Clinical-Community Linkages for Prevention Health Care Implementation Guide

STATEWIDE HEALTH IMPROVEMENT PARTNERSHIP (SHIP)
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Strategy Overview

Grantees are required to work on at least one Health Care Activity in each year of the five-year grant. This activity may stay the same or change within the five-year period.

The Clinical-Community Linkages for Prevention strategy with the Statewide Health Improvement Partnership (SHIP) links health care and community with state and federal health reform initiatives. This strategy is founded on effective collaboration between health care settings, local public health agencies and community-based organizations.

Goals

▪ Establish Clinic-Community Linkages for equitable access to health care prevention services to address tobacco cessation, pediatric and/or adult obesity, breastfeeding support, falls prevention, and dementia awareness and support.
▪ Create systems for medical professionals to connect patients to resources to support and enhance the linkages with the intent of assuring access to evidence-based programs to address tobacco, obesity, chronic disease self-management, breastfeeding, falls, dementia and other population-specific needs.

Foundational Practices

All activities that take place in the Health Care Strategy should use a health equity lens. Grantees should learn about, reach out to, and engage populations that are experiencing health inequities within their communities so that all people have access and the opportunity to live a healthy life. Populations that may be experiencing health inequities can include, but are not limited to low income, uninsured or underinsured, older adults, racial or ethnic minorities, etc. Resources to help you assess and identify opportunities include:

▪ Health Equity Data Analysis (HEDA)
▪ Local Public Health Community Needs Assessment
▪ Hospital Community Health Needs Assessment
SHIP Health Care Coordinator Role

Pursue systems and environmental changes that improve how community resources support the well-being of county populations with support of CLT or area advisory council:

- **Identify** and cultivate strong relationships with health care setting partners (e.g. clinics, hospitals, pharmacies) and community-based partners (e.g. YMCA, Area Agency on Aging, faith-based groups, community centers).
- **Assess** the needs of the community partners and health care settings that serve it; determine priorities to work on together.
- **Understand** the health care setting work flow and the roles represented.
  - What and how does the health care setting:
    - Screen
    - Counsel
    - Refer
    - Follow – up (closing the loop, aka bi-directional communication)

- **Build** a network of community resources for prioritized work, and determine how partners will use these resources and communicate with each other.
- **Monitor** impact of revised clinic workflows including follow-up to referrals.

MDH Role

- Provide feedback on work plans and ongoing support for grantee-identified priorities.
- Attend MDH-hosted grantee meetings via phone and/or in-person, as scheduled by Community Specialist.
- Provide infrastructure development of evidence-based programs, including but not limited to:
  - Breastfeeding
    - MDH Breastfeeding Friendly Maternity Center Recognition
    - MDH Breastfeeding Peer Support Program
  - Chronic Disease Management
    - Chronic Disease Self-Management Program (also called Living Well with Chronic Conditions).
    - Diabetes Prevention Program (also called I CAN Prevent Diabetes)
  - Older Adults
Workplace Strategy in a Health Care Setting

This strategy is intended to give grantees an opportunity to initiate a relationship with a health care partner and lay the groundwork for a longer term collaboration to support access to health care prevention services using evidence-based strategies.

If this is an option you are working on then you must:

▪ Be familiar with the Workplace Implementation Guide
▪ Recruit at least one local health care setting to be part of the Collaborative Model (if you are not using the collaborative model then you must be implementing the workplace wellness initiatives in the health care system)
▪ Attend the regularly scheduled Collaborative model meetings or meetings that focus on the workplace wellness initiative within the health care setting

Health care partners will agree to:

▪ Be part of a collaborative that will commit to (at least) a year long process to implement wellness programs within their organization
▪ Attend regular meetings facilitated by SHIP staff
▪ Create a healthier workplace
▪ Contribute to building a healthier community

The goal for the SHIP health care coordinator is to build a relationship with the health care setting contact person so that within six months to one year \(^2\) you can begin the health care strategy work that is described in this guide.

