

Minnesota Department of Health
Statewide Health Improvement Program



Prevention in Health Care

Guide to Implementation

Fiscal Years 2012 and 2013

Table of Contents

<u>Topic</u>	<u>Pages</u>
Overview	3-4
Description and Scope	
SHIP Objectives	
Summary of Changes	
Menu for <i>Prevention in Health Care</i>	5-7
Selection Requirements	
Target Populations	
Settings	
Recommended Partners	
Planning and Assessment	8-12
Step 1: <i>Screen</i>	13-15
Overview	
Implementation	
Step 2: <i>Counsel</i>	16-19
Overview	
Implementation	
Step 3: <i>Refer</i>	20-27
Overview	
Implementation	
Step 4: <i>Follow-up</i>	28-30
Sustaining Long-Term Change	31
Appendices	32

Prevention in Health Care

Description and Scope

The numbers tell the story: in 2009 approximately 63 percent of Minnesotans were overweight or obese, and 17 percent of Minnesotans used tobacco products. The annual obesity-related medical cost is estimated to be \$1.5 billion dollars, of which \$626 million are Medicaid and Medicare expenditures. Overweight and obesity also increases the risk of many chronic diseases such as diabetes, heart disease, some cancers, arthritis and others. This epidemic is placing a huge burden on our health care system and economy. It also underscores the important role of the health care system as a setting for addressing nutrition, physical activity, and tobacco use behaviors.

The *Prevention in Health Care Guide to Implementation and Evaluation* provides relevant guidance and useful resources to SHIP grantees, which include LPH and tribal communities, for implementing and evaluating strategies that integrate overweight/obesity and tobacco use prevention and reduction into the health care system. Grantees may use this step-by-step guide for recruiting clinic partners, conducting assessments, developing clinic action plans and implementing and evaluating *Prevention in Health Care* steps. *Note: References to resources are for informational purposes and not an endorsement of organizations or products.*

The *Prevention in Health Care* strategy includes the following steps:

1. Screen
2. Counsel
3. Refer
4. Follow-up

SHIP Objectives for *Prevention in Health Care*

The SHIP approach to *Prevention in Health Care* is founded on true collaboration between health care clinics, local public health (LPH) agencies and community-based organizations (CBOs), Tribal governments and their healthcare systems. The objectives for this approach are:

1. Convene and strengthen partnerships between LPH, health care facilities and clinics, health plans/payers, and community-based organizations that are committed to addressing obesity and tobacco use/exposure.
2. Convene and strengthen partnerships between tribal governments and their healthcare systems to address PSE changes within tobacco and obesity risk factors
3. Enhance methods for screening and documentation of Body Mass Index (BMI) and tobacco use and exposure status.

4. Provide technical assistance to clinicians and clinic staff on effective practices and approaches for addressing BMI status and tobacco use and exposure with patients, including motivational interviewing and goal setting.
5. Identify, catalogue and make available to clinicians, clinic staff and patients community resources that address behaviors related to nutrition, physical activity, and tobacco use and exposure. This may include uploading resources to a statewide online database and integrating into electronic medical record (EMR).
6. Create or strengthen referral system to in-house or community resources.
7. Develop or enhance a follow-up system.
8. Promote usage of existing billing codes for reimbursement of provision of services related to the SHIP approach to *Prevention in Health Care* (e.g., counseling, nutrition education, follow-up care).

Summary of Changes from the First Round of SHIP

In order to reflect lessons learned, national and state guidelines on obesity reduction and smoking cessation, and input from grantees, the SHIP health care strategy has been changed from the first round of SHIP. The following are highlights of these revisions:

- Health care intervention (C-HWHB-H1), supporting implementation of two ICSI Guidelines, *Prevention and Management of Obesity (Mature Adolescents and Adults)* and *Healthy Lifestyles* (formerly *Primary Prevention of Chronic Disease Risk Factors*) and health care intervention (C-HWHB-H2), referrals to local resources, have been combined and divided into four separate steps. Each step has a unique focus, builds upon the step that precedes it and will be most effective if the other three steps are implemented. The more steps that are implemented, the better the patient outcome.
- Pediatric populations have been added to target population.
- Patient Self-Management intervention (C-HWHB-H3) was dropped because zero grantees chose to implement it in the first round of SHIP; however, two self-management evidence-based programs, the Chronic Disease Self-Management Program (CDSMP), the I CAN Prevent Diabetes Program, and the MN Fax Referral Program for Tobacco Cessation are included in Step #3.

Menu for *Prevention in Health Care*

The SHIP approach to *Prevention in Health Care* consists of four steps, three of which are required (#1-3) and one that is highly recommended (#4). **Table 1** provides a list of these steps in order of implementation.

Table 1. Menu for *Prevention in Health Care*

Prevention in Health Care Strategy
1. Screen (Calculate and document BMI and tobacco use/exposure)
2. Counsel (Discuss BMI status and tobacco use/exposure)
3. Refer (Arrange clinical, community or self-management resources)
4. Follow-up (Arrange follow-up with patient and/or referral to assess utilization)*

*Implementation of the follow-up step is not required but highly recommended for grantees established in this work.

Rationale

The steps listed above in **Table 1** were adapted from evidence-based guidelines and recommendations, including:

- The Institute for Clinical Systems Improvement (ICSI) *Prevention and Management of Obesity (Mature Adolescents and Adults)* and *Healthy Lifestyles* (formerly *Primary Prevention of Chronic Disease Risk Factors*).
- The American Academy of Family Physicians (AAFP) *Ask and Act Tobacco Cessation Program*, “The Five A’s Of Tobacco Cessation Support.” The 5A’s (Ask, Advise, Assess, Assist, and Arrange) are reflected in the *Prevention in Health Care* strategy (see **Appendix A** for a diagram depicting their overlapping relationship).

Please also see **Appendix B: References** for supporting literature, **Appendix C: Talking Points** for Prevention in Health Care, and **Appendix D: Terminology and Abbreviations**.

Outcomes

Standardized outcomes for required steps are still under development. The strategy will be measured primarily on policy, systems and environmental change outcomes and health behavior change outcomes and then linked through literature projections to health care cost savings.

