPACITY asks partners to assess how their individual organization's abilities have changed as a result of participating in the partnership. CAPACITY BETWEEN PARTNER ORGANIZATIONS asks respondents about the impact of the partnership on capacity across organizations. Respondents are asked to indicate the extent to which they agree with the statements on the checklist.

In addition to providing feedback to the partnership, results of YOUR ORGANIZATION'S CAPACITY may be useful internally for organizations participating in the partnership.

3. Intermediate Outcomes Checklist

The INTERMEDIATE OUTCOMES checklist informally evaluates what has happened as a result of the partnership. The checklist acknowledges that change can occur on multiple levels. It is divided into four sections: individual, organizational, partnership, and community.

- The INDIVIDUAL LEVEL addresses outcomes for the clients or patients that the partnership organizations serve.

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- The ORGANIZATIONAL LEVEL focuses on outcomes for each organizational partner that resulted from working together.
- The PARTNERSHIP LEVEL deals with how the partnership has changed over time.
- The COMMUNITY LEVEL addresses how the partnership's work has affected the larger community around the health issue of concern.

Partners are first asked to answer whether the stated outcome has resulted from their partnership activities. Responses may be based on perception or may be supported by data. Hence, the last column asks respondents if data has been collected to measure the outcome of interest.

Prior to using these checklists, partnerships may find it helpful to:

- Discuss the rationale for administering the checklist(s) and plan ahead for how they will use the information.
- Determine the stage of their partnership and which checklist(s) would be appropriate and helpful at this time.
- Determine the timeframe and intervals for re-administering the same checklist(s) or administering the next one in the sequence.
- Choose an option for administering the checklists, e.g., 1) have all partners fill out independently and then meet to discuss responses, or 2) meet together and fill out/ discuss as a group. If the partners have elected to fill out checklists before meeting to discuss the results, they may find it helpful to have the results compiled and summarized prior to discussion.

Taking Action—Making Improvement

The discussion will likely reveal some differences in agreement to the checklist statements and/or satisfaction with aspects of the partnership. Discrepancies in responses or satisfaction offer important opportunities for discussion that can lead to improved communication and partnership function. The value of these checklists is not in the responses per se, but in the action that is initiated by discovery of areas identified for improvement by the partnership. The optional TAKING ACTION—MAKING IMPROVEMENT tool poses questions to the partnership that are intended to help them move from assessment to action in areas identified for improvement.

Documenting findings from the assessment and proposed changes can increase accountability and provide a record of progress.