Next Steps: Workplace Wellness opens doors to Clinic-Community Linkages

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\(^1\) There are more than 5 million Americans living with Alzheimer’s disease, including 88,000 here in Minnesota aged 65+ and 245,000 Alzheimer’s caregivers. These numbers are set to soar as the baby boomers continue to enter the age of greatest risk for Alzheimer’s disease. The projected growth of Alzheimer’s has created a public health crisis and Minnesota is taking action.

In 2009, the Alzheimer’s Association and our advocates led legislation to create a State Government Alzheimer’s Disease Plan for Minnesota, which launched the formation of Act on Alzheimer’s. Now with over 60 nonprofit, governmental, and private sector organizations, Act on Alzheimer’s serves as a volunteer driven, statewide collaboration who are preparing Minnesota for the impacts of Alzheimer’s disease and other dementias.

\(^2\) Six months to one year starting November 1, 2016.
Leverage work you’re involved in by enhancing what’s already happening in the workplace space. Consider the many ways that a health care partner can work with SHIP toward common goals.

- Do your local public health departments or programs (e.g. WIC, CTC, Immunizations, and Emergency Preparedness) already engage with health care partners? Ask your colleagues who their clinic contact is and if they could introduce you.
- Are other health care settings part of the worksite collaborative like long term care or skilled nursing that could be potential partners?
- What is the role of your current contact for worksite wellness? If you’ve been working with someone in Human Resources, ask if there is someone on the clinical side who can speak with you.
- Initiate communication between the different staff working on other SHIP strategies (internally or with neighboring counties) so there is a common understanding among all involved of what is happening around you and where collaboration opportunities may exist.

For more guidance on preparing for clinic outreach, review the section titled Assessment and Planning.

**Technical assistance and training**

Examples of community-based contracts include:

- Area Agency on Aging ([http://www.mnaging.org/Administrator/AAA.aspx](http://www.mnaging.org/Administrator/AAA.aspx))
- University of Minnesota Extension ([https://extension.umn.edu/](https://extension.umn.edu/))
Examples of clinic or practice transformation-based contracts\(^3\) that may be established by grantees can include:

- Institute for Clinical Systems Improvement
  https://www.icsi.org/
- Stratis Health
  http://www.stratishealth.org/index.html
- Motivational Interviewing
  http://www.motivationalinterviewing.org/trainer-listing

For more information and to learn about other programs to use for technical assistance, please follow the process described in the SHIP 4 Training and Technical Assistance Guide.

**Recommended partners**

**Minnesota Department of Health**

**Health care settings, such as:**

- Clinics serving a high volume of uninsured and/or self-pay patients
- Clinics serving a high volume of Medicare/Medicaid patients
- Clinics serving Minnesota Health Care Program (MHCP) patients
- Outpatient primary care clinics
- Pediatric clinics
- Maternity Centers
- Physical therapy clinics
- Dental clinics
- Women’s health/OB-GYN clinics
- Maternity Centers
- Public health clinics
- School-based clinics
- Visiting Nurse Association
- Hospitals
- Pharmacies
- Optometry clinics
- Ophthalmology clinics
- Chiropractic clinics
- Podiatrists
- Health care specialists

**Community-based partners, such as:**

- YMCA and/or YWCA
- Faith communities/groups

\(^3\) Grantees should be aware that practice transformation technical assistance is very intensive, which is reflected in the cost of those services.
- Youth centers
- Senior centers
- Fitness centers
- Community Education Programs
- University of Minnesota Extension Programs
- Area Agencies on Aging
- Community facilities that hold evidence-based programs, or other types of programs
- Community-based health or social service coalitions such as:
  - Breastfeeding Coalition
  - Obesity Prevention
  - Tobacco Cessation
- Community centers
Assessment and Planning

Planning and assessment are critical aspects of SHIP as they prepare grantees, community and clinical partners for implementation of evidence-based strategies.