Evaluation Measures		
Policy, Systems, Environmental Changes Existing tools or MDH database	Health Risks and Behavior Change Existing tools or medical records	Cost Savings Actual savings or literature projections

Selection Requirements

1. All grantees are required to plan and implement steps #1-3 (screen, counsel, refer) during the grant period.
2. All grantees are strongly encouraged to implement step #4 (follow-up), particularly those that are already implementing ICSI Guidelines or Referrals to Local Resources either from the first iteration of SHIP or as a result of standard practice.

Target Populations

- **Screen:** Every patient, every visit (ideally) with a minimum of annually.
- **Counsel, refer, follow-up:** Patients, regardless of age, identified as being overweight or obese (according to BMI measurement – see ranges below) or using/being exposed to tobacco.

Adults: BMI 25.0-29.9 = Overweight
BMI >30 = Obese

Children: BMI 85th-94th percentile = At-risk for overweight
BMI 95th percentile or higher = Overweight

Settings (clinics that are **bolded** reflect those serving high priority populations)

- **Clinics serving high volumes of uninsured (or “self-pay”)**
- **Clinics serving high volumes of Medicare/Medicaid patients**
- **Clinics serving Minnesota Health Care Program (MHCP) patients**
- Outpatient primary care clinics
- Pediatric clinics
- Physical therapy clinics
- University setting clinics (student health services)
- Occupational health clinics
- Dental clinics
- Women’s health/OB-GYN clinics
- Mental health clinics
- Public health clinics (may include school-based clinics if they exist)
- Visiting Nurse Association (see NOTE below)

Recommended Partners and Potential Responsibilities

Minnesota Department of Health (MDH)

- Coordinate state policy work to support LPH.
- Provide technical assistance and resources to LPH.
- Convene grantees through connect calls to share tools, knowledge and experience with strategy implementation.

Local Public Health (LPH) and Tribal Governments (referred to in this document as “grantees”)

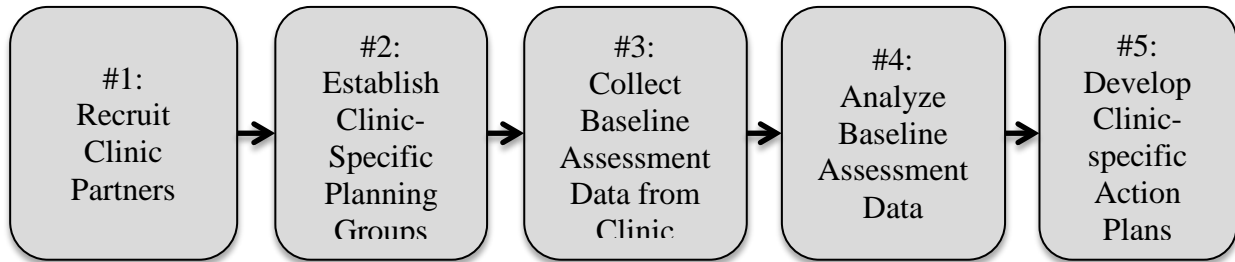
- Recruit health care partners.
- Conduct baseline assessment, analyze results and share findings with planning groups.
- Develop or identify resources that support strategy implementation including surveys, clinician materials, EMR measures, sample policies, etc.
- Work with clinic partners to identify or develop in-house, home-based and community-based referral resources.
- Identify and/or develop referral and follow-up processes.
- Offer technical assistance and on-site training for clinic partners as needed.

Clinic Partners (For SHIP 2.0 health care partners will be referred to as “clinic partners,” whether it is technically a clinic or a health care site)

- Complete assessments.
- Organize a clinic-specific planning group team (preferably including a physician or director champion).
- Participate in webinars, face-to-face sessions and conference calls to access technical assistance.
- Develop and implement action plan.

Planning and Assessment

Planning and assessment are critical aspects of SHIP as they prepare both grantees and community partners for implementation of evidence-based strategies. SHIP grantees must complete the process pictured in the diagram below prior to implementation of the *Prevention in Health Care* strategy steps.



1. Recruit Clinic Partners

Grantees will provide information to clinics and other health care sites about SHIP and the Prevention in Health Care strategy. Outreach should include information on how prevention can fit in with the clinic or health care system's current or changing workflow processes.

- A. Obtain a list of clinics in the community.
 - i. Engage existing network of partners (first round SHIP partners).
 - ii. Consider approaching local Health Care Home clinics.
- B. Contact clinic staff or clinicians, if possible, to schedule in-person meetings.
- C. Review measures clinics are responsible for reporting related to weight and tobacco use assessment, counseling, and referral services.
- D. Present SHIP materials, clinic tools, and clear vision: "This is what SHIP can offer you..."
 - i. Develop a plan/training to educate clinicians and clinic staff about the *Prevention in Health Care* strategy and objectives.
 - ii. Include materials/handouts, food and refreshments.

What Worked in the First Round of SHIP?

- Grantee scheduled and facilitated a 30-60-minute on-site SHIP Introduction training from an MD Consultant for clinicians and staff.
- Introductory webinar facilitated by ICSI.

- E. Ask clinic staff to identify any clinician "champions" within their clinics or health care systems.

Potential Milestones

- List of potential partners (clinics) generated
- Training scheduled
- Grantee-clinic partner commitment agreement signed, with each party's role delineated

Resources

- **Sample Recruitment Letters** (Appendix E)
- **Sample Recruitment Information** (Appendix F)
- **Clinician Talking Points** (*MDH will provide these at a later date*)
- **Clinician Champion presentations**
 - Dr. Neal Holtan and Sofi Ali's PowerPoint presentation (Appendix G)
 - Dr. Courtney Jordan's webinar and presentation
- **Uniform Data System (UDS) and Healthcare Effectiveness Data and Information Set (HEDIS) Measures** (Appendix H)

2. Establish Clinic-Specific Planning Groups

Grantees will facilitate the formation of clinic-specific planning groups which have been shown to markedly increase the success of implementation and sustainability. Grantees may also consider forming an area advisory committee to provide guidance, oversight, and coordination of SHIP health care strategy within their region.

