Session 4 - Building Strategic Partnerships

Thursday, March 11, 2021
9 am HT / 11 am PT / 1 pm CT / 2 pm ET

Welcome!
We will begin in a few minutes

DIABETES IN SPECIAL & VULNERABLE POPULATION: Learning Collaborative

Raising the Pillars for Community Engagement
Diabetes affects more than 34 million people in the United States. Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for special and vulnerable populations, which have unique characteristics that affect culturally and linguistically competent health care access and utilization. According to 2018 Uniform Data System (UDS), diabetes poses a unique challenge for the HRSA Health Center Program because 1 of 7 patients has diabetes and nearly 1 in 3 of those has uncontrolled diabetes.

To elevate the national conversation around diabetes, 14 National Training and Technical Assistance Partner (NTTAP) organizations formed the Special and Vulnerable Populations Diabetes Task Force to engage health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to increase knowledge of effective strategies that address diabetes among people experiencing homelessness, residents of public housing, migratory and seasonal agricultural workers, school-aged children, older adults, Asian Americans, Native Hawaiians and Pacific Islanders, LGBTQIA+ people, and other health center patients.

This Fall’s national learning series is sponsored by HRSA and will take a deeper dive into issues related to patient health literacy, community engagement, and team-based care.

For information about the Diabetes National Learning Series, visit chcdiabetes.org today.
Special and Vulnerable Populations Task Force Members:

- AAPCHO
- CSH
- Farmworker Justice
- Health Outreach Partners
- Migrant Clinicians Network
- National Center for Equitable Care for Elders
- National Center for Farmworker Health, Inc.
- National Center for Health in Public Housing
- National LGBT Health Education Center
- National Network for Oral Health Access
- National Nurse-Led Care Consortium
- School-Based Health Alliance

For more information on our NTTAP Partners, visit chcdiabetes.org
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NTTAP Faculty

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Senior Program Manager, Training and Technical Assistance of MCN
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Today's Agenda

- Welcome and Introductions (50 min)
- Fishbone Diagram Walkthrough (15 min)
- Discussion (15 min)
- Closing and Evaluation (10 min)
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Data

Cultural Humility

Partnerships
Megan Hiltner | she / her
Senior Consultant, JSI

HEALTH INFORMATION TECHNOLOGY,
HITEQ
EVALUATION, AND QUALITY CENTER
Learning Objectives

1. Learn how to identify opportunities for forming strategic partnerships with other organizations to advance care for diabetic patients
2. Explore the elements needed to ensure that organizational partnerships are mutually beneficial
3. Assess organizational readiness to engage in productive partnerships that benefit diabetic patients
Roadmap

- Overview of strategic partnerships: 10 minutes
- Organizational readiness: 10 minutes
- Barriers and Challenges to Partnerships: 10 minutes
- Evaluating Potential Partners: 10 minutes
ICEBREAKER

Log into Mentimeter https://www.menti.com/315mpgn7in
or go to www.menti.com and use the code 8401 0995
Partnership: Group of organizations with a common interest who agree to work together toward a common goal.
Purpose of Forming Partnerships

- Keep the community’s approach to issues consistent
- Concentrate the community’s focus on a particular issue
- Create alliances among those who might not normally work together
- Eliminate any unnecessary duplication of effort
- Obtain or provide services
- Pool resources
- Accomplish together what they cannot do alone
- Build networks and friendships
- Plan and launch community wide initiatives
- Revitalize wilting energies of members of groups who are trying to do too much alone
- Increase communication among groups and break down stereotypes
Partnership Continuum

**Coordination**
- Exchange of info and materials.
- Learn motivations for participating in the partnership.
- Organizational independence and self-interests defined.

**Cooperation**
- Joint strategies emerge.
- Increased understanding of audience and motivations to participate.
- Minimal agreement and defining roles.

**Collaboration**
- Plans put in writing.
- Recognition of values.
- Trust, respect, and clear understanding of benefits for each partner to meet the shared goal.

**Partnership**
- High level of trust and communication.
- Roles and responsibilities are well-defined.
- Overall vision. Plans are in writing.
Readiness

Assess your readiness to partner

- We are willing to model the principles and values behind partnering
- We are open to learning new skills and behaviors such as shared decision-making and teamwork
- We are willing to listen to others and work toward partnering communications
- We are ready to identify common goals and objectives
- We are willing to check our own agenda and do what's best for the partnership
- We agree to be a partner and learn our roles and responsibilities
- We have a strong group of people to bring to this partnership

Barriers and Challenges to Partnership: In our community,

<table>
<thead>
<tr>
<th>False</th>
<th>True</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are fewer public dollars available to address issues</td>
<td></td>
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<tr>
<td>Health problems and solutions are increasingly becoming the responsibility of our local community</td>
<td></td>
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<tr>
<td>Collaboration and interdependence will be important in addressing these issues</td>
<td></td>
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<tr>
<td>New strategies and tools are needed to develop plans and work together to address health issues</td>
<td></td>
</tr>
<tr>
<td>Community involvement is dependent on a few organizations</td>
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</tbody>
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Evaluating Potential Partners
Think about what type of organization would be most beneficial to pursue. Is it a nonprofit? Is it faith-based? Is it large or small? Describe the organization. (Organization Type)

What audiences are you trying to reach and who would be most helpful in reaching that audience? (Audience)

What benefits would this organization provide? What are the drawbacks? (Benefits and Challenges)

