5A Concepts and SHIP Prevention in Health Care (PHC) Steps

5As Concept	SHIP PHC Step	ICSI Prevention and Management of Obesity Guideline	Ask and Act Tobacco Cessation Program
ASK	#1: Screen	ASK about, and measure height and weight.	Ask: Identify and document the tobacco use/secondhand smoke exposure status of every patient at every visit
ADVISE	#2: Counsel	ADVISE to lose weight. In a clear, strong but sensitive and personalized manner, urge every overweight or obese patient to lose weight. Advise small changes and relate benefits of a 5-10 lb. weight reduction.	Advise: In a clear, strong, and personalized manner, urge every tobacco user to quit and everyone exposed to secondhand smoke to reduce exposure.
ASSESS readiness to change		ASSESS readiness to lose weight. Ask every overweight or obese patient if he or she is ready to make a weight loss attempt at the time, e.g., within the next 30 days.	For the current tobacco user, is the user willing to make a quit attempt at this time? For the ex-tobacco user, how recently did he/she quit, and are there any challenges to remaining abstinent? For those exposed to secondhand smoke, are they willing or able to reduce exposure?
ASSIST	#3: Refer	ASSIST in weight-loss attempt: • Help the patient with a weight-loss plan. • Refer to appropriate resources.	For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional behavioral treatment. For patients unwilling to quite at this time, provide interventions designed to increase future quit attempts. For the recent quitter and any with remaining challenges, provide relapse prevention. For those exposed to secondhand smoke, and willing/able to reduce exposure, provide tips and educational brochure.
ARRANGE	#4: Follow-up	ARRANGE follow-up. Schedule follow-up contact, either in person or via telephone.	For the patient willing to make a quit attempt, arrange for follow-up contacts, beginning with the first week after the quit date. For patients unwilling to make a quit attempt at this time, address tobacco dependence and willingness to quit at next clinic visit. For patient willing to reduce secondhand smoke exposure, follow-up during next office visit.

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Talking Points for Prevention in Health Care

Introduction/Background

These talking points are designed for grantees to use when engaging community partners- clinic staff and clinicians, as well as community resource referral organizations. They are organized to address each step in the process of implementing the entire Prevention in Health Care strategy. Talking points listed here will be reviewed over the course of several webinars for SHIP grantees; this written copy is for reference.

Planning and Assessment

What does SHIP Health Care work offer clinics?

Grantee Talking Points: "Speaking Clinician"

Describe the SHIP program as a means to help support clinicians in their practice by:

- Providing relevant research and updates on what is going on state-wide
- Linking clinicians together to help identify best-practices and problem-solve to improve patient care
- Connecting clinicians to referral resources in the community for weight management through nutrition and physical activity

SHIP staff can help take the burden off your practice, making your day easier, your clinic flow smoother and giving you the resources you need to do what you do best!

SHIP's health care strategy provides support with materials, toolkits and personalized guidance, including:

- A list of community referral organizations that provide free and low-cost weight management, nutrition and physical activity resources for patients across the continuum of care.

- American Academy of Pediatrics 5-2-1-0 program for reducing childhood obesity and its associated health risks; American Academy of Family Physician's Americans in Motion tools for transforming clinical practice to improve nutrition and physical activity and prevent chronic disease.

- Locally relevant charts of what nutrition and physical activity benefits are covered, by payer group, can be created and customized to your patient population.

- Techniques on how to begin the conversation with patients, including using the 5A Method to determine patients' readiness to change and motivational interviewing to help patients start a journey toward better health.

Step 1: Screen

The body of literature on the benefits of tracking chronic disease risk factor markers such at BMI, blood pressure, cholesterol and blood suger/HbA1C levels is growing rapidly. Yearly testing for blood cholesterol and tracking BMI, blood pressure and blood sugar/hbA1C at each clinic visit is emerging as a best-practice. SHIP work helps support system (charting) and environmental (scale, chart and patient education materials for BMI measurement) changes that integrate screening into daily practice.

- As of 2010, 63% of Minnesotans were overweight or obese; of children, 23.1% of Minnesota youth were overweight or obese—though this is one of the lowest rates in the country, it still means that almost 1 in 4 Minnesota children and adolescents are at risk for obesity-related diseases like diabetes.

- In 2010, the Minnesota Medical Association's annual physician survey revealed that more than 50% of physicians ranked obesity as the #1 health problem they see.

- In a 2010 survey of state providers and payers, reimbursement issues were identified as the key barrier to expanding obesity prevention and treatments like lifestyle change and behavior modification.

For clinicians and clinic staff/managers, SHIP local public health coordinators offer training, resources and process analysis on how to incorporate measurement and explanation of BMI (or equivalent percentile measures for pediatric populations) into daily practice.

Step 2: Counsel

Compelling evidence is mounting that intensive counseling contributes to lasting health behavior change for sustained weight loss, continued nutrition improvement and persistence with exercise routines. This evidence base has driven recent changes to preventive services coverage by entities like Medicare, who as of January 1 will cover health behavior counseling services for 12 months for patients with elevated BMI.

For Adults:

Beginning with small goals for increasing physical activity or improving nutrition can have significant health benefits. For example, weight reduction of just 5 to 7 percent body weight is associated with lower incidence of diabetes, reduced blood pressure, and improved dyslipidemia. For more data on this and other meta-analysis summaries, click to this short webpage produced by the US Preventive Services Task Force of the CDC/AHRQ:
http://www.uspreventiveservicestaskforce.org/3rduspstf/obesity/obesrr.htm

Exercise is Medicine® is a joint campaign by the American College of Sports Medicine (ACSM) and the American Medical Association (AMA) to help improve the health and well-being of our nation through a regular physical activity prescription from doctors and other health care providers. Exercise and physical activity are important to health and the prevention and treatment of many chronic diseases, and more should be done to address physical activity and exercise in healthcare settings. You can find tools for your practice at:
http://exerciseismedicine.org/physicians.htm