- A. Facilitate the formation of **clinic-specific planning groups**. The purpose of each planning group is to determine priorities, provide input on the planning and implementation of the strategy steps, and assist with evaluation activities. Members may include (but are not limited to) clinician champion, clinic manager, TA providers, medical assistants, nurses, quality improvement staff, community health workers, and other partners.
 - i. Ask clinic administration to identify and confirm group members.
 - ii. Schedule meetings, ideally monthly or more often to track progress, conduct assessment and develop clinic action plan.
 - iii. Utilize the first or second meeting to provide a general overview of SHIP and the SHIP health care strategy steps, including a suggested timeline and plan.

- B. *Optional Activity*: Facilitate the formation of an **area advisory committee**. The purpose of an area advisory committee is to allow peer-to-peer clinician conversations on what works, address common issues or concerns in the area with implementation, and strengthen the relationship between community referral organizations and clinics through collective problem-solving. Members may include (but not limited to): clinician champion from each clinic (if feasible), clinic representative (clinic manager), LPH staff, patients and representatives from select community-based organizations (that offer resources for nutrition, physical activity, and tobacco via referrals), depending on the area capacity.
 - i. Identify potential partner groups and send letter of invitation.
 - ii. Add new SHIP partners as recruitment proceeds.

- iii. Propose dates for meetings.
- iv. Upon assessing availability, schedule regular meetings (every month or every-other month).

What Worked in the First Round of SHIP?

- Minneapolis Health Care Work Group
- ICSI Collaborative

Potential Milestones

- Planning group formed
- Materials developed for meetings: agendas, list of attendees, presentations, and tools

Resources

- **Minneapolis MGI Health Care Work Group** (Appendix I)

3. Collect Baseline Assessment Data from Clinic Partners

Grantees will conduct baseline assessments of clinic partners to determine:

- Organizational readiness to change
- Quality improvement culture
- Current systems, practices, measures, and documentation related to:
 - screening for BMI and tobacco use/exposure
 - screening for nutritional and physical activity behaviors (optional)
 - addressing BMI and tobacco use/exposure
 - referring to community resources

A. Select assessment instrument/tool from list below (see Evaluation Tools).

B. Conduct baseline assessment in each clinic partner to determine current systems, practices, and measures (if any) related to the *Prevention in Health Care* strategy.

C. Collect and manage data.

Potential Milestones

- Baseline assessment conducted

4. Analyze Baseline Assessment Data

Grantees will work with participating clinics to interpret baseline assessment data and determine priorities/focus areas as well as technical assistance needs.

A. Analyze data.

- B. Generate a list of findings into a useable format.
 - i. Create presentation of clinic assessment, patient and provider survey results (to be presented at collaborative or meeting with clinic to determine protocols/process for referrals at that clinic).
- C. Share findings with clinic planning group.
 - i. Conduct Staff/Provider Focus Groups to get more clarity on clinic/provider survey results and ascertain further directed feedback from providers on current referral processes and needs.
- D. Based on findings, determine priorities. Incorporate findings into action plan or work plan.

Potential Milestones

- Data generated and analyzed
- Process flow chart of current clinic practices developed
- Findings shared with planning group
- Priorities/focus areas determined

Resources

- **Health Care Provider/Staff Focus Groups: Informed Consent and Questions** (Appendix J). Get feedback from providers on current referral process and needs to 1) identify opportunities for process improvement within the clinics; and 2) to inform the development of a broad-based referral directory. Discuss when to implement a quality improvement cycle for adapting clinic processes i.e. before or after formal referral system is developed. *To be conducted after the initial Clinic, Provider, and Patient Surveys are complete and before intervention implementation.*
- **Americans in Motion–Healthy Interventions (AIM-HI)**. Offers resources for family physician practice staff to serve as role models for patients. See page 7, step 3 of the AIM-HI Practice Manual for information on adjusting office processes and procedures. http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/aim/practicemanual.Par.0001.File.dat/AIMPracticeManual.pdf
- **SHIP Clinic Assessment Summary Form** (Appendix K)
- **SHIP Health Care Tracking Worksheets** (Appendix L)

5. Develop Clinic-Specific Action Plans

Using results from baseline assessment, grantees will work with clinic partners to develop clinic-specific action plans, including mapping current and proposed clinic flow process. Details included in the plan are based on what it will take to get to the proposed clinic flow process.

- A. Outline priorities and focus areas with planning group.
- B. Consider worksite wellness.

Americans in Motion–Healthy Interventions (AIM-HI) is an American Academy of Family Physicians initiative that encourages family physicians to be fitness role models for their patients by offering information and resources to create a fitness focus in their office environment (see *Resources* below).

- C. Create overall action plan for addressing priorities.
- D. Include a timeline for project.
- E. Develop clinic-specific action plan.
 - i. Map out readiness to change and ensure the plans are based on addressing the clinic partner’s readiness to change result.
 - ii. Map out the clinic patient flow goal and ensure plans are largely based on how to get to that revised clinic flow.
 - iii. Include a budget (for purchase of new items such as BMI posters).
- F. Indicate technical assistance needs.
- G. Pilot plans and revise accordingly using PDSA tool (see *Resources* below).

Potential Milestones

- Organization has a culture that is ready to change.
- Action plan has been developed and vetted through clinic.

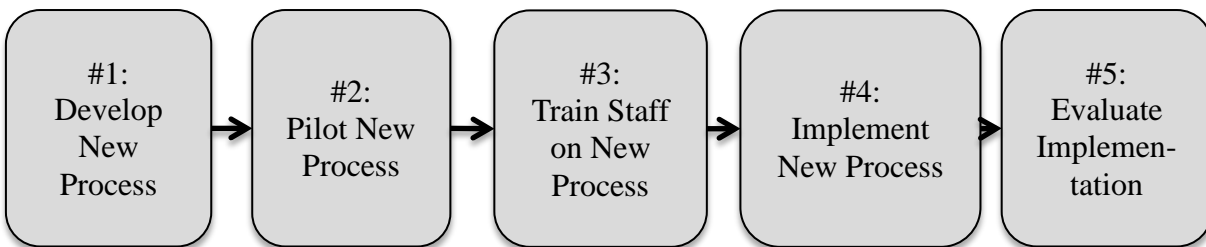
Resources

- MDH Quality Improvement tool: **Plan Do Study Act (PDSA)**
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- Action Plan templates
 - **Minneapolis SHIP Resource and Referral Network Clinic Action Plan** template (Appendix M)
 - **Clinic Action Plan Tracking Tool** (Appendix N)
 - **Carver-Scott Health Care Action Plan** template (Appendix O)
- **AIM-HI Resources:**
<http://www.aafp.org/online/en/home/clinical/publichealth/aim/about.html>

Step 1: Screen

Primary Aim: Clinicians will screen all patients (adults and children) at preventive and chronic disease visits (or a minimum of annually) for BMI and use/exposure of tobacco. Clinicians will document results in the medical record.