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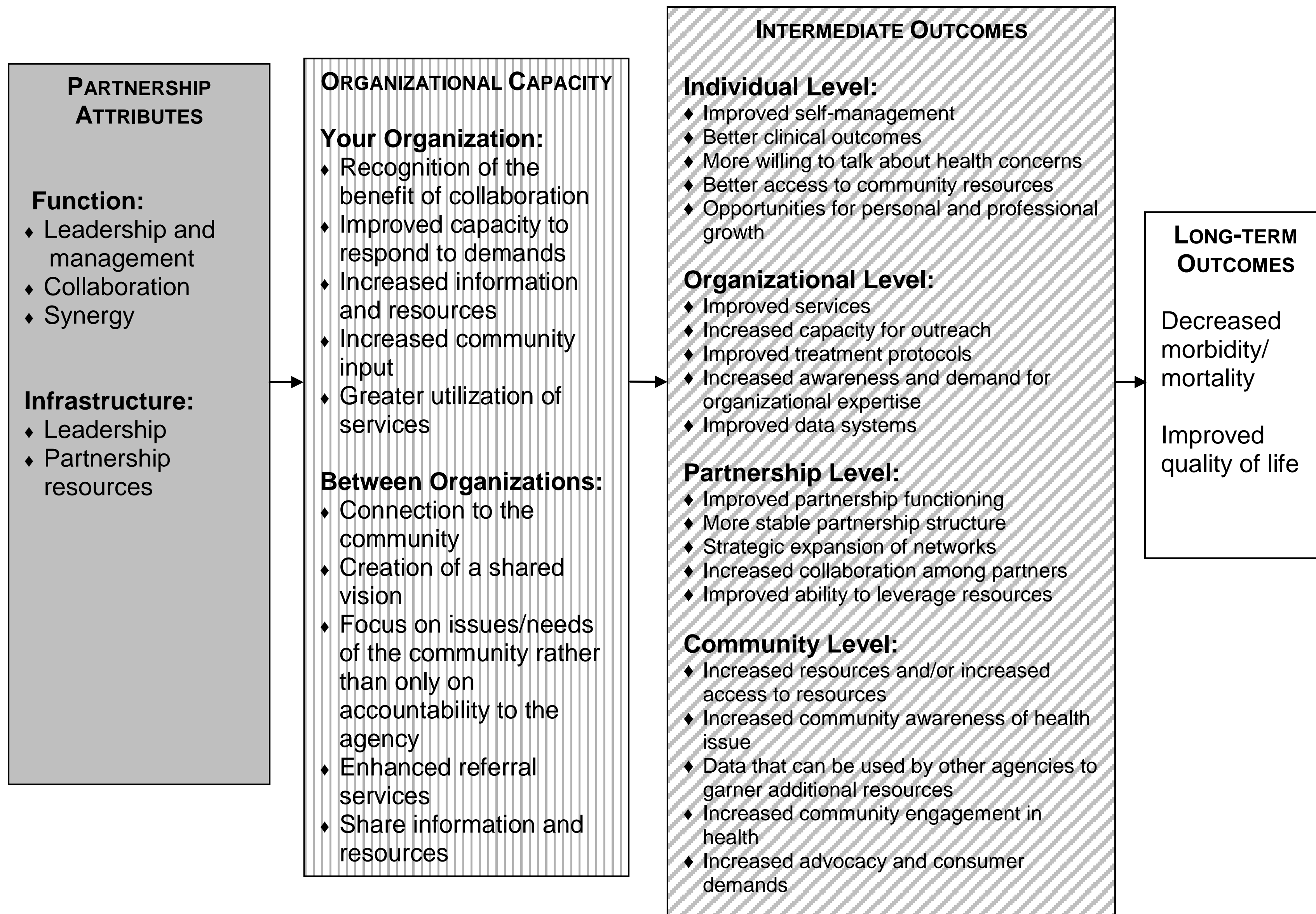
Figure 1. FRAMEWORK FOR BUILDING CLINIC-COMMUNITY PARTNERSHIPS TO SUPPORT CHRONIC DISEASE CONTROL AND PREVENTION



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I. Partnership Attributes

Partnership Function					
Leadership and management		**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
The partnership has…		(Check on answer for each numbered item)			
1.	Clear and open communication among partners.				
2.	Clearly defined methods of communication about the partnership.				
3.	Leadership/staff that coordinate and facilitate communication among partners during partnership meetings.				
4.	Leadership/staff that coordinate and facilitate communication among the partners between meetings.				
5.	An orientation for new partners as they join the partnership.				
6.	Well coordinated activities and meetings.				
7.	Information and materials necessary to make timely decisions.				
8.	An environment that fosters respect, trust, inclusiveness and openness.				
9.	An environment where differences of opinion can be voiced.				
10.	Are you satisfied with the leadership and management of your partnership? (Circle one) **Yes** **Somewhat** **No**				

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Collaboration		Strongly agree	Agree	Disagree	Strongly disagree
Are these processes in place…		(Check one answer for each numbered item)			
1.	To establish common goals and objectives that are supported by all the partners.				
2.	To support the implementation of the goals and objectives of the partnership.				
3.	That allow all partners to participate and influence decision-making equally.				
4.	That allow partners to frequently discuss *how* they are working together.				
5.	Are you satisfied with the processes that support collaboration among members in your partnership? (Circle one) **Yes** **Somewhat** **No**				

Synergy		Strongly agree	Agree	Disagree	Strongly disagree
By working together the partners are able to…		(Check one answer for each numbered item)			
1.	Identify new or creative ways to solve community health problems better than any of them could working alone.				
2.	Carry out comprehensive activities that connect multiple services, programs or systems better than any of them could working alone.				
3.	Respond to the needs of their community better than any of them could working alone.				
4.	Are you satisfied with the way people/ organizations work together in your partnership? (Circle one) **Yes** **Somewhat** **No**				

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Partnership Infrastructure

Leadership		Strongly agree	Agree	Disagree	Strongly disagree
The partnership's leadership is…		(Check one answer for each numbered item)			
1.	Formal with defined roles and responsibilities.				
2.	Shared among the partners.				
3.	Structured in a way that allows an easy transfer when leadership changes.				
4.	Are you satisfied with the leadership structure of the partnership? (Circle one) **Yes** **Somewhat** **No**				