The National Institutes of Health/ National Heart, Lung and Blood Institute has resources for clinicians on integrating obesity reduction and prevention into clinical practice. You can access their provider tools through the links on the left side of the screen at: http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/profmats.htm

For Children and Adolescents:

National Collaborative on Childhood Obesity Research provides a search tool for over 75 surveillance programs with data on childhood obesity: http://www.nccor.org/index.html

The American Heart Association and American Dietetic Association have designed a joint clinic protocol for PCPs and RDs to use for childhood obesity: http://www.aap.org/obesity/pdf/SuggestedPediatricWeightManagement_Protocols_20091015.pdf

The National Initiative for Children's Healthcare Quality has produced a summary based on 2007 CDC, AMA and HRSA expert review panel findings on clinical interventions for childhood obesity, including this best practices table:
http://www.aap.org/obesity/pdf/COANImplementationGuide62607FINAL.pdf
NICHQ Clinician Toolkits are available at:
http://www.nichq.org/childhood_obesity/childhood_obesity_toolkit.html

Let's Move, First Lady Michelle Obama's program to combat obesity, combines efforts from agencies overseeing Health and Human Services, Education and Agriculture. Clinicians can join these efforts and find tools to help transform their practice at:
http://www.aap.org/obesity/letsmove/index.cfm#practice

The National Institutes of Health offers provider resources for healthy weight and increasing physical activity for children at:
http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/health-professionals/index.htm

Step 3: Refer

The following points may be helpful in explaining to clinic partners and community referral resources and organizations what the SHIP health care strategy is aiming to do, based on the last 2 years of work:

- Local public health SHIP grantees are working with clinics to: 1) identify patient resources for physical activity, nutrition and tobacco cessation; 2) develop clinic processes for referrals and a referral system to these resources; and 3) work with clinics and community organizations to implement and evaluate the referral system, and where possible gain reimbursement for services.

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

- The SHIP health care referral strategy is aimed at building partnerships between clinics and community organizations to increase referrals to clinic- and community-based programs and services to help patients eat better, be more active and quit smoking.

- It is important to improve clinic referrals to community resources because patients need accessible and affordable community resources to make lifestyle and behavior changes.

- Community members want more coordinated activities and services across agencies (parks, schools, cities, YMCA, YWCA).

- Community organizations can promote and increase participation in their services and programs through referrals from clinics.

- Community organizations and clinics can work together to meet the needs of the community while fulfilling organizational goals.

Baseline assessment key findings from the first round of SHIP in Minneapolis found that:

  - Patients are interested in mainly public and low-cost resources such as trails, parks, public recreation centers and farmer's markets.

  - Patients are interested in activities such as walking and running; using exercise equipment; group classes for exercise and nutrition; and individual face-to face support for PA, nutrition and tobacco.

  - Providers are unaware of resources that are available in the community and unaware of how to refer to non-clinic based resources.

  - Providers lack systems to support referrals such as an updated directory of resources, a referral/follow-up system, and a way to communicate with organizations regarding referral and patient outcomes.

Step 4: Follow-Up

Through Community Transformation Grant work, MDH is working to connect SHIP grantees and their partner clinics to the Minnesota Health Care Homes' Learning Collaborative programs. Through the Health Care Homes project, many clinics throughout the state are embarking on care coordination changes to their practice, especially related to connecting community organizations that provide resources and health promotion services. Aligning SHIP health care work with the work of the Health Care Homes program is a priority during the 2012-13 SHIP funding cycle. For more information, please contact Deb McConnell at deb.mcconnell@state.mn.us.

Terminology and Definitions

Clinicians: MDs, NPs, PAs, chiropractors, nurses, dieticians, physical therapists, dentists, etc.

Clinic Staff: administrative/support personnel

BMI	Body Mass Index
EHR	Electronic health record
EMR	Electronic medical record
ICSI	Institute for Clinical Systems Improvement
IT	Information Technology
MD	Medical Doctor
NP	Nurse Practitioner
RD	Registered Dietitian
RN	Registered Nurse
PA	Physician Assistant
PDSA	Plan Do Study Act
PSE	Policy, system and environmental changes
QI	Quality Improvement
SHIP	Statewide Health Improvement Program
YDPP	YMCA’s Diabetes Prevention Program

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Dear Quality Improvement Clinician and/or Healthcare Setting Manager, November 19, 2009

As part of the Community Leadership Team for the Statewide Health Improvement Program (SHIP) I would like the opportunity to provide you with information about our regional SHIP project as well as opportunities for your healthcare setting.

On July 1, 2009, Becker, Clay, Otter Tail, and Wilkin Counties were awarded a SHIP grant which enables us to support healthy foods, physical activity and reduced tobacco exposure through policy, systems, and environmental interventions over the two year grant period. The SHIP grant requires that we work in four settings: community, healthcare, worksite, and school. (See the included fact sheets for further information.)

The SHIP project sets into motion an aggressive timeline; we submitted our selected interventions and accompanying strategies on September 1, 2009. As healthcare settings are key partners in this project we would appreciate your input. Thus, we respectfully request that you answer the following questions and ***fax this page back to us at 218-998-8352 by Friday, November 27, 2009.***

1. Your name:____
2. Your contact information (phone and/or email): ____
3. Your healthcare setting:____
4. Does your healthcare setting currently use the ICSI Guidelines "Prevention and Management of Obesity" and/or "Primary Prevention of Chronic Disease Risk Factors" in any way? (Check one) ☐ Yes ☐ No
5. If yes, please describe how it is being used: ____

   ____.
6. Would your healthcare setting be interested in partnering with us in the following SHIP intervention?

   Intervention #C-HWHB-H1: Support implementation of ICSI Guidelines for "Prevention and Management of Obesity" and "Primary Prevention of Chronic Disease Risk Factors" by health care providers for adults and children where applicable (See the included algorithms for details).

   ☐ Yes ☐ No ☐ Maybe

We appreciate your time and willingness to give us this input. We look forward to the possibility of partnering with you to improve the health of Minnesotans and reduce health care costs.