Secondary Aim: Clinicians will screen all patients (adults and children) at preventive and chronic disease visits (or a minimum of annually) for physical activity patterns and nutrition habits. Clinicians will document information in the medical record. Grantees working with clinics that are further along in this work should consider working on the secondary aim.



Screening patients to gather data to measure their lifestyle risks is the first step in a clinical intervention to address lifestyle risk factors. Gathering patient BMI requires measuring patient weight and height and using these to calculate BMI, and screening patients for tobacco use/exposure requires questioning patients about their tobacco behaviors/exposures. Measuring height and weight, calculating BMI, and asking patients about their tobacco use/exposure must be developed as a consistent process within every preventive and chronic disease management visit so that they are calculated at all non-acute visits, and at least annually for all patients.

Screening patients and documenting physical activity patterns and nutrition habits will provide additional helpful information to clinicians as they discuss goals and plans to improve the patient's health (Step 2).

Results of patient BMI calculations, and answers to questions regarding patient tobacco use/exposure, physical activity patterns and nutrition habits must be documented in the patient chart before the clinician sees the patient that day so that the clinician has the information available for discussion at that appointment. An Electronic Health Record may automatically calculate BMI, but this alone does not guarantee that the information is readily available to the provider seeing the patient that day. Process steps need to be built to ensure clinicians consistently have the information available to them as they meet with patients. This often includes visual reminders such as chart stickers, notes, BMI posters by the scales and in exam rooms and/or electronic chart flagging to bring the clinicians' attention to the patients' BMI and lifestyle risk results. Clinics vary in their reminder/flagging systems, and utilizing methods that clinicians are already accustomed to at each clinic is often useful.

Outcome: BMI and tobacco use/exposure are screened and documented.

Implementing Step 1: *Screen*

1. **Develop New Screening Process** (Measurement, Documentation and Clinic Flow)

- A. Determine if clinic needs additional lifestyle risk measurement tools and/or questions to add to their current intake forms.
- B. Consider needs of Step 2 (address risks) and Step 3 (refer to resources) when developing documentation—insure documentation is used as a flag/trigger for 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 including:
 - i. Which staff accomplish each part of the process
 - ii. Existing or new tools (forms, reminders, etc.) used throughout process

Potential Milestones

- Clinic has decided what lifestyle risk information they want gathered
- Clinic has developed forms that gather lifestyle risk information
- Revised clinic flow process has been developed that insures gathering and documentation of all information, including who will accomplish each part in the process

Tools

- **SHIP Lifestyle Risk Tool** (Appendix P)
- **Health Behavior Assessment** (Appendix Q)
- **5-2-1-0 Healthy Habits Survey** (recommend for pediatric population; Appendix R)

Resources

- **Your BMI Handout** (Appendix S)
- **AIM-HI Fitness Inventory:**
http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/aim/fitnessinventory.Par.0001.File.dat/FitnessInventory.pdf

2. **Pilot New Process**

- A. Conduct a pilot to test the new process (for example, one or two clinicians for a day or two) using a Plan, Do, Study, Act model for quality improvement.
- B. Review pilot results and change process based on what you've learned.
- C. Re-pilot and re-evaluate the process until it works smoothly.

Potential Milestones

- Pilot is conducted
- Process is finalized

Resources

- **MDH PDSA Storyboard Template** (Appendix T)
- **MDH PDSA Worksheet** (Appendix U)
- **RWJF Pre Practice Assessment Instrument:**
<http://www.prescriptionforhealth.org/results/NCObservationInstrument.doc>
- **RWJF Post Practice Assessment Instrument:**
<http://www.prescriptionforhealth.org/results/NCObservationInstrumentFU.doc>

3. Train Staff on New Process

- A. Schedule a time when all relevant staff can be trained on the new process.
- B. Provide training to staff on new process, including new expectations for their roles and how process improvement will be evaluated.

Potential Milestones

- Training completed

4. Implement New Process

- A. Pick a start day for the new process to be universally implemented on the entire target population.
- B. Implement new process.

Potential Milestones

- New process implemented for entire target clinic population

5. Evaluate Implementation

- A. Use chart audits or other quality improvement measurement tools monthly.
- B. Share results with clinicians to monitor progress.
- C. Gather feedback; determine and address needs for full implementation of the process.

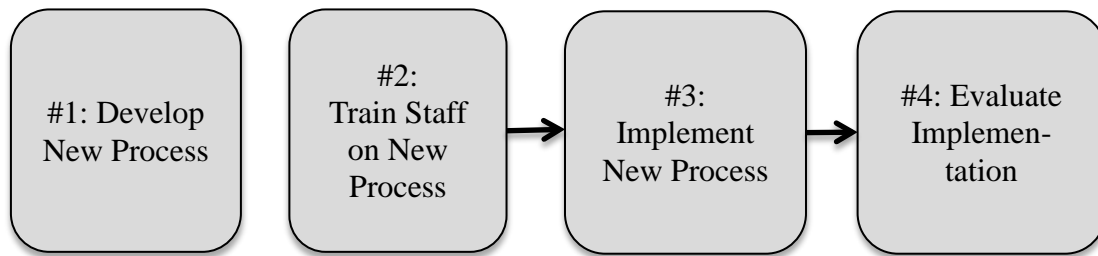
Potential Milestones

- Chart audit conducted monthly
- Chart audit shows consistent implementation of the process

Step 2: Counsel

Primary Aim: Clinicians will counsel regarding BMI and tobacco use/exposure with every patient at every visit; counseling and patient response will be documented in medical record.

Secondary Aim: Clinicians will counsel regarding nutrition habits and physical activity patterns with every patient at every visit; counseling and patient response will be documented in medical record.



