Bridging the Divide
SHIP Health Care Strategies

Making it Better Conference
November 16, 2011
Minneapolis, MN
SHIP: 2009-2011

• Grant funding through health reform legislation

• Built on work in 4 communities “Steps to a Healthier Minnesota” (CDC project)

• Statewide, working with 41 local entities
  – Community health boards (36)
  – Tribal groups (3)
  – Multi-grantees initiatives (2)
• 4 settings
  Schools
  Communities
  Worksites
  Health Care

• Chronic disease prevention and risk reduction
  – Nutrition
  – Physical activity
  – Tobacco use/exposure
ICSI Guidelines were derived from the practice guidelines of a leading health plan consortium to address obesity and chronic disease.

Referrals indicate efforts to link patients to weight management programs in their community for improving nutrition, increasing physical activity and supporting smoking cessation.
Example of Obesity Guideline Work
Examples of Referral Work
Resulting Policy Change

Stage of Policy Change for Clinics Implementing ICSI Guidelines

- Practice change AND formal policy: 40%
- Practice change but no formal policy: 25%
- Recognize need for change but no action: 13%
- Other: 13%

Stage of Policy Change for Clinics Implementing Referral Activities

- Practice change but no formal policy: 64%
- Recognize need for change but no action taken: 17%
- Practice change AND formal policy adopted: 13%
- Other: 6%
Ottertail MGI Innovation:
Breastfeeding Promotion & PSE Change

Golden Start Breastfeeding Initiative
sponsors:

Best Practice: Breastfeeding!

Evergreen Perinatal Education
Molly Pessl, BSN, IBCLC

May 24-26, 2011
Concordia College
Jones Science Center Room 212
Fugelstad Auditorium
Moorhead, MN 56560
Payment and Practice Innovation: Minneapolis MGI

- In addition to working with 19 clinic sites to transform practice
  - Created chart for patients and providers with community programs for weight management (nutrition/physical activity) & tobacco cessation
    - Covered by insurance (list by plan)
    - Free or low-cost
  - Billing & coding project of the Health Care Workgroup
Speakers

Deb McConnell, RN, MPH
• MN Department of Health

Courtney Jordan Baechler, MD, MS
• SHIP MD Consultant

Kristin Erickson, RN, BSN, PHN
• Otter Tail County Public Health

Kristen Godfrey, MPH
• Minneapolis Department of Health and Family Support

Three break-out discussions:
(1) clinics; (2) resources; (3) reimbursement
SHIP Grant Directed Intervention

• Uses ICSI Guidelines:

  – *Prevention and Management of Obesity (mature adolescents and adults)* (Jan 2009)

Primary Prevention of Chronic Disease Risk Factors Guideline

Targets 4 key behaviors

• Increase Physical Activity
• Improve Nutrition
• Decrease Tobacco Use and Exposure
• Decrease Hazardous Alcohol Use
Why?

• 40% of all deaths in US attributed to four behaviors
  • Poor nutrition
  • Inadequate levels of physical activity
  • Smoking and exposure to tobacco
  • Hazardous drinking
Healthy lifestyle - the best medicine!

- Changing behaviors in previous slide in middle age provides a 40% reduction in mortality compared to those who continue behaviors.

- Correlates with an extra decade of life expectancy.
Redesign For Results (R4R)

Goal: productive interactions between patients and providers

• Timely information and feedback to patients (tailored treatment plans and self-management)
• Delivery system design
• Multidisciplinary team and partnerships
• Systematic follow-up
• Public Health teams working with clinic to create systems that support providers in positive patient interactions
R4R uses a team approach

- Different staff have roles in process
- Rooming staff has BMI available on chart/in record
- Use MA/LPN to distribute educational materials
- Staff to help with referrals
- Use RNs and Health Educators to teach patients and follow-up
- We already do this with Well Child Checks and other visits
Health Risk Assessment

• Identify health risk factors
  – Screen patients for target behaviors
    • Questionnaire
    • Discussion
    • Checklist
  – Calculate BMI
  – Obtain smoking status

• Provide feedback on possible behavior changes
Feedback Matters!