Identify and engage community stakeholders and clinic partners
- Develop a list of key community stakeholders, agencies and clinics to contact. If applicable, consider approaching local Health Care Home clinics.
- Engage stakeholders through key informant interviews to solicit relevant feedback on:
  - Community resource access, barriers and needs;
  - Needs and preferences for a referral/resource system; and
  - Developing relationships among health care providers and community leaders to build partnerships for active referrals.

Compile a list of local evidence-based programs (EBPs) and resources
- Research and compile existing clinical, community and self-management resources through research, interviews and assessments.

Identify gaps and barriers in resources and processes for referral to EBPs
- Work with partner clinics to assess community and clinic-specific referral resources and processes through clinic assessments, provider surveys, provider focus groups and patient surveys.

Create an action plan
- Using results from the interviews and assessments, grantees will work with partners to determine which evidenced-based lifestyle program(s) they would like to establish in the community and who would sustain it.
  - Outline priorities and focus areas with a planning group
  - Create overall action plan with timelines for addressing priorities. The action plan should include recruitment of organizations to offer program(s), number of staff to be trained and logistics for training. SHIP will provide TA and guidance to support planning and implementation
Making the Case

Local Public Health and its Value in Clinical Settings

The health care provider is not alone in helping people live a healthier lifestyle. Local public health plays an important role in bridging community and clinical resources toward a common goal of healthier communities. Use these statements below for your “elevator speech” when talking with health care partners.

▪ **Provider encouragement of healthy lifestyle**: SHIP is dedicated to encouraging medical professionals to be proactive about sharing the harmful health effects of obesity and tobacco and offering ways to encourage healthy living. Research has shown that patients are more likely to check out a resource referred by their health care provider.

▪ **Early referral and intervention**: SHIP is dedicated to the idea that early referral and intervention allows for patients to integrate into “prevention” care, which over time will alleviate the need for costly restorative care delivery. Prevention now can lessen the need for expensive treatment later.

▪ **Communication infrastructure**: SHIP encourages health care providers and community leaders to develop a structured and well-organized strategy for communication, which will lead health care providers and community leaders to an effective system of referral of patients.

▪ **SHIP Health Care Strategy**: Increase Clinic-Community Linkages through supporting access to health care prevention services (Screen-Counsel-Referral-Follow up) in clinical settings using evidence-based strategies.

Grantee Questions

These questions are for you to answer (as the grantee) and share responses in meeting with a health care facility leader. Build on the sample answers to put your best foot forward.

▪ Why would a clinic want to collaborate with you?
  ▪ See bullets above

▪ What community resources can you bring to the relationship?
  ▪ Local PH is more than a funding resource
  ▪ Local PH can share regional resources clinic may not be aware of
  ▪ Local PH can bring community partners together

▪ What relationships do you want to create and why?
  ▪ Clinics work with patient populations, local PH agencies work with whole communities. Working together increases the potential for serving greater number of people by reaching into community to bring people into the clinic for assessment.
  ▪ Do you regularly refer to your community health needs assessment? How does it drive your goals and priorities?
  ▪ Develop a list of your resources and relationships (access to WIC, resources for seniors, safe housing, food access, safety, etc.) Don’t assume these resources are known outside your agency; in many cases they are not.
▪ What resources or agencies do you see as your partners, either currently or in the future?
  ▪ What are your different partner types (i.e. contractors, champions, community leaders, and business leaders) who share your vision and common action steps
▪ Do other SHIP strategies you’re working on have any application in a health care environment? For example:
  ▪ Healthy food and labeling in hospital cafeterias
  ▪ Active Living Bicycle-Friendly Business as a health care worksite
  ▪ HUD Smoke-Free Rule implications of driving public housing residents to clinics for cessation resources

Clinic Questions

The following are guiding questions used for an in-person conversation with a clinic champion, usually someone in a leadership position like a chief executive or medical officer, clinic manager or nurse supervisor. These questions would follow your “elevator speech” about SHIP. These are not meant as a script, but should provide a framework for learning about clinic priorities, efforts already underway, and where your agency would fit in.