After the clinician/staff or clinical team has asked about, or screened, and documented BMI and tobacco use/exposure (and nutrition and physical activity, if desired), the next step is to counsel each patient.

The task for each grantee in Step #2 is similar to that of Step #1 in that the grantee must support and assist each health care partner as they systematically incorporate patient counseling into a new or revised clinic system while enhancing clinician/staff work flow. It is indeed all about system redesign and fostering a culture of change through the entire process. Counseling refers to clinicians advising patients of risks of current BMI or tobacco use/exposure status and the benefits of change, assessing patients' readiness to change, and assisting with care plan creation for 1-2 patient-identified health goals. Grantees working with clinics that are further along in this work should consider working on the secondary aim as well.

Outcome: **Results of BMI status and tobacco use/exposure (and healthy eating and physical activity if these behaviors are also being measured) discussion are documented.**

Implementing Step 2: *Counsel*

The following should be implemented following completion of Planning and Assessment and Step 1. Additionally, adopting and implementing a Worksite Wellness Policy (for the clinic staff) is suggested prior to initiation of Step #2. Finally, these activities should be implemented in conjunction with clinic partners.

1. Develop New Counseling Process

- A. Diagram current process, compare to evidence-based recommendations, and identify gaps.
- B. Develop and diagram revised process that will support counseling, incorporating feedback from clinic planning group.
- C. Identify and obtain resources and tools needed for revised process.

Potential Milestones

- Process outline revised into a swim lane diagram based on clinician and staff feedback in order to delineate clinician and staff roles

Resources

- **AIM-HI Practice Manual (page 7, step 3).** Adjust Office Processes and Procedures (evaluate patient flow including patient visit flow chart):
http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/aim/practicemanual.Par.0001.File.tmp/AIMPracticeManual.pdf
- **Act and Ask Practice Manual (pp. 4-5 and 18-19):**
http://www.msafp.org/upload/file497_AAFPPpracticeManual.pdf
- **Flow Chart and Swim Lane Templates:**
<http://office.microsoft.com/en-us/visio-help/create-a-cross-functional-flowchart-HP010357078.aspx>
- **MDH SHIP QI Collaborative Monthly Report Forms and Storyboard Template.**
 - MN Public Health Collaborative for Quality Improvement Obesity and Tobacco Use (SHIP) Monthly Report Form (Appendix V)
 - MDH PDSA Storyboard Template
 - MDH PDSA Worksheet
- Institute for Clinical Systems Improvement *Prevention and Management of Obesity Guideline* (2011, p. 8): http://www.icsi.org/obesity/obesity_3398.html

2. Train Staff on New Counseling Process

- A. Identify training needs, which may include the following:
 - Motivational Interviewing Techniques
 - Documentation training
 - Role Training and Talk-back Session
- B. Arrange sessions to cover all clinic team members.
- C. Complete sessions and administer post-test to evaluate learning.

Potential Milestones

- Training completed

Resources

- **Motivational Interviewing in Health Care: Helping Patients Change Behavior** by Stephen P. Rollnick, William R. Miller, & Christopher C. Butler:
<http://www.amazon.com/Motivational-Interviewing-Health-Care-Applications/dp/1593856121>
- Sue Eckmaahs, **Motivational Interviewing Trainer:**
<http://www.eckmaahs.com/home>
- **Collaborative Decision-Making and Brief Interventions** (Appendix W)

3. Implement New Counseling Process

- A. Create an action plan to implement new process.
- B. Create, run, and evaluate new process using pilot and/or Rapid Cycle PDSAs.
- C. Develop prompts for staff and clinicians and provide incentives for clinicians/staff who implement new process correctly and consistently.
- D. Embed new process in paper chart or EMR.

Potential Milestones

- Action plan implemented and rapid cycle PDSAs completed
- Prompts implemented and paper chart or EMR adapted to incorporate new process

Resources

- **MDH QI Collaborative PDSA Tools:**
http://www.ci.minneapolis.mn.us/dhfs/PDSA_Monthly_Report.pdf
http://www.ci.minneapolis.mn.us/dhfs/PDSA_Worksheet.pdf
- **AIM-HI Practice Manual:**
http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/aim/practicemanual.Par.0001.File.tmp/AIMPracticeManual.pdf
- **Act and Ask Practice Manual:**
http://www.msafp.org/upload/file497_AAFPPacticeManual.pdf

4. Evaluate Implementation of New Process

- A. Contact health care partner at least monthly to review progress.
 - i. Discuss successes and barriers; assist to overcome barriers.
 - ii. Discuss next steps and plans for sustainability.
 - iii. Offer resources, tools and support as needed.
 - iv. Schedule quarterly on-site visit.
 - v. Provide health care partner with feedback, encouragement and motivation to continue the process.

- B. Use chart audits or other quality improvement measurement tools monthly.

- C. Share results with clinicians to monitor progress.

- D. Gather feedback and determine and address any needs for full implementation of the process.

Potential Milestones

- Progress call conducted monthly
- On-site visit completed
- Chart audit shows consistent implementation of the process

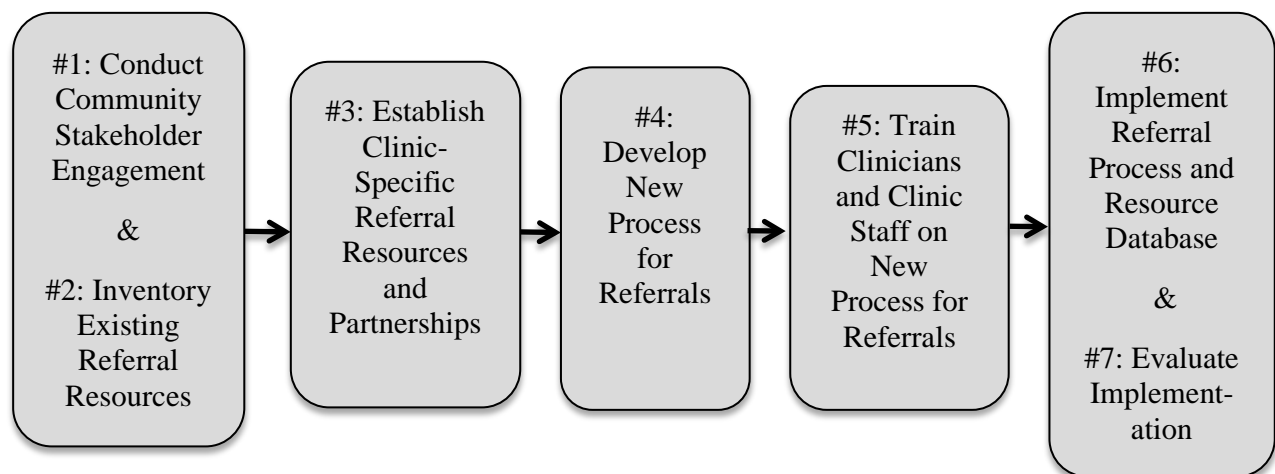
Resources

- Glasgow et al., D.C. (2006). **Assessing delivery of the five ‘As’ for patient-centered counseling.**

