Prevention in Health Care

Screen, Counsel, Refer & Follow-up: Introduction to a new model of preventive care

Presented by:

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Objectives

• Identify at least 3 risk factors for CVD, and Stroke
• Identify current best practices for pre-hypertension and hypertension management
• List 2-3 specific steps clinics can take to incorporate Screen Counsel Refer & Follow-up for Blood Pressure
Chronic disease are highly prevalent in Minnesota

- Asthma: 302,000
- Cancer: 329,000
- COPD: 116,000
- Coronary heart disease: 144,000
- Diabetes: 267,000
- Heart attack: 136,000
- Prediabetes: 241,000
- Stroke: 75,000

Source: MN BRFSS 2009/2010
Leading causes of death in Minnesota

<table>
<thead>
<tr>
<th>Cause</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>9599</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>7144</td>
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<tr>
<td>Stroke</td>
<td>2154</td>
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<tr>
<td>Unintentional Injury</td>
<td>2087</td>
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<tr>
<td>Chronic Lower Respiratory Disease</td>
<td>2012</td>
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<tr>
<td>Alzheimer’s Disease</td>
<td>1450</td>
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<tr>
<td>Diabetes</td>
<td>1036</td>
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<tr>
<td>Nephritis</td>
<td>895</td>
</tr>
<tr>
<td>Suicide</td>
<td>599</td>
</tr>
<tr>
<td>Pneumonia &amp; Influenza</td>
<td>591</td>
</tr>
</tbody>
</table>

Source: MN Center for Health Statistics, 2010 data
Cost of Chronic Disease

- Loss of years good health
- Early death
- Financial costs of chronic diseases increasing
  - State of Minnesota
    - $1.5 billion annually in obesity-related medical costs
    - $3 billion annually in tobacco-related illness costs
Risk Factors for CHD and Stroke

- **Physical inactivity**
  - 15.8% of adults in Minnesota do not participate in ANY leisure time physical activity

- **Use of commercial tobacco products**
  - 16.7% of adults in Minnesota currently smoke commercial tobacco.

- **Eating less than 5 fruits and vegetables each day**
  - 78.1% of adults in Minnesota consume less than 5 fruit and vegetable services per day

- **Obesity**
  - 24.9% of adults in Minnesota are obese

- **Diabetes**
  - 6.4% of adults in Minnesota are diabetic

- **High Blood Pressure**
  - 21.6% of adults in Minnesota have high blood pressure

- **High Cholesterol**
  - 33.8% of adults in Minnesota have high cholesterol

Source: Heart Disease and Stroke in Minnesota: 2011 Burden Report
Risk Factors appear early in life: Among Minnesota Students

Source: 2009 Minnesota Student Survey
86% of deaths are due to behavioral risks

Source: JAMA 2004:291 (10) 1238-45
Determinants of Health

Modifiable areas that contribute to health outcomes

- Clinical care: 40%
- Social and economic factors: 30%
- Health behaviors: 20%
- Physical environment: 10%

Health Affairs, August 2013 32:8
Clinical-Community Linkages

• Clinics offer a setting/environment to detect early onset
• Clinics are just a piece of the puzzle to better health
• Communities play a role in positive lifestyle change
  • Local Public Health/Tribal Health Services
  • Community based organizations
• Clinic/Community Linkages are the key!
Goals of Clinical-Community Linkages

- Strengthen partnerships between
  - LPH/Tribal Health Services
  - Health care clinics
  - Health plans/payers
  - CBO’s
- Enhance methods for screening and documentation of BMI and tobacco use/exposure
Screen

Clinicians will screen all patients (adults and children) at preventive and chronic disease visits (or a minimum of annually)-

**Primary Aim:** for BMI, use/exposure of tobacco, high blood pressure and/or high cholesterol. Clinicians will document results in the medical record.