▪ Are there specific clinic priorities you’ve identified that fit with the SHIP strategy of lowering obesity and commercial tobacco use, or building dementia-friendly communities?
▪ Can you please tell us about a recent clinic activity that you’ve considered or started related to one of these priorities?
▪ In the current list of your priorities, where does this project/activity sit?
▪ How was this identified as a priority?
▪ Are there champions; who are they?
▪ What steps have already been taken?
▪ Tell us about any community resources or agencies you see as your partners
▪ Are you able to share resources that haven’t yet been mentioned?
▪ Who within the clinic is responsible for conducting quality improvement activities?
▪ Does that person facilitate an internal committee that meets regularly?
▪ Determine if the clinic is a certified Health Care Home (HCH) or recognized by NCQA as a Patient Centered Medical Home (PCMH) Level 1-3 (1 is basic, 3 is advanced)
▪ If not, then ask if the clinic is currently in the process of becoming a certified health care home or NCQA PCMH
Get a list of Minnesota Health Care Homes (https://www.health.state.mn.us/facilities/hchomes/hchmap/index.html).

- Do you have an Electronic Health Record (EHR) capable of documenting referrals and/or bi-directional communication to other organizations outside your health system?
- Tip: Bi-directional communication = closing the referral loop. How does a health care provider know if an outside referral was fulfilled?
- How should information from community-based programs be communicated so that it can get added to the patient’s EHR?
- How do you see [LPH Agency name] contribute to the work you’re doing?
- Are there other ways [LPH Agency name] can contribute to the clinic’s priorities?
  - Tip: Also add your suggestions based on your “grantee question” answers
- Is there anything that we haven’t asked you that you’d like us to know?
Implementing Screen, Counsel, Refer and Follow-Up

Description
The outline below documents specific steps to establish a screen, counsel, refer and follow-up process in a health care setting. The accompanying questions are suggestions and not intended as a script. The coordinator will need to adapt to the pace and focus areas within the clinic environment so some adjustments may be necessary. It is recommended that before the work begins, an agreement or memorandum of understanding is established with the participating clinic and local public health so that the goals and expectations for both parties are clearly understood at the outset of the work.

In conclusion, these activities take time and success is based on the quality of the relationships that make this work possible. Take the time necessary to establish trust with partners and align with the priorities of the clinic.

Screen
Primary aim
Screen all patients (adults and children) at preventive and chronic disease visits (or a minimum of annually) for BMI, use/exposure of tobacco, and for older adults: cognitive function and fall risk. Document results in the medical record.

Secondary aim
Screen all patients (adults and children) at preventive and chronic disease visits (or a minimum of annually) for physical activity patterns and nutrition habits. For prenatal visits, screen for gestational diabetes. Document information in the medical record.

Step 1: Assess
Develop an understanding of how patients are screened for lifestyle risks

▪ What are patients being screened for today? Tobacco, BMI, physical activity, nutrition, etc.?
▪ Are patients aware of what they’re being screened for?
▪ Do screening tools follow clinical guidelines?
▪ How are the screens documented? Chart or electronic health record?
▪ Is there an established clinic workflow to know for what and how to screen?
▪ Who is responsible for each part of the workflow?
▪ Are there clear communication expectations between staff?
▪ Identify individual steps from patient entering clinic to leaving
Step 2: Determine next steps
- Which health risk does the clinic want to focus on?
- Write out updated workflow based on clinic feedback and answers to the above questions
- Create a plan to pilot recommendations

Step 3: Pilot, Rework, Implement and Evaluate (these steps are the same for counsel, refer and follow-up)
Guide clinic team to do the following:
- Test updated workflow with one or two clinicians for a day or two and review results
- Use results to improve process
- Train staff on new process
- Implement new process
- Continue to evaluate the process steps periodically and modify as necessary

Counsel
Primary aim
Counsel every patient at every visit regarding BMI and tobacco use/exposure; counseling and patient response will be documented in medical record.