Step 3: Refer

Primary Aim: Clinicians will refer patients who are overweight or obese and/or who use tobacco to local resources that increase access to high quality nutritious foods, opportunities for physical activity, and tobacco use cessation for education and support, ultimately leading to behavior change. Clinicians will document referrals in the medical record.

Secondary Aim: Clinicians and clinic staff will develop relationships with community organizations and leaders that build partnerships to facilitate referral of patients to local resources that increase access to high quality nutritious foods, opportunities for physical activity, and tobacco use cessation for education and support, ultimately leading to behavior change.



Beyond their traditional role of informing patients of their health status and giving general directives to improve that status, clinicians should be aware of and recommend programs, services, and activities (from here on referred to as “resources”) that can help patients work to achieve those general directives. These resources can be clinic-based services and programs (in-house or referred out); programs, places or activities in the community; and/or self-management activities conducted by the patient in their home or daily life. Initially, clinicians and clinic staff must be aware of local resources, including their focus, schedules, and target population as well as the clinic’s patient population needs and preferences for resources (e.g. location, cost, language, etc.). Clinicians and clinic staff will also need access to an updated list or database, such as www.MNHHelp.Info, of information on available local resources and a process to use it within the clinic.

Clinicians must use their roles as clinicians, community leaders and health advocates to convey a clear, strong, personal message about the advisability and benefits of health behavior change (complimenting Step# 2). In addition, they must provide a referral to community-level resources appropriate to their patients’ health conditions, current health status, and degree of motivation and document it in the medical record. An effective system of referral of patients to resources focused on nutrition, physical activity and tobacco cessation will require a high level of communication and coordination. A system must be in place at the clinic to document the

referral in the medical record and if necessary, involve the health care team to carry out different components of the referral process (e.g. locating and selecting a resource, tracking referrals, arranging transportation, etc.). Clinics should be able to provide patients with handouts, links, or contact information to resources before they leave the clinic, to increase the likelihood that patient's will follow-through. Additionally, scheduling referral appointments, utilizing referral forms or electronic referrals, and developing relationships with resource agencies for a warm hand-off will help facilitate follow-through by the patient.

Outcome: Referral to resource is documented.

Implementing Step 3: *Refer*

1. Conduct Community Stakeholder Engagement

- A. Develop a list of key community stakeholders and community agencies to conduct assessment, consider getting contacts from clinic assessments and inventory of existing programs.
- B. Conduct Community Stakeholder Engagement key informant interviews to solicit community and culturally relevant feedback on 1) community resource access, barriers, and needs; 2) needs and preferences for a referral/resource system; and 3) developing relationships among health care providers and community leaders to build partnerships for active referrals.
- C. Compile document of key findings and recommendations.
- D. Get feedback from area health advisory committee.

Potential Milestones

- Key findings and recommendations from community/stakeholder engagement activities are documented and incorporated into work plan

Resources

- **Referral and Resource Key Informant Interview Themes**, Minneapolis SHIP 2010 (Appendix X)

2. Compile an Inventory of Existing Resources and Populate Resource Database

- A. Research and compile existing clinical, community and self-management resources through research, interviews, and assessments.
- B. Develop an internal database or list to organize resources.
 - i. Consider using MNHelp.Info inclusion criteria
 - ii. Consider limiting your list by your jurisdiction or area served by clinics
 - iii. Be sure to include programs in your area
 - iv. Collect key data points identified in patient and staff/provider assessments (e.g. cost, location, etc.)
- C. Populate state-wide resource database (MNHelp.Info) with compiled resources.
 - i. Familiarize yourself with key features of resource database MNHelp.Info.
 - ii. Complete MNHelp.Info excel template with compiled resource information.
 - iii. Submit MNHelp.Info excel resource spreadsheet to MNHelp.Info. Note that MNHelp.Info will: determine taxonomy and terms; send each agency an email indicating that their organization has been invited to be listed in the database; and provide instructions on how to log-in and enter/update agency and program information.

- D. Conduct community agency outreach to notify them of MNHelp.Info and encourage participation.
- i. Work with community organizations of interest to develop and enter standard information into MNHelp.Info by populating MNHelp.Info agency survey's for each organization with information to be listed on the database (e.g. cost, hours, languages, key descriptions of services, etc.)
 - ii. Hold community events to notify community organizations and clinics of MNHelp.Info and provide a tutorial on how to enter and update agency information, how to search the system, and how to save searches etc.
- E. Share compiled resources with other SHIP grantees, community agencies, clinics and other clearinghouses such as United Way 2-1-1.