Feel free to call or email me if you have any questions or concerns. Thank you for your time. Sincerely,

Kristin Erickson, RN, PHN
Ph: 218-998-8336 Fax: 218-998-8352
kerickso@co.ottertail.mn.us

Health Care

The Statewide Health Improvement Program

The Statewide Health Improvement Program (SHIP), an integral part of Minnesota's nation-leading 2008 health reform law, strives to help Minnesotans lead longer, healthier lives by preventing the chronic disease risk factors of tobacco use and exposure, poor nutrition and physical inactivity. SHIP seeks to create sustainable, systemic changes in schools, worksites, communities and health care organizations that make it easier for Minnesotans to incorporate healthy behaviors into their daily lives.

SHIP in Health Care

A key component of this initiative is to work with area clinics to create or enhance referral systems that connect patients with local resources around high quality nutritious foods, opportunities for physical activity, and tobacco use cessation.

Through this initiative clinics can work with Carver-Scott SHIP to:

- ☐ **Assess existing referral practices** and identify opportunities to refer patients to area resources that address chronic disease risk factors.
- ☐ **Implement a plan to connect more patients with local resources** that is appropriate and beneficial for both patients and clinic staff.
- ☐ **Participate in baseline assessment and follow-up evaluation** activities related to creating or enhancing a referral process.

The Critical Role of Physicians*

Achieving healthier lifestyles- increased physical activity, improved nutrition, and decreased tobacco use and exposure- will be more attainable if the medical community and community-based groups coordinate their efforts. In addition to informing patients of their health status and giving general directives to improve that status, health care providers can be aware of and recommend programs and resources in the community that can help patients work to achieve those general directives.

Physicians are uniquely situated to promote healthy eating and healthy behaviors among their patients. A clear, strong, personal message from the primary care provider appears to be a very helpful intervention for establishing long-term behavior change, particularly when combined with personalized educational materials, follow-up, and referral when appropriate.

*MDH Guide to Implementing and Evaluating Interventions

SHIP Funding for Partnering Clinics

To assist clinics in Carver County and Scott County that are interested in creating or enhancing a referral process that connects patients to local resources around healthy eating, physical activity and tobacco cessation, financial reimbursement through SHIP is available. Clinics that partner with Carver-Scott SHIP will be expected to complete the three steps outlined below and can receive the corresponding reimbursement.

SHIP Health Care Activities	Financial Reimbursement through SHIP
1. Conduct an assessment to identify existing referral processes and determine what type of SHIP activities would be most effective.	$2,500
2. Create an action plan that outlines activities the clinic will implement to connect patients with local resources around healthy eating and healthy behaviors.	$1,000
3. Implement action plan and work with the Carver-Scott SHIP evaluation team at Wilder Research to collect data and evaluate the success of SHIP activities.	$1,500

Technical Assistance and Support

In addition to the financial reimbursement highlighted above, participating clinics will be able to take advantage of the following:

- ☐ **Support** from the Institute for Clinical Systems Improvement (ICSI) with planning efforts and overall project implementation.
- ☐ **Assistance with assessment and evaluation** activities from Wilder Research.
- ☐ **Public recognition** for working in the community to promote healthy eating and healthy behaviors.

For more information on the implementation of the Statewide Health Improvement Program in Carver and Scott Counties, visit www.carverscottship.org or contact Alexis Bylander, SHIP Coordinator, at 952-496-8072.

UDS and HEDIS Measures

Uniform Data System (UDS) – a standardized set of core information established and collected annually by the Health Research and Services Administration (HRSA) for the purpose of reviewing Federally Qualified Health Centers (FQHCs). Four new clinical measures have been proposed for CY 2011 UDS reporting. The following three measures are relevant to the Prevention in Health Care Strategy:

1) Weight Assesssment and Counseling for Children and Adolescents: Percentage of patients age 2 to 17 years who had a visit during the current year and who had a BMI Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.
2) Adult Weight Screening and Follow-up: Percentage of patients age 18 years or older who had their BMI calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented.
3) Tobacco Use Assessment and Counseling:
    a) Tobacco Use Assessment: Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months.
    b) Tobacco Cessation Counseling: Percentage of patients age 18 years and older who are users of tobacco and who had a visit during the current year who received (charted) advice to quit smoking or tobacco use.

* Meaningful Use Core Measures include: (1) record smoking status for patients 13 years old or older; and (2) record and chart changes in the following vital signs: (a) calculate and display BMI (adults); and (b) plot and display growth charts for children 2-20 years, including BMI.

Healthcare Effectiveness Data and Information Set (HEDIS) - is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. The following 2011 HEDIS measures are relevant for the Prevention in Health Care Strategy:

1) Adult BMI Assessment
2) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
3) Medical Assistance with Smoking and Tobacco Use Cessation

MINNESOTA'S VISION | SHIP
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SHIP Multi-grantee Health Care Work Group

Background
The Minneapolis Department of Health and Family Support, the Hennepin County Human Services and Public Health Department and Bloomington Public Health Department received Statewide Health Improvement Program (SHIP) funds to implement policy, systems and environmental strategies to reduce obesity and tobacco use. Interventions will occur in schools, worksites, health care and community settings. A portion of these funds are designated to implement Institute for Clinical Systems Improvement (ICSI) guidelines on Prevention and Management of Obesity and Chronic Disease Prevention at clinics and health systems in Hennepin County over two years, ending June 30, 2011.

Work Group Purpose
This collaborative project will be guided by a Work Group (the Health Care Work Group) that will provide feedback, guidance and support to the health departments working with clinics and systems to implement the guidelines. Work Group members will also be encouraged to use the project's information and tools within their own organizations.