Partnership resources		Srongly agree	Agree	Disagree	Strongly disagree
The partnership has …		(Check one answer for each numbered item)			
1.	Dedicated staff responsible for the management and coordination of the partnership.				
2.	Tangible (e.g., funding) as well as intangible (e.g., expertise) resources for its work.				
3.	A structure that allows the partnership to receive resources.				
4.	Resources (e.g., space, materials, expertise, funds) for the partnership that come from multiple sources.				
5.	Resources that all partners are able to use.				
6.	Are you satisfied with the level and types of resources available for the work of the partnership? (Circle one) **Yes** **Somewhat** **No**				

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II. Organizational Capacity

Your Organization’s Capacity					
		Strongly agree	**Agree**	**Disagree**	**Strongly disagree**
Participation in the partnership has…		(Check one answer for each numbered item)			
1.	Been a benefit to *your organization*.				
2.	Been a benefit to *your organization* that outweighs the costs (e.g., time).				
3.	Enhanced *your organization’s* ability to fulfill its goals and objectives.				
4.	Increased the capacity and/or professional skills of *your organization’s staff*.				
5.	Helped *your organization* acquire knowledge about services, programs or people in the community.				
6.	Encouraged *your organization* to ask the people you serve for input regarding programs and services (e.g., planning, implementing and/or evaluating them).				
7.	Improved *your organization’s* capacity and/or skills to meet the needs of the people you serve.				
8.	Increased the number of *referral*s from your partners to *your organization*.				
9.	Increased the *overall* use of *your organization’s* services.				
10.	Increased *your organization’s* access to resources.				

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Capacity Between Partner Organizations

		Strongly agree	Agree	Disagree	Strongly disagree
Working with partner organizations has…		(Check one answer for each numbered item)			
1.	Increased the partner agencies' feelings of connectedness to the community they serve.				
2.	Resulted in a common vision for the partnership and strategic plan for achieving it.				
3.	Helped shift the sense of accountability for results from individual agencies to the partnership as a whole.				
4.	Increased the *number of* referrals back and forth among partner agencies.				
5.	Resulted in a formalized system of referrals among partnering agencies.				
6.	Increased the amount of information or resources (e.g., staff, space, expertise) shared among partnering agencies.				

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III. Intermediate Level Outcomes

<table>
<tr><th colspan="8">Individual Level Outcomes</th></tr>
<tr><th colspan="2" rowspan="2"></th><th rowspan="2">Yes</th><th rowspan="2">Somewhat</th><th rowspan="2">No</th><th rowspan="2">Not Applicable or Don't Know</th><th colspan="2">Are you collecting data to measure this outcome?</th></tr>
<tr><th>Yes</th><th>No</th></tr>
<tr><td colspan="2">As a result of the partnership's work, have the people the partnership serves…</td><td colspan="4">(Check one answer for each numbered item)</td><td colspan="2">Check one</td></tr>
<tr><td>1.</td><td>Increased their knowledge about the health issue?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2.</td><td>Improved health behaviors?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>3.</td><td>Improved key clinical outcomes?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4.</td><td>Asked more questions about their health?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>5.</td><td>Increased their knowledge about community resources and services?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>6.</td><td>Increased their use of community services appropriate for patient needs?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>7.</td><td>Used clinical services more appropriately?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>8.</td><td>Become more involved in the program itself (e.g., served on committees or boards, provided peer mentoring)?</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>9.</td><td>Reported change in family involvement in healthy lifestyles (e.g., support for or participation in healthy eating and physical activity)</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Note: In the current form this checklist generally applies to any chronic disease or condition. It can be tailored to address a specific disease by identifying the disease specific health behaviors and clinical outcomes. For example, for diabetes, the clinical outcomes of interest may include hemoglobin A1c, blood pressure, blood lipids, body mass index, etc. Specific behaviors might include some of AADE 7 ™, i.e., healthy eating, being active, monitoring, taking medications, problem solving, reducing risks and healthy coping.

