Today, when it comes to community-clinical linkages, what's ROCKING your world in the REACH-community?
Overview and Conceptual Framework of Clinical Community Linkages

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Clinical Community Linkages

• Linkages involve formal partnerships, aiming to:
  – Create action on evidence-based behavior guidelines
  – Promote healthy behaviors & population health
  – Coordinate care delivery with informal resources
  – Cultivate multi-sectoral partnerships
  – Encourage expanded involvement in health
Clinical Community Linkage Example

- “King County Steps to Health Linkage”
  - Used community health workers as liaisons
  - Fostered referrals to community resources
- Improved health behaviors and outcomes

Steps to Health King County: Summary Evaluation Report
March 2009
Conceptual Framework

• Three basic **elements**:  
  – Clinic or clinician  
  – Community resource  
  – Patient

• Three dyadic **relationships** between these three basic elements  
  – Clinician-patient relationship  
  – Clinical-community resource relationship  
  – Patient-community resource relationship
Conceptual Framework

- **A linkage** is the combined interactive influences of all three elements and dyadic relationships.

- **A relationship** is not a linkage!

- We focus on the relationship between the clinic and community resource.
Conceptual Framework

• Each element and relationship has characteristics that influence the effectiveness of efforts to connect patients with community resources.

• Target these characteristics in our linkages efforts.

• Aim to facilitate the referral of patients to receive chronic disease services relevant to this NOFO.
Influencing Characteristics: Clinic & Community Resource

**Relationship**
- Level of interrelationship along Himmelman’s continuum for collaborative processes
- Formal mechanisms for referrals
- Effective mechanisms for feedback from community resource to clinic.

**Clinic/Clinician**
- Awareness of community resources
- Capacity and training to deliver particular clinical preventive services
- Organizational infrastructure, openness for change
- Information technology infrastructure.

**Community Resource**
- Capacity to deliver the services
- Organizational infrastructure
- Information technology infrastructure.
Influencing Characteristics: The Patient (down the road)

- **Patient element:** stage of readiness for change, health literacy, capacity for self-management, and accessibility to the community resource.

- **Clinic/clinician-patient relationship:** trust between the clinician and patient, shared decision-making, and mechanisms for mutual support of patient self-management.

- **Patient-community resource relationship:** patients’ perception and trust of the community resource, formal mechanisms for referrals, and effective communication between patient and community resource.
Context is Everything

• All six factors do not exert an equal influence in making linkages
• Each relationship and element is unique, in a larger unique system
• Resources, accessibility, and community may influence the effectiveness of linkages
CCL Sustainability

• Programs must be lasting to see any changes in health outcomes
• Even shorter-term outcomes helps keep stakeholders engaged, and set the stage for expanded efforts

• There are multiple components to sustainability!
  – Funding, partnerships, barriers to deliver services, and linkage effectiveness

• Start Small!
  – Refine implementation efforts before scaling up
  – Easy wins on short-term goals in small areas builds momentum, commitment and trust
### Strategic Roadmap: Community-Clinical Linkages work of REACH2018 Projects

<table>
<thead>
<tr>
<th>Potential Recipient Activities *</th>
<th>Outputs</th>
<th>Short-Term Outcomes</th>
<th>Later Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify and promote appropriate, locally-available health programs that are culturally-tailored for the community</td>
<td>Formal partnership agreements with healthcare providers and community partners established</td>
<td>Clinics aware of community resources</td>
<td>Increased number of patients referred to locally available health and preventive programs in the community</td>
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<tr>
<td>• Work with healthcare systems to increase the use of referrals to non-pharmaceutical interventions and services (that is, health and preventive programming in the community)</td>
<td>Clinic-based IT systems have integrated decision support tools to promote referrals and care consistent with clinical practice guidelines</td>
<td>Clinics have demonstrated competency and capacity to manage referral process</td>
<td>Improved health outcomes among priority populations</td>
</tr>
<tr>
<td>• Expand the engagement of health professionals such as community health workers, patient navigators, and pharmacists, to increase referrals</td>
<td>Clinic and community organization IT systems capable of managing referrals and tracking of patient data</td>
<td>Patients have increased awareness of appropriate community resources</td>
<td>Increased number of patients who have enrolled in locally available health and preventive programs in the community</td>
</tr>
<tr>
<td>• Develop strategies and trainings with clinical and community setting partners to increase the number of health professionals with cultural competency to provide culturally and linguistically appropriate services.</td>
<td>Supportive coverage and reimbursement environment</td>
<td>Patients see added-value of community resources</td>
<td>Reduced disparities in chronic conditions</td>
</tr>
<tr>
<td>• Work with clinical and community partners to increase access to health programs by improving coverage of or reimbursement for these services</td>
<td></td>
<td>Community orgs providing relevant services aware of local clinic resources</td>
<td></td>
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<td>• Enhance or use a health IT system to improve population-level chronic disease management by identifying at-risk patients and initiate referrals processes;</td>
<td></td>
<td>Community orgs providing relevant services have demonstrated competency and capacity to manage referrals and enrollments</td>
<td></td>
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<td>• Ensure existing IT systems of clinical partners have integrated decision support tools or prompts into the system to promote referrals and care consistent with clinical practice guidelines</td>
<td></td>
<td>Community facilitators (for example, CHWs) have demonstrated competency to provide appropriate and culturally-tailored patient assistance</td>
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<td>• Implement communication activities that directly support community-clinical linkages efforts</td>
<td></td>
<td>Sustained bi-directional referral system established</td>
<td></td>
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</tbody>
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* Source: Implementation Guide: Racial and Ethnic Approaches to Community Health Program (October 2018)