The Guidelines
Obesity prevention and management:
http://www.icsi.org/guidelines_and_more/gl_os_prot/preventive_health_maintenance/obesity/obesity__prevention_and_management_of__mature_adolescents_and_adults___.html

Chronic disease risk factor prevention:
http://www.icsi.org/guidelines_and_more/gl_os_prot/preventive_health_maintenance/chronic_disease_risk_factors__primary_prevention_of__guideline__23506/chronic_disease_risk_factors__primary_prevention_of__guideline_.html

The Role of the Health Care Work Group
- Assist project staff in assessing current ICSI guideline use in clinics.
- Develop mutual goals in adopting guidelines, including connecting providers to available community resources.
- Provide feedback on the project action plan addressing priority areas within the guidelines.
- Assist project staff in identifying clinics/systems to work with, and strategies for recruiting them.
- Review and respond to project progress, including assuring project reaches at-risk populations and populations experiencing chronic disease health disparities.
- Respond to project strategies and help identify new strategies as needed.
- Provide feedback and input to the project with the aim of creating institutionalized and sustained impact.

The Process

- Members will be formally briefed on the progress and challenges of the intervention.
- Members will be given sufficient time to review materials prior to the meetings.
- Members will discuss issues and make recommendations.
- The Work Group will determine under which circumstances recommendations move forward. (Example: 75% majority vote of members in attendance.)
- Time commitment will be determined by the Work Group membership. Proposed monthly meetings for 6 months, followed by quarterly meetings through June 2011.

Membership

The Work Group is comprised of 15-20 members from health organizations serving Hennepin County, including health plans, systems and clinics.

Staffing

The Work Group will be staffed by Megan Ellingson, MHA, SHIP Multi-Grantee Coordinator, at the Minneapolis Department of Health and Family Support. The project will also be supported by program and evaluation staff at the three health departments. For more information about this Work Group please contact Megan at 612-673-3817; megan.ellingson@ci.minneapolis.mn.us.

Health Care Provider/Staff Focus Group
Informed Consent

Background Information
The Minneapolis Department of Health and Family Support (MDHFS) received a 2-year grant through the Minnesota Department of Health as part of the State Health Improvement Program (SHIP) to begin to develop a mechanism or system for referrals to clinic and community-based healthy eating, physical activity and tobacco cessation programs. Referrals are one component to implement the Institute for Clinical Systems Improvement (ICSI) guidelines for primary prevention of chronic disease and obesity. Kristen Godfrey works at MDHFS and is managing this project. Today's discussion is one of various similar discussions being conducted by MDHFS in Minneapolis clinics. Results from these discussions will allow MDHFS to incorporate your perspectives into the development of appropriate mechanisms or systems to refer patients to clinic and community-based healthy eating, physical activity and tobacco cessation programs.

Procedure
As part of this project, staff from the Minneapolis Department of Health and Family Support, namely Jared Erdmann, will ask you some questions to guide today's discussion. During the discussion, Andrew Pisansky or Kristen Godfrey will take notes. We anticipate that this discussion will last no longer than forty-five minutes.

Privacy
What you say will be summarized along with what others say, so your name will not be connected to what you have said. A summary report will be shared with the public (e.g. clinic providers and administrators, interested community residents, or the funding agency, Minnesota Department of Health).

Voluntary Participation
There is minimal risk to you for participating in this discussion. We will ask you to tell us about your current work practices in a group setting but only as they pertain to this project. We will ask for your opinion about appropriate referral mechanisms and systems and how they might be integrated effectively into your clinic or practice. If at any time you are uncomfortable during the discussion you may leave. If you decide to leave, it will not affect your relationship with Andrew, Kristen or Jared, your clinic or MDHFS.

Consent and Contacts
What questions or comments do you have about what I have said do you have before we begin?

Later, if you have questions about this project, you may call:
- Kristen Godfrey, Phone: 612-673-2075

If you have questions about your rights as a participant you may call:
- Dr. Patricia Harrison, Minneapolis Department of Health and Family Support, Phone: 612-673-3883

By agreeing to join our discussion today, you are telling us that you understand and accept this agreement. **Do you agree to participate?**

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City of Lakes

Health Care Provider/Staff Focus Group Questions

1. (Optional) To begin I would like to go around and have each person introduce themselves and tell us briefly what your understanding of a patient referral is and your role in making patient referrals to clinic or community programs?

2. In general, what methods are used at your clinic to refer patients to clinic and community-based resources? **Probe:** What works well? Not so well?

3. Now, I would like you to think about referrals to resources for healthy eating, physical activity and tobacco cessation, how would a referral system to these types of resources be similar or different than what already exists? **Probe:** From what other clinics do?

4. Would the ideal resource referral system to healthy eating, physical activity and tobacco cessation resources look like at your clinic and who would use it? **Probe:** Electronic? Paper? Role of insurance? Within small clinic networks? Statewide?

5. Broader conversations at the systems and state levels are thinking of building upon existing referral systems such as the clinic-fax referral program for tobacco or a clearinghouse such as United Way 2-1-1 or MNHelp.info (home of the senior, veteran, and disability linkage line), what are your perspectives on building healthy eating and physical activity referrals into these approaches? **Probe:** What if the referral system resembled a clinic fax model? A clearinghouse 2-1-1 model? A web-based model?

6. What other factors should be taken into account in developing an appropriate referral system for these patients at your clinic that we have not yet talked about?

Native American Community Clinic

Annual Exam
Weight and Lifestyle Management
Adults (18–69.9 years) with BMI: 18.5–29.9
(Normal to Overweight)

Policy Statement

The purpose of the Annual Exam Weight/Lifestyle Management Protocol for Adults is to incorporate routine BMI screenings; and develop personalized self-management goals, referral, and follow-up on adults 18–69.9 years of age at low to moderate risk for weight-related conditions. The goal is to improve patient self-management, and offer ongoing community resources and support to maintain normal weight and prevent further weight gain leading to obesity.

This policy and procedure is based on the guideline for Prevention and Management of Obesity (Mature Adolescents and Adults, January 2009) issued from the Institute for Clinical Systems Improvement (ICSI).The Native American Community Clinic (NACC) is working with Hennepin County Public Health Promotion to implement ICSI Prevention and Management of Obesity and Chronic Disease Prevention Guidelines through funding provided by the State Health Improvement Program (SHIP) grant.