• Individualized feedback and health education improve health behaviors and conditions such as:
  • measurements of physical activity
  • reducing dietary intake of fat
  • decreasing tobacco use
  • reducing overall (median) blood pressure measurements
  • reducing overall (median) cholesterol measurements

Source: Task Force on Community Preventive Services, 2005a [R].
Your role as a provider: name the problem; help make a plan

- Collaborative decision-making and brief, combined interventions are effective in helping motivate and engage patients in healthier lifestyles
- Patients see providers as experts
- Patients assume if we don’t mention a problem, it isn’t a problem
- “No message” sends the wrong message
Ask/address topic

• “You’ve gained a little weight since your last visit”

• “We use weight and height to calculate BMI, yours puts you in the “overweight” category. I’d like to help you make a plan to get that weight off before it causes you health problems”
Uncomfortable?

• Remember, only 53 % of overweight patients perceived themselves to be overweight.
• Many overweight adults become obese.
• Many patients will not follow through with a referral.
• We need to diagnose and address the problem and come up with solutions together with the patient.
We Are All on a Continuum

• Optimal Health Goals:
  – don’t smoke
  – eat 5 servings fruits and veggies a day
  – exercise 5+ days/week
  - do not consume excessive alcohol
• Please consider if all of these are true for you
• If not, will you commit to one small step to improve your health?
• What feelings does this raise?
Small Bouts of Activity

• Take the stairs
• Play with your kids
• Park further away
• Activity breaks from TV (during commercials) or computer
• Start wearing a pedometer
• Walk 10 minutes a day
• Get off one bus stop earlier and walk
• Take an exercise class or join the Y
Helping patients choose healthy foods - the big picture

• Eat fewer processed foods
• Eat in moderation
• Portion control
• Eat a variety of foods
• Smaller, more frequent meals
• Learn to read food labels
Setting small goals with patients

• Pack lunch instead of fast food
• Eat a healthy breakfast
• Review portion size
• Add 1 fruit or vegetable per day
PartnerSHIP4Health

SHIP in
Becker, Clay, Otter Tail, and Wilkin Counties
PartnerSHIP4Health
Health Care Initiative

- Goal
- Partners
- Process
- Tools
- Outcomes
- Recommendations/Lessons Learned
Goal

Support implementation of the following Institute for Clinical Systems Improvement (ICSI) Guidelines:

- “Prevention and Management of Obesity" and
- “Primary Prevention of Chronic Disease Risk Factors” (“Healthy Lifestyles” as of 2011)

www.icsi.org
Partners

• Primary Care Clinics (six):
  – Essentia Health Clinic in Detroit Lakes
  – Sanford Health Clinic in Pelican Rapids
  – Sanford Health Clinics in Perham, New York Mills, Hawley, Ottertail City, and Ulen
  – Migrant Health Services, Inc. in Moorhead
  – Family Healthcare Center in Fargo, ND
• Physical Therapy Clinic (one):
  – Orthopedic Sports & Physical Therapy, Inc. in Breckenridge
• Public Health Agencies (four):
  – Becker, Clay, Otter Tail, and Wilkin Counties
Process

• Baseline Assessment
  – Current Practice
  – Compare to Guidelines
  – Ready to change?

• 12 Month Collaborative
  – ICSI: face-to-face sessions, webinars, conference calls, action plan review, progress reports review
  – LPH: resources, tools, support
  – Partner: action plan creation and implementation

• Post-Initiative Assessment
Tools and Resources

- Health Care Organization
  - Assessment Surveys
  - Chart Audit
- Clinician
  - Motivational Interviewing Algorithm
  - Readiness to Change Tool
- Patient
  - Healthy Habits Survey and Record
  - Brochure: What does BMI mean to me?

www.partnerSHIP4Health.org
Outcomes

One Partner Reported:

- *Ht/Wt now taken at every visit*
- *BMI automatically calculated at every visit*
- *BMI chart and material posted in every exam room next to scale*
- *Nurses trained and adapted to asking additional “vital sign” (nutrition/physical activity) questions*
- *Nutrition and physical activity educational materials located in waiting area and staff hallway*
- *Healthy eating and activity posters in waiting room*
- *Employee wellness initiatives on-going*
Outcomes

A Public Health Nurse Partner Commented:

“This intervention adds at least 15 minutes to every client visit and it is easier with some clients than others. Those who don’t feel it’s important to them sometimes can feel offended. At other times, I have gotten the reaction of “what’s this got to do with the reason for this visit?” But I have also gotten the comment that it opened the door to changes. We need to normalize the intervention.”
Outcomes

Another Partner Stated:

• *It was a great honor to work with PartnerSHIP4Health-ICSI during the 12 month collaborative. We accomplished things beyond what we thought was possible.*

• *We will continue to promote healthy weight and tobacco cessation with every patient.*
Recommendations for LPH

• Foundational work is critical:
  – Assist partners in engaging staff.
  – Assist partners in setting clear goals, aims, measures, and use of rapid cycle PDSAs.