Potential Milestones

- List of resources for referrals is developed and sent to MNHelp.Info (and other clearinghouses such as United Way 211)
- Resource database is populated

Resources

- **MNHelp.Info Inclusion Criteria** (Appendix Y)
- **Resource Database Attributes and Values** (Appendix Z)
- **MDH SHIP Guide 2008 List of Evidence-based Resources** (Appendix AA)
- **MNHelp.Info SHIP Information Sheet** (Appendix BB)
- **MNHelp.Info Excel spreadsheet template** (Appendix CC)
- **MNHelp.Info PowerPoints – MHI Power User Version** (Appendix DD)
- **MNHelp.info PowerPoints – MHI Provider Portal Instructions** (Appendix EE)
- **MNHelp.info [webinar training](#)**
- **MNHelp.Info Saved Plans Guide**, Minneapolis (Appendix FF)
- **MNHelp.Info Keyword Search Guide**, Minneapolis (Appendix GG)
- **Resource and Referral Network Aggregate Baseline Assessment Findings**, Minneapolis (Appendix HH)

3. Identify Resource Gaps and Develop Referral Partnerships

- A. Work with partner clinics to identify current clinic specific referral resources through assessment (clinic assessment, provider survey and focus group, patient survey).
- B. Work with partner clinics to establish clinic-specific referral resources as described in the table below:

Risk Factor	Type of Referral Resource		
	Clinic-based	Community	Self-Management
Tobacco	Train clinicians to offer on-site tobacco cessation classes such as Freedom From Smoking; offer clinician or pharmacist cessation counseling; other clinic-based tobacco cessation counseling off-site	Enroll in or improve referral processes for MN Clinic Fax Referral Program; MN QuitPlan services	Online tobacco cessation tools through QuitPlan, their health insurer, etc.
Physical Activity	Internal or external clinicians such as a health coach or physical therapy; conduct on-site group exercise classes utilizing Kinesiology Interns from your local University	Public or private health clubs (YMCA, YWCA), Community Education and Parks and Recreation exercise classes, local parks and trails, sports leagues, etc.	Exercise videos, exercise tutorial hand-outs, hand-outs on how to get small bouts of exercise, or home exercise equipment (hand weights, exercise ball, etc.)
Nutrition	Internal or external clinicians such as RD or health coach; provide nutrition classes on-site utilizing RD, UMN Extension, or RD interns from your local University	Nutrition classes through Community Education, Parks and Recreation programming and UMN Extension; farmer's markets, Fare for All and other places to access healthy foods	Informational handouts on eating well, recipes, food logs, etc.
Weight and Chronic Disease Management	Internal or external clinicians such as RD or clinical weight management, offer prediabetes (I Can or YDPP) or chronic disease prevention classes (CDSMP) on-site	Public or private weight management classes such as Weight Watchers, prediabetes classes (I Can or YDPP), chronic disease prevention classes (CDSMP), and other evidence-based classes	Educational information and tips on losing weight

- C. Develop clinic specific list of selected resources and informational hand-outs.
- D. Create partnerships/relationships with the most relevant and important community resource agencies and create a warm hand-off process with referral form.
 - i. Conduct community agency assessment (see Evaluation Tools).
 - ii. Facilitate partnership meetings, presentations, or conversations between providers and community agencies.
- E. Identify gaps in community and clinic based programs at individual clinics through assessment.
- F. Develop new resources to address gaps at individual clinics via additional clinical, community and self-management resources.
 - i. Identify clinics and agencies that are best-suited to offer programs on-site and facilitate implementation (e.g. I Can Prevent Diabetes and CDSMP).
 - ii. Facilitate partnerships or conversations between clinic and community agencies to offer new or additional programming in the community for referral.
- G. Work with clinic to develop a plan for sustaining partnerships and making updates/changes to referral resource system.

Potential Milestones

- Clinic-specific resources identified and list developed
- At least one new partnership with a community organization has been developed and a clinic referral process to the resource developed

Resources

- **Resource List Examples** (Appendix II)
- **Warm Hand-off Process Map** (Appendix JJ)
- **Referral Form Examples**
 - **Healthy Living**, Minneapolis (Appendix KK)
 - **Lifestyle Action Plan**, Hennepin County (Appendix LL)

4. Develop New Process for Referrals to Clinical, Community and Self-management Resources

- A. Familiarize yourself with existing clinic referral systems and coordination models (CHW, EMR, warm hand-off, etc.) and assess feasibility for use with partner clinics based on clinic assessments.
- B. Determine current referral process at the clinic and address barriers.
 - i. Use clinic assessment and staff/provider surveys and focus groups to determine current process for referrals e.g. where resources are and what

- processes are required: for example, if your organization refers patients to an outside source, what are the criteria for referral?
- ii. Ascertain data specific to registration in the Call It Quits Fax Referral System and the number of providers that actively refer patients.
- C. Determine how to integrate resources into clinic process (how to link patients with these resources).
- i. Map out current clinic processes for referral (PA, tobacco, HE).
 - ii. Make changes to map ideal process and tools necessary (provider conversation, responsible referral person, assessment tools, readiness tools, clinic decision support/EMR integration).
 - iii. Create a warm hand-off process and referral forms (see additional resources under #5 below for examples).
 - iv. Conduct clinic process changes for referrals (PDSA, lean management, etc.).
 - v. Conduct PDSAs to make desired changes.
 - vi. Finalize ideal process for referrals in clinic.

Potential Milestones

- Clinics have developed new process for referral of at-risk patients

Resources

- **Referral Model Grid**, Minneapolis (Appendix MM)
- **Health Care Referral and Follow-Up Model Map**, Minneapolis (Appendix NN)
- **MDH QI Collaborative PDSA Tools** (Appendices T, U, V)
- **MN Tobacco Fax Referral Process** (Appendix OO)

5. Train Staff on New Referral Process

- A. Present new process to clinic staff and get input.
- B. Conduct provider/staff training on clinic referral process/protocols, available resources and how to use the “Power User” features of MNHelp.Info to access saved favorites list (Saved Plans), conduct keyword searches and create printable directories (Saved Directories).
- C. Work with individual partner clinics on saving favorite resources, integrating into referral processes, and provide staff/provider training.

Potential Milestones

- Clinic staff has been trained on resource database
- Clinicians and clinic staff have been trained on new process for referral of at-risk patients

Resources

- **MNHelp.info webinar [webinar training](#)** (available on SHIP TA page)

6. Implement New Referral Process and Resource Database

- A. Partner clinics implement use of referral process and resource database using clinic action plan.