Policy Intent

BMI screenings for all NACC adult patients will take place at least annually, and an individualized self-management and support plan will be developed, monitored, and adapted as needed.

The use of the ICSI guidelines in primary care clinics will:

1. Facilitate consistent BMI, nutrition, physical activity, tobacco screening, and appropriate individualized patient feedback.

2. Empower providers and patients making collaborative decisions regarding healthy lifestyle changes to reduce weight, and improve diet and nutrition. Providers will follow the 5 A's (Ask, Advise, Assist, Assess, and Arrange) approach when trying to influence patient self-management.

3. Establish a referral and follow-up process to support and monitor patients' progress towards self-management goals.

4. Support the use of a special diagnosis code for abnormal or excessive weight gain, which would allow reimbursement for additional time spent addressing evaluation and management of overweight and obesity.

Minnesota's VISION A Better State of Health
Statewide Health Improvement Program | SHIP
Hennepin
The Statewide Health Improvement Program (SHIP), an integral part of Minnesota's nation-leading 2008 health reform law, strives to help Minnesotans lead longer, healthier lives by preventing the chronic disease risk factors of tobacco use and exposure, poor nutrition and physical inactivity. For more information, visit <www.health.state.mn.us/healthreform/ship>.

PROCEDURE

Overview of Staff Responsibilities:

Medical Assistants (M.A.)
Measure and record height, weight, and BMI of all adult annual exam patients.

Dietician/ Community Health Worker
Normal, Overweight, and Obese Risk: Provide BMI feedback; negotiate *self-management* weight maintenance/loss plan; offer community-based resources, referrals, and follow-up support.
Overweight or Obese BMI: Provide feedback on BMI and support physician/nurse practitioner *medical management* plan.

Physician (M.D.) and Nurse Practitioners (N.P.)
Normal, Overweight, and Obese Risk: Reinforce Dietician/Community Health Worker-negotiated *self-management* plan.
Obese: Provide feedback, negotiate *medical management* plan, and offer medical referrals and support.

I. Screen for BMI, Physical Activity, Diet

BMI screening, calculation, and feedback are incorporated into every adult patient's annual physical exam as a vital sign built into the annual physical exam procedure and rooming protocol.

Pre Exam Screening: Receptionist/Medical Assistant	
Tasks	**Action Tools**
1. BMI Screening, recording Medical Assistant measures current height and weight. Calculates and records BMI on patient chart. **2. Patient has a BMI between 18.5–29.9** Medical Assistant or Community Health Staffer gives patient lifestyle self-assessment prior to provider encounter.	**Patient completes:** Self-assessment survey (Survey includes self-assessment on diet, physical activity, stress, smoking, and readiness to change questions.) **Review/Record**: Record BMI on Adult PE chart form (green) in vital box. **Tool used**: BMI wheel

II. BMI Feedback, Education and Weight Maintenance/Loss Self-Management Plan

Providers routinely provide patient-centered education and negotiate self-management goals regarding weight management for patients with normal weight and low-to-moderate overweight to motivate them to practice patient self-management.

<table>
<tr><th colspan="2">A. Pre Exam Meeting: Dietician/Community Worker</th></tr>
<tr><th>Tasks</th><th>Action Tools</th></tr>
<tr><td>

►Normal Weight (BMI 18.5–24.9)

a. Review and discuss self-assessment to determine patient readiness, perceived confidence, and importance to make changes in diet, activity, smoking, and stress.

b. Review last annual exam BMI and determine BMI risk category to determine weight changes. Use BMI brochure.

c. Negotiate weight maintenance self-management goals and complete action plan.

d. Obtain patient signature on action plan.

e. Insert action plan into patient record/chart for M.D./N.P. to review during exam.</td><td>

Form Reviewed: Completed self-assessment survey

Patient Handouts:
▪ BMI Brochure (with plotted BMI)
▪ Weight Maintenance Action Plan

Messages:
▪ Inform patient of his/her BMI risk level
▪ Reinforce patient's current weight maintenance success and encourage patient to self monitor weight gain/loss.
▪ Encourage patient to maintain current weight and to take small steps to reduce weight if gain is noticed.</td></tr>
<tr><td>

►Overweight (BMI 25–29.9)

a. Review chart for current and past BMI.

b. Review medical history to identify medications that increase weight or interfere with weight loss, or a history of eating disorders or depression.

c. Provide brief feedback on BMI risk. Use BMI brochure.

d. Review and discuss patient self-assessment to determine patient's readiness, perceived confidence, and importance of changing diet, activities, smoking, or stress.

e. Negotiate weight loss self management goals and complete action plan.

f. Recommend and document referral to community resource.

g. Recommend, document, and inform patient that they will either receive a follow-up phone call or will schedule a follow up visit within 4–12 weeks.

h. Obtain patient signature on action plan.

i. Insert action plan into patient record/chart for M.D./N.P. to review during exam.</td><td>

Form Reviewed: Completed self-assessment survey

Patient Handouts:
▪ BMI brochure (with plotted BMI)
▪ Weight Loss Action Plan

Messages:
▪ Inform patient of his/her BMI risk level.
▪ Ask about their concerns regarding weight and other health habits.
▪ Ask about past attempts to manage weight.</td></tr>
</table>

BMI Feedback, Education, and Weight Maintenance/Loss Self-Management Plan (*continued*)

B. Physical Exam : Physician / Nurse Practitioner	
Tasks	**Action Tools**
▶**Normal Weight** (BMI 18.5–24.9) a. Review completed Weight Maintenance Action Plan. b. Sign the Action Plan. c. Make copy to give to patient and insert original into patient record/chart.	**Forms Reviewed:** ▪ Completed self-assessment survey ▪ BMI brochure (with plotted BMI) ▪ Weight Maintenance Action Plan **Messages:** ▪ Ask about their concerns regarding weight and other health habits. ▪ Ask about past weight management.
▶**Overweight** (BMI 25 to 29.9) a. Review chart for current and past BMI. b. Review medical history to identify medications that increase weight or interfere with weight loss, a history of eating disorders, or depression. c. Provide brief feedback regarding BMI risk. d. Review completed Weight Loss Action Plan. e. Sign the action plan. f. Make copy to give to patient and insert original into patient record/chart.	**Forms Reviewed:** ▪ Completed self-assessment survey ▪ BMI brochure (with plotted BMI) ▪ Weight Loss Action Plan **Messages:** ▪ Ask about their concerns regarding weight and other health habits. ▪ Ask about attempts to decrease weight and possible barriers to success. ▪ Emphasize the importance of the action plan.
▶ **Obese** (BMI 30–plus) Refer to and follow existing obesity management protocols.	