• Adaptive vs. technical work:
  – Assist partners to realize that change requires both.
  – The most common cause of leadership failure is treating an adaptive problem with a technical fix.

_Leadership on the Line_ by R. Heifetz
Lessons Learned

• A collaborative approach keeps partners accountable and allows for rapid spread of knowledge and ideas.

• Every partner has a unique response to guideline implementation.

• Partners who have a physician and/or direct champion make the most progress.
Resources

• For electronic copies of assessments, tools, and/or resources, go to www.partnerSHIP4Health.org and click on the Health Care Link

• For questions, email kerickso@co.ottertail.mn.us

• Follow us on facebook!
Minneapolis SHIP
Health Care Referral Project

The purpose of this project is to increase patient referrals from clinics to community resources providing high quality nutritious foods, opportunities for physical activity, and tobacco cessation.

This Minneapolis Department of Health and Family Support program is funded through the Minnesota Department of Health’s Statewide Health Improvement Program.
Goals

- Develop a resource system that health care providers can use to refer patients to clinic- and community-based programs and services for obesity and tobacco cessation.

- Assist 10 clinics to implement and evaluate a resource referral system and increase patient referrals to resources.
Project Partnerships

MDHFS is working with the following clinics to develop, implement, and evaluate a resource referral system:

- AXIS Medical Center
- Broadway Family Medicine
- Neighborhood HealthSource (Fremont, Central and Sheridan)
- Neighborhood Involvement Program
- NorthPoint Health and Wellness Center
- Park Nicollet system (Minneapolis pilot site)
- Phillips Neighborhood Clinic
- The People’s Center Medical Clinic

MDHFS is working with a variety of health care stakeholders, community organizations, SHIP grantees, and the Minnesota Department of Health to broaden the scope and impact of this work locally and statewide.
2010 Baseline Assessment Results indicate:

- Only 7% of providers and 14% of staff surveyed refer all or most at-risk patients to obesity and nutrition resources.
- 71% of providers and staff surveyed indicate that a referral system or mechanism would assist them in making referrals for obesity and tobacco cessation.
- 63% of providers and staff surveyed indicate they are unaware or unfamiliar with programs and services available.
- Patients are interested in free, accessible resources:
  - Trails; parks; fitness and recreation centers; farmer’s markets
  - Walking/running; exercise machines; exercise/nutrition classes
  - Face-to-face counseling/coaching and support groups
Key Strategies

- **Clinic referral processes and resources** - Develop clinic-specific resource lists and systematic processes for referrals

- **MinnesotaHelp.info®** – Establish a statewide health and wellness resource database to maintain resources

- **Direct referral pipelines** - Build partnerships between clinics and community organizations to offer programs on-site and/or in the community

- **HealthyLiving Minneapolis** – Develop network of accessible and affordable programs and services to partner with clinics for referrals
Process

- Conduct assessment of patient and provider needs and barriers
- Research and select resource directory systems
- Conduct inventory of resources in Minneapolis
- Submit resources to [www.MinnesotaHelp.Info](http://www.MinnesotaHelp.Info) and United Way 2-1-1
- Develop clinic resource lists to meet patient and clinic needs
- Conduct clinic training on resources and MinnesotaHelp.Info
- Review current process for making referrals and identify improvements
- Develop clinic roles and process for linking patients to resources
- Develop tools, forms and/or EMR modifications for referrals
- Clinics track referrals to resources
- Identify gaps in resources and opportunities for onsite programs and community partnerships
- Conduct follow-up assessment to determine outcomes
What is MinnesotaHelp.info® (MHI)?

- A searchable online database of health and human services in Minnesota for seniors, people with disabilities, parents and families, veterans, youth, and people with low-income
- Expanded through SHIP to include health and wellness resources

How can clinics use MHI?

- Use the Power User Version to easily search, save, print, export, email, and map resources
- Narrow search results by location, zipcode, language, and target group
- Create customized printable clinic resource directories
- Link a customized version directly to a website or EMR

How can community agencies use MNHelp.Info?