Potential Milestones

- Clinic specific process for referrals to resources has been developed
- Clinic specific process for referrals to resources has been implemented

Resources

- **SHIP Health Care Provider Toolkit for Obesity and Chronic Disease Prevention.** Initial toolkit to contain brief (1-2 pages) information on referral resources to include: 1) Evidence based community interventions (reimbursement), 2) list of current referral databases/directories, 3) select other resources from ICSI guidelines or otherwise. *To access this toolkit, please contact SHIP Health Care Strategy Coordinator Deb McConnell at deb.mcconnell@state.mn.us*
- **Referral and Prescription Forms:**
 - Let's Move (Appendix PP)
 - AIM-HI Prescription (Appendix QQ)
 - Parks Prescriptions:
<http://www.parksconservancy.org/our-work/igg/events/park-prescriptions.html>
 - Exercise is Medicine:
http://www.exerciseismedicine.org/documents/B_ExPrescripReferral.pdf
 - Blend:
<http://www.aap.org/obesity/whitehouse/Rx%20COLOR%201%20up%20v2.pdf>

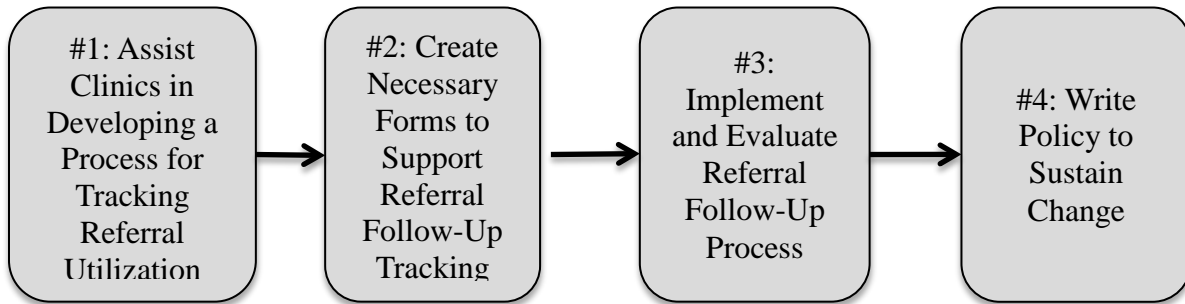
7. Evaluate Implementation of New Referral Process and Resource Database

- A. Conduct baseline assessment of number of referrals and track increase (including the Call It Quits Fax Referral program).
- B. Collect outcome and process measures and report progress towards goal and aims.
- C. Review ongoing clinic progress and updates with clinic staff and providers at meetings.
- D. Assist clinic to conduct continuous quality improvement to increase referrals to resources.

Potential Milestones

- Assessment tools completed
- Survey/ focus group of clinic staff completed

Step 4: *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.

Description: As follow-up is integrated into the fabric of the medical encounter, this further coordination can increase patient outcomes. A follow-up visit can be arranged for separate visits or during the next routine medical visit. During these visits, patients' participation in referral resources should be assessed.

As relationships and communication between clinicians, in-house and community resources, and patients grow, clinics should implement systems that ensure consistent follow-up between medical visits to assess participation in programs to which patients were referred. This allows the clinician to assess progress, learn about and resolve barriers, and suggest additional or different activities. Community organizations should be encouraged to play a role in following-up with patients by communicating outcomes with clinics. Clinics can arrange partnerships with agencies to take on the responsibility of the referral by reporting back to the clinic via a referral form.

Outcome: Clinics/community organizations track patient access and utilization of referral resources. Patient follow-up is completed with evidence documented of patient utilization of referral and/or behavior change.

- **Definition of Policy for *Follow-Up*:** Relationship between clinics and referral entities grows; communication infrastructure is established and allows feedback on referrals to flow between clinicians and clinical, community and self-management resources.

Requirements:

- Process for securing patient data or de-identifying patient information if necessary
- Providing classification of referral type used: e.g., in-clinic, out-clinic, community non-profit, community private partner, etc.
- Classification of referral follow-up used: e.g., follow-up call, follow-up email, clinic or referral agency raw numbers, flag/documentation in patient chart at next visit (within 6-12 months)

Implementing Step 4: *Follow-Up*

1. **Develop new process for tracking referral utilization and behavior change** (for each type of referral utilized for the clinic)
 - A. Review survey feedback on clinic referral process completed in step #3.
 - B. Incorporate clinic needs assessment and build on existing referral work plan. Types of referrals may include:
 - i. Clinical referrals (e.g., case manager, dietitian, health coach, physical therapy)
 - ii. Community referrals
 - a. Non-profit organization referrals (e.g., YMCA, health plan?)
 - b. Private organization referrals (e.g., Weight Watchers)
 - iii. Self-management resources or programs (e.g., home-based exercise handouts, personal diet or exercise regimen)

Potential Milestones

- Clinics have incorporated activities into their action plans for increasing follow-up on referrals for at-risk patients
- Follow-up process training complete for clinic staff and use integrated into practice within 6-12 months

Additional Resource

- See Step #3 Referral Resource Lists

2. **Create necessary forms to support referral follow-up tracking process** (or electronic eLinks system can be used for electronic referral from EMR or MNHelp.Info)
 - A. Assist with chart flag/ pop-up and or clinician note template for referral follow-up creation.
 - B. Trial or pilot follow-up call/discussion interview model.
 - C. Conduct follow-up process PDSA review and make necessary changes.

Potential Milestones

- Template for note complete, model interview script finalized, both in use in clinic
- Pilot of follow-up process complete.

Resources

- Sample Referral and Prescription Forms (see under Step 3: Referral, #3 and #6)

3. Implement Referral Follow-up Process

- A. Partner clinics implement follow-up process according to clinic action plan.

Potential Milestones

- Clinic specific process for referral follow-up has been implemented

4. Evaluate Referral Follow-up Process

- A. Collect outcome and process measures and report progress towards goal and aims.

- B. Review ongoing clinic progress and updates with clinic staff and providers at meetings.

- C. Assist clinic to conduct continuous quality improvement on referral and follow-up process.

- D. Build on relationship with referral resource partners established in Step #3 to relay follow-up data; continue relationship building to enhance referral utilization.

Potential Milestones

- Evaluation of first 6 months of follow-up process completed

5. Amend existing clinical practice policy to include follow-up component.

Sustaining Long-Term Change

1. Write Policy to Sustain Change

- A. Determine if writing a policy will assist in sustaining the revised practice.
- B. Write the policy.
- C. Share the policy following clinic standards for new policy dissemination.

Potential Milestones

- Policy written
- Policy shared

Resources

- **Sustaining Change: Once Evidence-Based Practices Are Transferred, What Then?** Tazim Virani, Louise Lemieux-Charles, David A. Davis and Whitney Berta:
<http://www.longwoods.com/content/20420>

Appendices