Is this organization or individual well-regarded in the community? Connecting yourself with an organization that has a bad reputation may hurt your position in the community. (Benefits and Challenges)
What does each organization want to accomplish by working together? (Goals, Aims and Outcomes)

Which kind of organizational relationship is necessary to accomplish those goals? (Purpose)

Is there sufficient trust and commitment to support these kinds of relationships? (Quality)

Are there resources available for this kind of organizational relationship, such as time, skills, client understanding, financial resources, community support, commitment, health and human resources? If not, can those resources be accessed? (Resources)
Negotiation Practice

1. Honor the Relationship
2. Create a Negotiation Environment that Encourages Innovation
3. Be Realistic and Fair
4. Recognize that Each Partnership is Unique
5. Engage in Active Listening
6. Know Your Bottom Line
7. Know the Difference Between “positions” and “interests”
8. Come Prepared to Commit Resources
9. Take a Fresh Look at Practices and Standards
10. Allow Sufficient Time for Partners to Work Out Details
## Implementing and Maintaining Partnerships

1. Identify and engage the stakeholders.

2. Establish personal relationships, and begin to build trust.

3. Clarify the goals and objectives each partner wants to accomplish.

4. Choose and implement a partnership that is mutually beneficial.

5. Establish governance, procedures, ground rules, and decision-making structure.
Elements of Successful Partnership

1. A Shared Purpose
2. Flexibility and Willingness to Collaborate
3. Complementary Strengths
4. Agreed Upon Boundaries
Thank you.

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Fishbone Diagram - Template

[Data]

[Cultural Barriers]

[Partnerships]

[Main Cause]

[Insert Problem Statement Here]

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
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Fishbone Diagram - Problem Statements by LC Cohort Members

- "Better connection with potential participants not already engaged with the agencies."
- "Better connection with potential participants that are not already engaged with our AAA (PTRC)."
- "There is no grocery store in Chester, PA"
- "Hemoglobin A1c (HbA1c) Poor Control (> 9%) is increasing for some health centers rather than decreasing to reach our Healthy 2020 goal of 16.2%.
- Adapted from conversation: "The rate of A1c tests has decreased by 25% since the initiation of telehealth due to COVID-19."
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Fishbone Diagram - Template

[Data]
[Partnerships]
[Cultural Barriers]
[Main Cause]

Week 2 Assignment
Fillable diagram on Moodle

[Insert Problem Statement Here]

X
X
X
X
X
X
X
X

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
**Fishbone Diagram - Template**

**[Data]**
- Factor 1: Lack of data due to limited clinic appointments
  - Data collected on rolling basis (overlap)
  - Factor 2: Adding measures related to SDOH
- Factor 3: Staffing shortages
- Factor 2: Collaboration amongst staff eg nurses, QI, MAs
- Factor 3: Funding

**[Cultural Humility]**
- Factor 1: Mostly Latino and Black patients that may need tailored approaches
  - Factor 2: Spanish-speaking providers, nurses etc
  - Factor 3: Understanding cultural practices that contribute to poor control eg no show rates

**[Partnerships]**

**[Main Cause]**
- Factor 1: Covid-19 pandemic limiting visits
  - Factor 2: Staff turnover
  - Factor 3: Socioeconomic factors: population risk factors

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Hemoglobin A1c (HbA1c) Poor Control (> 9%) is increasing for health center A (from 44% to 50% in last 3 measurement periods) rather than decreasing to reach our Healthy 2020 goal of 16.2%.

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
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Source: Holyoke Health Center
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https://unsplash.com/photos/MAYsdoYpGuk
Fishbone Diagram

[Data]
- Outstanding labs: whose is checking?
- # missed appointments; who is doing flu calls
- County, state DM data

[Main Cause]
- Increased food prep knowledge
- Increased health food access
- Support group-hospital group (are we using it to the fullest; how do we partner?)

[Partnerships]
- Access to medications, MAP programs, FQHC prices
- Access to healthy foods, food desserts
- Knowledge—understand disease, treatment, medications, causes high blood glucose

[Cultural Humility]
- a lifelong process of self-reflection and self-critique whereby the individual not only learns about another’s culture, but one starts with an examination of her/his own beliefs and cultural identities

COVID, but previous # were >35%; we were not doing well before! COVID not a significant factor!

Uncontrolled (A1c>9 or untested in past 12 months, 2020) >40% up from 1 yr ago

Observations/Questions:
- Missed flu DM appts; who monitors? Action plan?
- What drives 3 mo vs 6 mo DM flu by providers
- Outside labs not ordered by KPCHC provider not entered in EMR
- How many DM pts see RD (strong correlation b/t lower A12c)?
- What other supports besides rx provided to pts? (exercise, food, rx, behavior health for DM fatigue, RD, support groups, compassion)
- A1c finger stick—do at MHK clinic why not JC7 Cost, accuracy??
- Impact of healthy food rx when implemented (data)

Adapted from: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
Hemoglobin A1c (HbA1c) Poor Control (> 9%) is increasing for health center A (from 44% to 50% in last 3 measurement periods) rather than decreasing to reach our Healthy 2020 goal of 16.2%.

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
Referral gap between patients with diabetes from rural and marginalized communities in Rockingham County and DSMES services provided by PTRC.

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
There has been a 20% decrease in A1c completion with telehealth visit(s).

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
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Discussion
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Closing & Evaluation

In order to improve for next year, please help us by completing our live session poll as well as a 3-5 minute post-learning collaborative evaluation for yourself and your organization.

https://www.surveymonkey.com/r/chcdiabetes-lc-2021