- Use the Provider Portal to easily add and update program and service information
- To keep community partners informed on programs
Direct Referral Pipelines

Clinic-based programs and services
- Childhood obesity program “We Can”
- Dietetic Intern support to offer nutrition services and classes to patients
- Tobacco cessation class for Somali patients

Community-based programs and services
- Nutrition cooking class “Cooking Matters” offered in collaboration with Community Ed and Headstart
- “I Can Prevent Diabetes” classes in collaboration with Simply Good Eating
- YMCA Diabetes Prevention Program referrals
- HealthyLiving Minneapolis
HealthyLiving Minneapolis

What is HealthyLiving Minneapolis?
- Network of organizations that provide accessible and affordable programs and services for healthy eating, physical activity, and tobacco cessation.
- Partners with clinics to accept referrals and link patients to resources.

Network organizations
Participating organization were selected based on patient and provider needs and preferences:
- Minneapolis Community Education
- Minneapolis Park & Recreation Board
- U of M Extension, Simply Good Eating and Cooking Matters
- WellShare International
- YMCA of Metropolitan Minneapolis
- YWCA of Minneapolis
Outcomes

Overview of PSE changes:

- 10 clinics made systematic referral process changes to increase referrals, 6 adopted a formal policy change
- 10 clinics made physical changes to support process changes (e.g. medical record; referral forms; resource displays, signs, calendars, brochures; dietetic personnel)
- 100 resources were added to MNHelp.Info and the Greater Twin Cities United Way 2-1-1 caller database
- Over 60 clinic staff/providers received training on using MNHelp.Info to link patients to resources
- 5 new patient education and support classes as a result of partnerships between clinics and community orgs
- 3 clinics pilot HealthyLiving Minneapolis
Outcomes

2011 follow-up assessment results indicate that compared to a year ago:

- 53% of providers reported increased awareness of community and clinic-based resources for obesity
- 43% of providers/staff reported increased referrals to obesity resources
- 28% of providers/staff reported increased referrals to tobacco resources
- 97% of providers/staff respondents thought MNHelp.Info was a useful tool and would recommend other clinics use it
- 70% of providers/staff reported the priority level that their clinic places on referrals to resources has increased
Outcomes

“Having something to offer allows me to make the referral.”
- Clinic Provider

“I can finally now see that patients are starting to think about their health. Some even ask about their BMI and what that means.”
- Clinic Provider

“The MNHelp.Info database has cut time spent on finding the appropriate resource. It is a very effective tool!”
- Clinic Representative

“It was very helpful to meet the people behind the organizations. I look forward to [the end of the HealthyLiving Minneapolis pilot] to see how many referrals become connections.”
- Clinic Representative
Lessons Learned

What will support implementation?
- Information and training on available resources
- Paper list and web-based directories of resources
- Availability of resources to meet patient needs
- Using a team effort of health care staff to implement
- Combination of clinic and community based programs through community partnerships

What are barriers to implementation?
- Provider/staff awareness of and access to resources
- Even when community resources are convenient and available for free, it’s difficult to get patients to use them.
- Perceived barrier of patient/family interest and cooperation

What is still needed?
- A follow-up mechanism
- Individualized support for lifestyle behavior change
- Expand use of MNHelp.Info at clinics statewide
Tools and Resources

- www.MNHelp.Info
- United Way 2-1-1
- MN Clinic Fax Referral System
- SHIP Clinic Toolkit: http://www.ci.minneapolis.mn.us/dhfs/toolkit.asp
  - Minneapolis and clinic-specific resource lists
  - HealthyLiving Goals referral form
  - SHIP health plan and clinic system services grids
- HealthyLiving Minneapolis Map
Contact Us

- Megan Ellingson, (612) 673-3817
  megan.ellingson@ci.minneapolis.mn.us

- Kristen Godfrey, (612) 873-9947
  kristen.godfrey@hcmed.org
Choice of three discussion tables:

The clinic experience:
Terra Carey, MPH, Neighborhood HealthSource
Rhonda Eastlund, Cedar Riverside People’s Center
Lisa Harvey, RD, MPH, Pak Niccollet

Resources and referrals:
Kristen Godfrey, MPH, Mpls Dept of Health and Family Support
Kristin Erickson, RN, BSN, PHN, Otter Tail County Public Health
April Sutor, MPA, United Way of Olmsted County

Reimbursement:
Deb McConnell, RN, MPH, MN Department of Health
Megan Ellingson, MHA, Mpls Dept of Health and Family Support