**Secondary Aim:** for physical activity patterns and nutrition habits.
Counsel

In this case…counseling refers to:

• advising patients of risks of current BMI, tobacco use/exposure status, hypertension or hyperlipidemia and the benefits of change

• assessing patients’ readiness to change, and

• assisting with care plan creation of 1-2 patient-identified health goals.
Primary Aim:
Clinicians will refer patients who are overweight or obese, who use tobacco, have high blood pressure, and/or high cholesterol to local resources that improve self management skills, increase access to high quality nutritious foods, opportunities for physical activity, and/or tobacco use cessation for education and support, ultimately leading to behavior change.
Secondary Aim:

Clinicians and clinic staff will develop relationships with community organizations and leaders that build partnership to facilitate referral of patients to local resources that improve self management skills, increase access to high quality nutritious foods, opportunities for physical activity, and/or tobacco use cessation for education and support, ultimately leading to behavior change.
Follow-up

**Primary Aim:**
Clinics will follow-up with at-risk patients to provide support and encouragement, ensure accountability, and evaluate patient’s progress towards achieving a healthier lifestyle.

**Process:**
Communication infrastructure is established and allows for feedback on referrals to flow between clinicians and clinical, community and self-management resources.
SCRF: Hypertension Example

- **U.S. Preventive Services Task Force Recommends:**
  - Screening for high blood pressure in adults 18 years or older.
  - JNC7 recommends screening:
    - every 2 years in persons with BP less than 120/80 mm Hg
    - every year in persons with a systolic of 120 – 139 mm Hg and a diastolic of 80 to 90 mm Hg.

- **Other factors that need to be assessed along with actual blood pressure elevation to determine treatment of high blood pressure include:**
  - Patient’s overall cardiovascular risk profile
  - Status of using commercial tobacco
  - Diabetes
  - Abnormal blood lipid values
  - Physical activity or inactivity level
  - Obesity
  - Age and gender
Step One: Screen

Understand the current process by asking the clinic Team:
- Who screenings blood pressure and documents it in the chart?
- Where is blood pressure currently noted in the chart/Electronic Medical Record? (Get copies of forms or screen shots)
- Is blood pressure recorded at every visit?
- Does every exam room have a regular, larger and extra large adult cuff?

Develop new screening process...if necessary:

A. Does clinical team need additional blood pressure tools or questions to add to their current intake forms?
B. Insure documentation is used to flag/trigger addressing risks and referring to resources
C. Develop new forms (paper and/or electronic) to gather the required information
D. Diagram the revised clinic process flow

(Implementation Guide, p. 14)
Step Two: Counsel

- After the clinician/staff or clinical team screened, and documented blood pressure, the next step is to counsel each patient.
- **SHIP 2.0 Primary Aim**: Clinicians will counsel regarding blood pressure, either:
  - the importance of maintaining a healthy blood pressure and what lifestyle behaviors can help the patient maintain a healthy blood pressure.
  - the importance of lowering elevated (pre-hypertension) or high (hypertension) blood pressure. Including lifestyle changes and pharmacological methods if necessary.
- This will be done with every patient at every visit; counseling and patient response will be documented in the medical record.
Advise and Counsel: Tool = MI

“**Motivational Interviewing** is a *directive, patient-centered* counseling style for eliciting behavior *change* by helping patients to explore and resolve *ambivalence.*”

*Bill Miller & Stephen Rollnick*
5 Basic Principles of Motivational Interviewing

1) **Express Empathy**
2) **Develop Discrepancy**
3) **Avoid Arguing**
4) **Roll with Resistance**
5) **Support Self-Efficacy**
Counseling: Tool = MI

Does Motivational Interviewing work?

- MI will increase patient change talk
- MI will diminish patient resistance
- The extent to which patients verbally defend *status quo* (resistance) will be inversely related to behavior change
- The extent to which patients verbally argue for change (change talk) will be directly related to behavior change—STRENGTH of the change talk is important

Patient’s who express the **Desire**, **Ability**, **Reasons**, **Need** for change—these are the areas to appreciate
How to “appreciate” change talk?

• **Open-ended questions**
• **Affirmations**
• **Reflections**
• **Summarize**
Refer

Referrals to resources:
- Internal = Clinic Dietician
- External = Community resources
  - Physical activity and healthy eating resources (Ex: parks, trails, farmers markets, etc.)
  - Community base dietician
  - Tap Local Public Health to identify resources
Follow-up:

• Set a follow-up time frame for the patient
  • “I would like to see you back in ____ to reassess the goals we set today around your blood pressure.”

• If patient is utilizing community resources:
  • Look for ways to have information sharing agreements between the clinic and community resource so updates can be given to clinicians on patients using those resources
Launching Pad Take-Aways

• Work with your patients where they’re at
• Suggest one small change at a time
• Don’t be afraid to jump in and begin to try