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Organizational Level Outcomes

		Yes	Somewhat	No	Not Applicable or Don't Know	Are you collecting data to measure this outcome?	
						Yes	No
As a result of the partnership's work, have the organizations in the partnership (yours and the others)…		(Check one answer for each numbered item)				(check one)	
1.	Created a better trained workforce (staff and volunteers)?						
2.	Experienced greater administrative support for partnership program(s)?						
3.	Increased capacity for outreach?						
4.	Increased organizational capacity to support consumers' engagement in their health and health care?						
5.	Improved program or treatment approaches or protocols?						
6.	Increased access to services?						
7.	Increased the number of patients with a medical home or primary care physician?						
8.	Increased physician referrals to support services such as self management education, exercise classes, etc?						
9.	Increased awareness and demand for your organization's expertise?						

		Yes	No	No, Already Exists	Not Applicable or Don't Know
10.	Developed shared approaches or standards of service delivery?				
11.	Developed coordinated referral systems?				
12.	Developed client/patient appointment systems?				

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Partnership Level Outcomes

		Yes	No	Not Applicable or Don't Know	Are you collecting data to measure this outcome? Yes	No
As a result of working together, is there . . .		(Check one answer for each numbered item)			(Check one)	
1.	Increased trust among partners?					
2.	Improved coordination among partners?					
3.	Reduced duplication of effort or service?					
4.	Improved conflict resolution among partners?					
5.	A better understanding of partner's roles?					
6.	Improved ability to identify and address barriers to working together?					
7.	A better understanding of what partners need from their participation?					
8.	Increased involvement of partners in the partnership?					
9.	Increased collaboration on spin-off projects?					
10.	Increased likelihood of partnership sustainability when project specific funding ends?					
11.	A level playing field among partners to interact more as equals within partnership?					
12.	An evolution from "what can the partnership do for us" to "what we can do together"?					
13.	An increased ability to leverage resources from other agencies (e.g., space, expertise, new partners, volunteers or funds)?					

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Community Level Outcomes

		Yes	No	Not Applicable or Don't Know	Are you collecting data to measure this outcome?	
					Yes	No
As a result of the partnership's focus (e.g., diabetes, heart disease), does the community the partnership serves have …		(Check one answer for each numbered item)			(Check one)	
1.	More information, programs, and services that address the health issue?					
2.	Better *access* to information, services and programs that help them manage that health issue?					
3.	Increased awareness of the health issue?					
4.	Access to data the partnership generated to garner additional resources for the partners or other organizations in the community?					
5.	Increased involvement in advocacy or consumer demand for services and programs that address the health issue of concern?					
6.	Improved access to environments that support health (e.g. clean air, safe places to walk, access to healthy food)?					
7.	More local or state level policies that support, health care, healthy behaviors and/or healthy environments.					

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Taking Action—Making Improvements

Which checklist(s) did your partnership complete?
_____ Partnership attributes
_____ Organizational capacity
_____ Intermediate level outcomes

Date of completion______________

For each checklist, tally the responses (e.g., count the number of people that strongly agreed, agreed, disagreed or strongly disagreed) so the group can see the range of responses and the degree of consensus on the items. As a group, discuss any patterns you observe regarding areas of agreement/ disagreement and satisfaction/ dissatisfaction.

Areas of strong agreement: ____

____

Areas of strong disagreement: ____

____

Areas with satisfaction: ____

____

Areas with dissatisfaction: ____

____

Decide which issue of concern your partnership would like to address first (and a timeframe for addressing other issues if more than one emerged). There is no one best course of action. Your decision about where to start may be based on a number of factors, e.g., the degree of disagreement or dissatisfaction in a specific area, the importance of the issue to the partnership, opportunities and resources available to take a specific course of action, readiness of the group to make changes, a combination of these, or other factors unique to your partnership.

The following questions may be used to guide the development and implementation of and accountability for plans your partnership makes to improve the function or structure of the partnership. Use a separate form for each issue targeted for improvement.

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Taking Action—Making Improvements

1. Indicate an area your partnership has targeted for improvement. What specific action will you take to try to improve this situation?	Focus: Action:
2. What do you hope will be the impact of making this change? Are there any downsides to making this change?	Impact: Possible downside:
3. Describe the steps you will take to make improvement: a. Who is responsible for what tasks? b. When are the actions to be completed? c. How will you measure success? Note: You may want to write these as SMART objectives - Specific, Measurable, Achievable, Relevant, and Time-Specific	Who: When: Measure of success:
4. Do you anticipate any obstacles? If so, how will you address them?	Obstacles: Response:
5. What might help this change come about?	Facilitators:
6. How will you maintain this improvement?	Maintenance:

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