III. Face to Face and/or Phone Follow-Up

Providers routinely provide patient-centered follow-up to support and reassess self-management goals regarding weight management for patients with BMI 25–29.9.

Dietician/Community Health Worker	
Tasks	**Action Tools**
►Patient has completed *Weight Loss Action Plan* a. Dietician and/or Community Health Worker gives reminder call to patient 1-2 days prior to scheduled visit and/or determines time to conduct visit on phone. b. Review *Weight Loss Action Plan* prior to meeting or call. c. Discuss progress and barriers; offer support and praise for progress; and brainstorm possible solutions to barriers. d. Determine if patient is ready to try a different community resource or take on another small step. e. Renegotiate action plan to address weight loss.	**Review Form:** *Weight Loss Action Plan* **Message**: ▪ Reinforce positive behavior changes. ▪ Assist patient in problem-solving for changes they find challenging. ▪ Assist patient in goal setting or goal changing to help patient be successful.
►Obese (BMI 30+) Medical Management Goals Refer to and follow existing obesity management protocols.	Protocols: Obesity and other co-morbid conditions related to obesity

ANOKA COUNTY COMMUNITY HEALTH AND ENVIRONMENTAL SERVICES
PUBLIC HEALTH NURSING
BREASTFEEDING POLICY

Policy:

It is the policy of Anoka County Community Health and Environmental Services (CHES) that breastfeeding will be promoted to the community and clients of Anoka County Community Health and Environmental Services as the healthiest option for infant nutrition.*

Procedure:

Roles and Responsibilities

1. Family Health PHN Supervisors, WIC Supervisor, WIC Coordinator and Public Health Nurses with specialized training in breastfeeding will (a) assist in policy implementation, (b) serve as a resource related to breastfeeding inquiries, and (c) review and revise the policy annually to reflect current evidenced-based practice.
2. All PHNs providing care for the mother-baby dyad will become familiar with the breastfeeding policy and will be responsible for acquiring the skills and the knowledge necessary to support policy implementation including maternal education, community resource awareness, and legal protections for nursing mothers.
3. The PHN breastfeeding specialists will review and update staff training as well as resources for patient education.
4. Anoka County CHES will support continuing education as merited to keep staff current with best practices.
5. The PHN breastfeeding specialists will be available for staff consultation and to make home visits or co-visits.

Review/Approved: Review/Updated:

*The policy is consistent with the recommendations and breastfeeding policy statements published by the American Academy of Pediatrics (AAP) and the *Ten Steps to Successful Breastfeeding* as recommended by the Surgeon General's call to action to support breastfeeding

ANOKA COUNTY COMMUNITY HEALTH AND ENVIRONMENTAL SERVICES
PUBLIC HEALTH NURSING
BREASTFEEDING POLICY IMPLEMENTATION

Staff Knowledge and Training:

A. Maternal Education

1. Breastfeeding will be normalized and promoted whenever possible. The PHN will incorporate breastfeeding education and conversation into every / or most home visits. An example would be addressing how breastfeeding reduces SIDS when discussing safe sleep. Education will be concentrated prenatally.
2. The PHN will encourage mothers to breastfeed by discussing the benefits for the baby and the mother, addressing barriers, providing information and support, answering questions, and referring clients to breastfeeding resources in the community.
3. Breastfeeding should be assumed until a mother has received complete information regarding breastfeeding and clearly expresses her decision to formula feed. All mothers will be treated with respect and support whether they opt to breastfeed or formula feed their baby.
4. The PHN will recommend exclusive breastfeeding unless it is contraindicated. When a mother plans to combine both breastfeeding and formula feedings, the PHN will discuss the advantages of beginning with full breast feedings in order to establish her milk supply and be encouraged to pump and store milk for use when she is away from her baby.
5. The PHN will guide a mother as appropriate if breastfeeding is contraindicated. When unsure of an associated risk, the mother will be directed to consult with a physician. Should a risk be deemed temporary, the mother can be taught methods of maintaining her milk production.
6. The PHN will direct the mother to resources outlining the legal protections for nursing mothers.
7. Visible support for breastfeeding, (e.g. culturally appropriate articles, pamphlets, photos, posters, literature, and videos that portray women breastfeeding in a positive and normative light) will be available.
8. Suggestions for communicating with women about infant feeding are provided. (*See Appendix A*)

B. Prenatal Education

Breastfeeding education should begin with the first antepartum visit and continue throughout the pregnancy. Education should include:

1. Anatomy of the breast;
2. Breast changes and how these changes are getting the breast ready to feed baby, including
   1st trimester – tenderness, veins, changes in areola, Montgomery glands, nipples;

3. Benefits of breastfeeding for the baby and mother (*See Appendix B*);
4. Colostrum/Components of breast milk- the perfect food for baby;
5. How to prepare for breastfeeding (including hand expression after 37 weeks);
6. Hunger and satiation cues;
7. Resources available to support breastfeeding, including information on the legal protections for nursing mothers;
8. Frequency of feedings, including:
    a. Feed early. Feed often. Feed on demand.
    b. Breastfeeding should be offered 8-12 times, every 24 hours
    c. Many babies will feed every 1 ½ to 3 hours;
9. Positions for nursing;
10. Possible barriers to breastfeeding and how to overcome them.

