PARTNERING TO IMPROVE CARE: STRENGTHENING PRIMARY CARE AND COMMUNITY-BASED ORGANIZATION LINKAGES
Objectives

- Understand the benefits of establishing partnerships between clinical and community-based organizations and how partnerships can address the social determinants of health.
- Describe the CDC LINKAGES model and how to use this in your community.
- Identify current examples of clinical-community linkages in Wyoming.
- Understand how value-based care is supporting the development and expansion of clinical-community linkages.
Introductions

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Why Partnerships Matter

• Comprehensive, Coordinated Care
• Better Outcomes
• Higher Provider Satisfaction
• Improved Patient Experience
What is a linkage?

• Community-clinical linkages are connections between community and clinical sectors to improve population health.

• Wide variety of types of linkages

• Informal → Formal
The Key Players

Figure 1. Public Health Sector Linking Community and Clinical Sectors

**Community Sector**
Composed of organizations that provide services, programs, or resources to community members in non-health care settings.

**Public Health Sector**
Composed of public health organizations that can lead efforts to build and improve linkages between community and clinical sectors.

**Clinical Sector**
Composed of organizations that provide services, programs, or resources directly related to medical diagnoses or treatment of community members by health care workers in health care settings.
Public Health’s Role in Linkages

• Establishing and maintaining strategic partnerships within community and clinical sectors.
• Facilitating the connection between community and clinical sectors.
• Contributing infrastructure and capacity support (e.g., content area expertise, such as evaluation, funding, and staff).
• Providing a population-based perspective on local issues related to chronic disease prevention and control.
• Informing practitioners and community representatives about the latest evidence-based approaches.
• Linking and aligning local and state efforts to national initiatives, such as Million Hearts®.
LINKAGES Model

- Learn about community and clinical sectors.
- Identify and engage key stakeholders from community and clinical sectors.
- Negotiate and agree on goals and objectives of the linkage.
- Now which operational structure to implement.
- Im to coordinate and manage the linkage.
- Row the linkage with sustainability in mind.
- Evaluate the linkage.
Resources to Guide Linkage Development
Resources to Guide Linkage Evaluation
Level of Community Linkage

- **Networking**—Exchanging information for mutual benefit. The primary focus is on sharing information, and it involves minimal levels of time and trust.

- **Coordinating**—Exchanging information and altering activities for mutual benefit and to achieve a common purpose. The primary focus is on increasing accessibility to services and resources, and it involves moderate levels of time and trust.

- **Cooperating**—Exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose. The primary focus is on extensive sharing of resources, risks, responsibilities, and rewards. Cooperating involves substantial levels of time, trust, and access to each other’s resources.

- **Collaborating**—Exchanging information, altering activities, sharing resources, and enhancing each other’s capacity for mutual benefit and to achieve a common purpose. The primary focus is on full sharing of resources, risks, responsibilities, and rewards. Collaborating involves significant levels of time, trust, and access to each other’s resources.

- **Merging**—Integrating information, activities, and resources to enhance each other’s capacity for mutual benefit and to achieve a common purpose. The primary focus is on organizational restructuring to achieve full integration and to operate as one entity.
Figure 2. Continuum of a Community-Clinical Linkage

- **Networking**: Exchanging information
- **Coordinating**: Exchanging information and altering activities
- **Cooperating**: Exchanging information, altering activities, and sharing resources, and enhancing each other’s capacity
- **Collaborating**: Exchanging information, altering activities, sharing resources, and enhancing each other’s capacity
- **Merging**: Operating as one entity, where roles and cultures have blended

Social Determinants of Health

• “Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect ... health, functioning, and quality-of-life” CDC
Social Determinants of Health

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care
- Access to Care
- Quality of Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
Example from Community Sector

Mission: to optimize the health and wellbeing of Wyoming's older residents and their caregivers through interagency partnerships, basic and applied research, community education, and clinical training and services.
Evidence-based & Evidence-informed Programs

- **EBPs:**
  - Healthy U: Chronic Disease Self-Management Program
  - TCARE: Tailored Caregiver Assessment and Referral system
  - SHARE for dementia: Support, Health, Activities, Education, and Resources

- **EIPs:**
  - Supported Independence for dementia
  - Dementia-Capability Education
    - First-responder training
    - Community Gatekeeper training
• Heathy U:
  - Family communication
  - Improved health behaviors
  - Communication with HealthCare providers & treatment adherence
• TCARE:
  - Family relationships, patient safety
  - Home safety
  - Health behaviors of patient & family caregiver
  - Caregiver mental health, Communication with HealthCare providers & treatment adherence
SHARE for dementia:
- Family relationships, patient safety
- Home safety
- Health behaviors of patient & family caregivers
- Planning for future, mental health
• Supported Independence for dementia

Family relationships, socialization, safety

Safety

Nutrition

Communication with and access to Health Care providers

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care
- Access to Care
- Quality of Care
Dementia-Capability
Education (First-responder training; Community Gatekeeper training)

Safety & Well-being

Safety
Importance of Community-Clinical Linkages

“Wyoming”
Importance of Community-Clinical Linkages

Working Interdependently versus Independently

Photo by Barbara Matthews
Importance of Community-Clinical Linkages
Importance of Community-Clinical Linkages
Coalition building is a smart strategy that promotes coordination and collaboration and makes efficient use of limited community resources.
Care Coalition

- Coalitions seek to ensure that all causes of identified problems are addressed vs being more focused on single strategies.