Secondary aim
Counsel regarding nutrition habits, including pregnant women for herself and breastfeeding for baby, and physical activity patterns with every patient at every visit; counseling and patient response will be documented in medical record.

Step 1: Assess
- Are clinical staff counseling patients using best practices or clinical guidelines?
- Do clinic staff have the necessary information to counsel patients?
- Do clinic staff know where or how to get most current guidelines to better counsel patients?
- Are clinic staff trained in motivational interviewing techniques or shared decision-making? If not, what counseling techniques have staff been trained in?
- Is training ongoing?
- Are clear clinic roles (physicians, social workers, nurses) established (i.e. who should do what, when and how)?
- Are roles dependent on health risk (i.e. tobacco, BMI, etc.)?

Step 2: Determine next steps
- Share information collected from individual clinic staff with all staff to determine focus area for improving patient counseling
- Develop and diagram revised workflow that supports input from clinic
- Identify and obtain resources and tools needed for revised workflow
• Identify resource and arrange training for all clinic staff on motivational interviewing, if applicable

**Step 3: Pilot, Rework, Implement and Evaluate**

**Refer**

**Primary aim**
Refer patients who are overweight or obese and/or who use tobacco to local resources including evidence-based programs that increase access to high quality nutritious foods, opportunities for physical activity, and tobacco use cessation education and support. Document referrals in the medical record.

**Secondary aim**
Clinic staff to develop relationships with community organizations and leaders that build partnerships to facilitate referral of patients to local resources including evidence-based programs that increase access to high quality nutritious foods, opportunities for physical activity, and tobacco use cessation for education and support.

**Step 1: Assess**

• Is there a system in place at the clinic to document the referral in the medical record?
• Is there a coordination model for 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.)?
• Has a list of selected referral resources including existing clinical and/or community evidence-based self-management programs been developed?
• Are patients provided with handouts, links (either online or paper) or contact information to resources before they leave the clinic?
• Before patient leaves, are referral appointments scheduled, utilizing referral forms or electronic referrals?
• What relationships exist with resource agencies for a warm hand-off? (making sure the patient makes the connection with resource)

**Step 2: Determine next steps**

• Inventory existing referral resources including evidence-based programs, internal and external to clinic
• Engage with community stakeholders and establish additional referral resources and partnerships, if applicable

**Step 3: Pilot, Rework, Implement and Evaluate**
### TYPES OF REFERRAL SOURCES

<table>
<thead>
<tr>
<th>FOCUS AREA</th>
<th>Clinic-based</th>
<th>Community</th>
<th>Self-Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOBACCO</td>
<td>Train clinical educators 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. Which smoking cessation fax referral program does the clinic utilize?</td>
<td>Enroll in or improve referral processes for the Call it Quits Referral Program; QUITPLAN Services. Any evidence-based program</td>
<td>Online tobacco cessation tools through QUITPLAN Services, their health insurer, etc. Which QUITPLAN Services does the patient’s insurance pay for? Any evidence-based program</td>
</tr>
<tr>
<td>PHYSICAL ACTIVITY</td>
<td>Internal or external health care team members such as a health coach or physical therapy; conduct on-site group exercise classes utilizing kinesiology students from your local university.</td>
<td>Local Area Agency on Aging, Public or private health/fitness clubs or gymnasiums. Community Education and Parks and Recreation exercise classes, local parks and trails, Culturally appropriate fitness classes, sports leagues, Community Centers etc.</td>
<td>Exercise videos, exercise tutorial hand-outs, Falls Prevention classes such as A Matter of Balance or Tai Ji Quan; Moving for Better Balance</td>
</tr>
<tr>
<td>NUTRITION</td>
<td>Internal or external health care team members such as RD or health coach; provide nutrition classes on-site utilizing RD, U of M extension, or RD interns from your local university, lactation counselor, diabetes educator</td>
<td>Nutrition classes through Community Education, Parks and Recreation programming and U of M Extension, places to access nutritionally balanced foods</td>
<td>Culturally appropriate informational handouts on eating well, recipes, food logs, etc.</td>
</tr>
<tr>
<td>WEIGHT AND CHRONIC DISEASE MANAGEMENT</td>
<td>Internal and external clinicians such as RD or clinical weight management offering culturally appropriate classes such as the National Diabetes Prevention Program/I CAN Prevent Diabetes, Chronic Disease Self-Management Program, Diabetes Self-Management Program</td>
<td>Public or private culturally appropriate weight management classes such as Weight Watchers, TOPPS, National Diabetes Prevention Program, Chronic Disease Self-Management Program (CDSMP) and other evidence-based programs</td>
<td>Culturally appropriate educational information and tips on losing weight to be healthy.</td>
</tr>
</tbody>
</table>