C. **Preparing for Delivery/Delivery/Early Postpartum**

The PHN will provide information to the mother regarding:

1. How breasts make milk and how hormones play a part;
2. Feed early /Feed often, including
    Mothers should also be encouraged to breastfeed within the 1st hour of birth if the baby is healthy;
3. Skin-to-Skin Contact, including
    Mothers who intend to breastfeed their baby should be encouraged to have skin-to-skin contact with their baby for the first two hours after birth;
4. Asking for Help, including
    Mother should be instructed that it is OK to ask for advice from healthcare professionals (e.g. lactation specialists, nurses, etc.) and that it is natural to have questions;
5. Rooming-In, including
    Mother should try to remain roomed-in with their newborn throughout their hospital stay to allow for frequent, on-demand breastfeeding attempts unless otherwise contraindicated;
6. Feeding Plan/Communication of Breastfeeding Decision & Supplementation including
    Mothers should be encouraged to communicate their decision to breastfeed their baby to the doctors and nurses in the hospital;
7. Mothers can and should request that their baby receive no supplementary bottle feedings of formula, sugar water, water, or other fluids;
8. Pacifiers, including
    Mothers should be instructed not to give pacifiers to breastfeeding infants until breastfeeding is well established;
9. Hunger Cues;
10. Engorgement;
11. Breast Pumping, including hand expression
    Information about breast pumps should be provided as needed;
12. Support system, including
    Identify those in circle of support who can help and help the mother identify ways others can help;
13. Family Planning, including non-hormonal options.

The PHN should discourage pumping except for the following reasons:

1. When milk production is low, pumping after nursing can increase milk production.
2. For convenience, to leave the baby with a caregiver while mom is temporarily away.
3. When mothers are going back to work or school part-time or full-time.
4. For medical indications; when mothers or infants are separated and/or unable to breastfeed, or anytime baby is unable to latch or extract enough breast milk.

D. **<u>After Delivery</u>**

1. No Formula
   The PHN will not provide packets containing infant formula, formula coupons, or any other formula promotional materials to mothers unless otherwise ordered by the health care provider.
2. Home Visits
   The PHN will complete home visit and documentation per Family Health policies. Weekly visits will be offered for the first 4-6 weeks, then every 2 weeks for the next month. If there are no breastfeeding concerns, the mother and the PHN will determine the frequency of home visits.
3. Frequency of Feeds and Infant Hunger
   PHN will address feeding frequency, infant hunger and satiation cues.
   The baby should be weighed to ensure adequate intake and be evaluated for jaundice and hydration status.
   If there are concerns about baby getting enough at breast, the PHN can weigh the baby before and after a feeding to determine the amount of breast milk infant obtained.
4. PHN Duties
   The PHN will:
   - Support mothers in exclusive breastfeeding during the first 6 months and maintaining breastfeeding up to 12 months and beyond.
   - Ensure mothers receive information about safely expressing and collecting breast milk.
   - Inform mothers on how to appropriately store fresh, frozen, and thawed breast milk.
   - Discuss how to appropriately label containers and use oldest dated containers first.
   - Provide information about breast pump options. In addition, inform mothers that they may be able to include the cost of breast pumps and supplies that assist lactation as medical expenses for flexible spending accounts and as a tax deduction in limited circumstances.
   - If a mother is returning to work, PHN will provide mothers with information, tips, and resources of how to do so and how to successfully maintain their milk supply. This information will include resources outlining the legal protections for nursing mothers in the workplace.

Other Tools:

The *Breastfeeding Observation Form, Latch Assessment,* and NCAST Feeding Assessment are tools available to assess breastfeeding and address problems. (*See Appendix C*)

Support

1. PHN will be familiar with community breastfeeding resources such as those in the *A Breastfeeding Resource List from the Central MN Breastfeeding Coalition,* La Leche League, and WIC programs including peer breastfeeding counselors. (See Appendix D)
2. PHN will make appropriate referrals to these resources. Lactation counseling will be readily available.
3. PHN will provide information regarding legal support for nursing mothers. (See Appendix E)

MINNESOTA'S VISION | SHIP Statewide Health Improvement Program
A Better State of Health

Minneapolis City of Lakes

Minneapolis SHIP Resource and Referral Network
Clinic Action Plan

Resource Referral and Follow-up System Key Components:

a. Incorporates health care clinician roles and responsibilities for referral in standard clinic processes
b. Identifies and addresses patients that can benefit from lifestyle changes that support healthy behavior
c. Establishes clinic processes for patient referral and follow-up
d. Develops a function for monitoring or tracking referrals and follow-up
e. Identifies patient resources and creates system to retain resources, using MinnesotaHelp.info® if possible
f. Creates at least one new community partnership and makes available at least one new patient resource
g. Designates responsible staff for maintaining resources, relationships, and systems

Agency:______________________________ **Date:**________________

Team Members:______________________________________

Goal(s): What is the purpose?		
1.	Implement a resource referral system to increase provider referrals to clinic and community resources for obesity and tobacco cessation.	• Focuses on one type of activity? • Relatively long time frame? • No implied measure?
2.	Develop relationships with local resources that can assist patients with prevention and management of obesity and tobacco.	
Aims: What are we trying to accomplish? *(E.g. Increase # of referrals for physical activity, healthy eating, and tobacco cessation for all patients by 50% by June 2011.)*		
1.		• Specify numeric target and timeframe • Patient population defined? • Measure implied?
2.		
Measures (process and outcome): How will we know that a change is an improvement? *(E.g. # of patients referred, % of patients with unhealthy behaviors referred to resources, % of patients with referral outcome result, # resources available)*		
1.		• Is it driven from the Aim? • Patient population (denominator) defined? • Event occurs frequently enough to show improvement? • Able to obtain measure frequently over time? • Demonstrates whether a process or outcome has been impacted?
2.		
3.		
4.		
Key Action Steps: What changes can we make that will result in an improvement? *(e.g. identify current referral process and number of referrals, identify resources and incorporate into referral system, integrate resources into clinic referral process)*		
1.		• Are changes small enough to be easily tested? • Can changes be tried on a small scale with interested individuals? • Can changes be easily evaluated for effectiveness?
2.		
3.		
4.		
5.		