- Coalitions measure success by examining community level indicators. This applies to all coalition outcomes (short- and long-term) vs measuring change in individuals who have been directly affected by the intervention(s).

- Coalition activities are diffused and taken by all members playing a coordinating or supporting role vs individual entities leading the process and being responsible for implementing interventions.
Health System Collaboration Vital to Sustainable Process Change in Frontier Communities

• BACKGROUND: The expansive geography and low population density of Wyoming has led to barriers among health care providers. Health Care Systems Home- and Community-Based Services have all worked independently in the ever-changing health care climate.

• METHODS: This collaborative intervention will align efforts of medical services and aging services across the state and coordinate a planning session to strengthen long-term services and support chronic care coordination, specifically with the diabetes project for older Wyoming residents. This collaboration will include local community stakeholders along with state-based agencies with goals to
  – establish an ongoing discussion between organizations and providers that is integral to the care and treatment of older adults and will promote mutual understanding of each other’s programs and accompanying challenges and
  – facilitate the development of systems that join hospitals, physicians, health information technology, community-based programs and aging networks to improve access to care for older adults with diabetes.

• INTERVENTION: Mountain-Pacific Quality Health (Mountain-Pacific), the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) serving Wyoming, conducted a survey of current Sublette County services for those Medicare beneficiaries with diabetes and a needs assessment to evaluate collaborative efforts among health care providers and services. A coalition was formed with multi-agency and stakeholder participation. Through relationship-building and collaborative strategizing, educational opportunities for both health care providers and their patients with diabetes were implemented.
Health System Collaboration Vital to Sustainable Process Change in Frontier Communities

• RESULTS: One year after the formation of the coalition, a collaborative approach was implemented for the care of residents with diabetes. Provider education and the collaboration of stakeholders offered more referrals to the accredited diabetes program, based on the need for scheduled days in the clinics. Beneficiary education opportunities for those with diabetes have increased in Sublette County. Ongoing communication among state agencies has been helpful in developing programs throughout the state of Wyoming.

• CONCLUSIONS: Identification and collaboration among diabetes health care providers in Sublette County and implementation of an ongoing dialog has drastically improved the “partnership mentality” when it comes to care for those residents in the county with diabetes. Referrals to accredited diabetes programs have increased through ongoing education and physician buy-in. Although improvement in all quality improvement monitors was noted, continued work and collaboration is needed for sustainable culture change.
As published by the White House Council for Community Solutions, “Community participation is critical to ensure that the interlinked efforts of many partners both reflect the context of the community and genuinely meets its needs... ‘Without true community ownership, collaborative efforts will not be sustainable or lasting.’”

Reimbursement Support Linkages & Partnerships

- Patient-Centered Medical Homes
- Chronic Care Management
- Behavioral Health Integration
- Quality Payment Programs
Call to Action • Link with WyCOA programs

We’re here today! We’d like to be here!

Figure 2. Continuum of a Community-Clinical Linkage

Networking
Exchanging information

Coordinating
Exchanging information and altering activities

Collaborating
Exchanging information, altering activities, sharing resources, and enhancing each other’s capacity

Merging
Operating as one entity, where roles and cultures have blended

Least complex and intense

Most complex and intense

Call to Action

• Link with WyCOA programs and those of other community-based organizations

• If you work with
  – People with chronic illness
    • People who have or may have dementia
  – Family members of people with chronic illness or disability

• Refer patients and their families
Looking to the Future of Clinical-Community Partnerships

- CMS, HRSA
- WY Dept of Health – Public Health Division
- EHR Integration
- Funding
- Value-Based Care
CMS 12th Scope of Work

1. Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse
2. Increase Patient/Resident Safety
3. Increase Chronic Disease Self-Management (Cardiac and Vascular Health, Diabetes, slowing and preventing End Stage Renal Disease (ESRD))
4. Increase Quality of Care Transitions
5. Improve Nursing Home Quality
CMS 12th Scope of Work

QIN-QIOs shall coordinate with existing community-based efforts and reach community stakeholders to form community coalitions that focus on improvement. This shall include the recruitment and engagement of providers across all care settings, including acute, post-acute (e.g. dialysis facilities, nursing homes) and Long Term Support Services (LTSS) at the community level.
Resources


- Wyoming Center on Aging www.uwyo.edu/wycoa