### 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.

**Step 1: Assess**

- After referral is made, what are the communication expectations between referring clinician and in-house resources?
▪ After referral, what are the communication expectations between referring clinician and community-based resources?
▪ Do clinic staff outreach to patients about referrals after “?” amount of time? By phone? By mail? By email?
▪ Are patients expected to contact the clinic or provider if either they do or don’t follow through with the referral?
▪ Is a web-based patient portal an option for communication between patients and providers?

**Step 2: Determine next steps**

▪ Ensure a process for bi-directional communication; communication between those referring and those being referred to
▪ Is the patient included in communication between provider and program
▪ Based on existing and new partnerships established in the “refer” stage, diagram how and when this communication takes place
▪ Share with clinic staff and make changes as necessary, based on their input

**Step 3: Pilot, Rework, Implement and Evaluate**
Innovations or Promising Practices

The following are examples of Innovations or Promising Practices for the Clinical Community Linkage strategy:

▪ Support the use of health care extenders (i.e. health education specialists, community paramedics, pharmacists, nutritionists, etc.) and education/navigation extenders (i.e. community health workers, community health representatives, patient navigators, etc.) to improve engagement of disparate populations in evidence-based lifestyle change programs.

▪ Collaborate with behavioral health clinic staff to address tobacco cessation in adults with mental illness.

▪ Prepare clinics serving public housing populations for the impact of HUD smoke-free housing rule, which will likely increase the volume of public housing residents seeking cessation resources.

▪ Support the use of Screening, Brief Intervention, Referral to Treatment (SBIRT) model in clinical settings for specific populations, e.g. adults over 60 years.

▪ Integrating Exercise is Medicine’s Physical Activity Vital Sign (PAVS) into Electronic Health Records.

▪ Screening for food insecurity (Hunger Vital Sign) and referring to local food shelf or farmer’s market. See MN Food Charter Health Care Mini-Guide in Resources section.

▪ As of January 1, 2017, a new program for clinic reimbursement replaced fee-for-service with value-based payments under the Quality Payment Program (QPP). This new program consolidates Meaningful Use, Physician Quality Reporting System (PQRS), and value-based modifier programs into Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

▪ If you have an innovation or promising practice you’d like to discuss, or if you’re interested in learning more about any listed above, reach out to MDH health care staff.
Resources by Topic

**Breastfeeding**

*Baby-Friendly Hospital Initiative*  
([https://www.babyfriendlyusa.org/](https://www.babyfriendlyusa.org/))

**Breastfeeding Friendly Medical Systems**  

**Breastfeeding Peer Support Programs**

*Best Start resources* ([http://www.beststart.org/resources/breastfeeding](http://www.beststart.org/resources/breastfeeding))

*WIC Breastfeeding* ([https://www.health.state.mn.us/people/wic/bf/support.html](https://www.health.state.mn.us/people/wic/bf/support.html))

**Minnesota Breastfeeding Coalition (MBC)**

There are currently 30 local coalitions in Minnesota. Some coalitions are contained within a county, others cover two or more counties, and some join with counties in neighboring states. Breastfeeding advocacy and promotion begin at the grassroots level. Grantees are encouraged to contact their local coalition and check if there is potential synergy for projects, i.e. working with clinics on breastfeeding protocols or Baby-Friendly Hospital Initiatives. Review the [map of the local coalitions in Minnesota](http://mnbreastfeedingcoalition.org/bfa-in-mn/).