Action Plan Implementation

Tips:
- Create an implementation or project team
- Utilize baseline assessment findings to guide process and incorporate staff feedback
- Consider using MinnesotaHelp.info to manage resources and referral hand outs
- Engage clinic administration and staff in the project and encourage them to participate
- MDHFS can provide clinic training on SHIP, Motivational Interviewing, MinnesotaHelp.info, etc.

Establish clinic specific processes for referrals to community and clinic-based resources

1. Identify strategies for implementing key action plan steps and collecting measures (e.g. chart audits, system reports) and assign timeline and staff
2. Determine how to integrate referral system into clinic process (how to link patients with resources)
   a. Map out current and ideal clinic processes for referrals (refer to Resource Referral and Follow-up System Key Components on your SHIP Clinic Action Plan)
   b. Develop and compile tools to support process (e.g. assessment or readiness tools, referral tracking and follow-up tools, clinic decision support/EMR integration, MinnesotaHelp.info)
3. Conduct action steps for referrals using process improvement (e.g. PDSA, lean management)
   a. Pilot small changes with a few staff using outcome and process measures as a guide
   b. Present the new referral process to clinic staff and get input before finalizing
4. Conduct provider/staff training on final process, resources and systems (MinnesotaHelp.info, EMR)
5. Implement and evaluate referral resource process in clinic
   a. Collect outcome and process measures and report progress towards goal and aims to MDHFS
   b. Review ongoing clinic progress and updates with clinic staff and providers at meetings

Establish clinic specific community- and clinic-based referral resources and partnerships

1. Identify current clinic referral resources and gaps in resources through baseline assessment findings
2. Ascertain data specific to number of active referrals to the Call It Quits Fax Referral System
3. Establish 3-5 key clinic specific clinic and community based referral resources for each risk factor
4. Create partnerships with community organizations for existing and new resources (address gaps)
   a. Identify programs and services best-suited to offer at your clinic and facilitate implementation
   b. Facilitate partnership meetings or presentations with community leaders/agencies
5. Incorporate selected referral resources into clinic referral and resource system (EMR, MinnesotaHelp.Info)
   a. MDHFS to assist listing resources and create clinic directory in MinnesotaHelp.Info
6. Develop a plan for sustaining partnerships and making updates/changes to referral resource system

Pursue reimbursement for clinic-based programs and services from health plans or other funding

1. Identify current billing practices and reimbursement codes for lifestyle behavior change services
2. Pursue reimbursement options for clinic- and community-based lifestyle behavior change program

MINNESOTA'S VISION | SHIP Statewide Health Improvement Program
A Better State of Health

Minneapolis
City of Lakes

Action Plan Tracking Tool

Action Item	Responsible Person	Date Due	Comments

CARVER SCOTT SHIP STATEWIDE HEALTH IMPROVEMENT PROGRAM

www.carverscottship.org

Clinic Implementation Action Plan

A key component of SHIP is creating or enhancing clinic referral processes to connect patients with local resources around high quality nutritious foods, physical activity and tobacco use cessation.

1. Please complete the attached implementation action plan, highlighting what projects you would like to do in your clinic to accomplish that goal. If you have any questions about completing the action plan or would like assistance with writing it, please contact Alexis Bylander at abylander@co.scott.mn.us or Mary Anne Smalley at masmalley@gmail.com.

2. After you have completed your action plan, please email a copy to Alexis Bylander at abylander@co.scott.mn.us.

3. Finally, mail your completed invoice form and a copy of your completed action plan to:

   Carver County Public Health
   Attn: Joy Ahern
   Govt Center, Administration Bldg
   600 East Fourth St
   Chaska, MN 55318

We look forward to working with you!

Alexis Bylander, SHIP Coordinator, Carver and Scott Counties
Mary Anne Smalley, Project Lead, Institute for Clinical Systems Improvement (ICSI)

Carver-Scott SHIP Action Plan

Clinic Name:	**Contact Person:**
Overall SHIP Health Care Goal: Develop relationships among health care providers and community leaders and build partnerships to facilitate active referral of patients to local resources that increase access to high quality nutritious foods, opportunities for physical activity, and tobacco use cessation.	
Project 1:	
Project Goal:	
This project will result in the following: (please circle all that apply) Policy Change Systems Change Environmental Change	

Activities	**Timeline**	**Accountable Organization/ Individual**	**Tracking Measure** *(Ex: meeting notes, press release, evaluation forms, newsletter etc.)*
1.			
2.			
3.			

<table>
<tr><td colspan="4">Project 2:</td></tr>
<tr><td colspan="4">Project Goal:</td></tr>
<tr><td colspan="4">This project will result in the following: (please circle all that apply)

Policy Change Systems Change Environmental Change</td></tr>
<tr><th>Activities</th><th>Timeline</th><th>Accountable Organization/ Individual</th><th>Tracking Measure (Ex: meeting notes, press release, evaluation forms, newsletter etc.)</th></tr>
<tr><td>1.</td><td></td><td></td><td></td></tr>
<tr><td>2.</td><td></td><td></td><td></td></tr>
<tr><td>3.</td><td></td><td></td><td></td></tr>
</table>

Project 3:			
Project Goal:			
This project will result in the following: (please circle all that apply) Policy Change Systems Change Environmental Change			
Activities	**Timeline**	**Accountable Organization/ Individual**	**Tracking Measure** *(Ex: meeting notes, press release, evaluation forms, newsletter etc.)*
1.			
2.			
3.			

Is there any assistance you need from the SHIP staff to complete the activities outlined in your action plan?

What will you need to keep these efforts going after the SHIP grant ends?

Wilder Research will be working with you to identify information that needs to be collected as part of the evaluation process. Is there any information that would be particularly helpful to your organization that should be collected through the evaluation activities?