If there is not a coalition in the grantee area, contact the Minnesota Breastfeeding Coalition at [mnbreastfeedingcoalition@gmail.com](mailto:mnbreastfeedingcoalition@gmail.com) for ideas on how to start one.

**MNBC Toolkits**

- Pediatric Toolkit ([http://mnbreastfeedingcoalition.org/pediatric-toolkit/](http://mnbreastfeedingcoalition.org/pediatric-toolkit/))
- Perinatal Hospital Toolkit ([http://mnbreastfeedingcoalition.org/hospital-toolkit/](http://mnbreastfeedingcoalition.org/hospital-toolkit/))

**Clinical Guidelines**

- *Academy of Breastfeeding Medicine (Primary Care Clinics-Breastfeeding Policies)* ([http://www.bfmed.org](http://www.bfmed.org))
- *ICSI Preventive Services for Adults* ([https://www.icsi.org/guidelines/](https://www.icsi.org/guidelines/))
Diabetes

**National Diabetes Prevention Program (NDPP)**
(https://www.cdc.gov/diabetes/prevention/index.htm)

**Prevent Diabetes STAT**
(https://preventdiabetesstat.org/index.html)

To help prevent type 2 diabetes, the Centers for Disease Control and Prevention and the American Medical Association have created a toolkit that health care teams can use as a guide to **screen, test and act today** by referring patients to in-person or online diabetes prevention programs.

Emerging Professions

**Community Health Workers (CHWs)**

CHWs are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes. As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality, cultural competence and affordability; and empower individuals and communities for better health. CHWs are an emerging workforce, newer to most “mainstream” public health and health care settings.

- [Community Health Worker Toolkit (PDF)](https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/docs/2016chwtool.pdf)
- [Minnesota Community Health Worker Alliance](http://mnchwalliance.org/)

The mission of the Minnesota Community Health Worker Alliance is to build community and systems capacity for better health through the integration of community health worker (CHW) strategies.

**Community Paramedic Toolkit (PDF)**
(https://www.health.state.mn.us/facilities/ruralhealth/emerging/cp/docs/2016cptoolkit.pdf)

**Community Pharmacists (PDF)**

Health Care Quality and Reimbursement

**CMS Quality Payment Program (QPP)**
(https://qpp.cms.gov/)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Physician Fee Schedule (PFS)
and replaces it with a new approach to payment called the Quality Payment Program that rewards the delivery of high-quality patient care through two avenues: Advanced Alternative Payment Models (Advanced APMs) and the Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups under the PFS.

**Healthy Eating**

**Minnesota Food Charter Health Care Mini-Guide (PDF)**


This guide offers ideas for action steps to take such as integrating the “Hunger Vital Sign,” a two-question food insecurity screening tool, into their electronic health record system.

**Hospital Toolkits**

- CDC Steps to Wellness (https://www.cdc.gov/physicalactivity/worksite-pa/toolkits/pa-toolkit.htm)

**Obesity**

**5-2-1-0, Let’s Move Obesity Resource Toolkit for Health Care Providers**

(https://mainehealth.org/lets-go/childrens-program/pediatric-family-practices/tools)

The Let’s Go! Healthcare Setting currently focuses on educating primary care physicians on childhood obesity. The Healthcare Setting provides educational outreach, supporting materials and training to physicians working with patients and their families on promoting healthy eating and physical activity to prevent obesity. Introducing the Let’s Go! messages in the provider offices not only provides a credible location for the messages, it also emphasizes the important role healthcare professionals can play as community partners.

**Intensive Behavioral Therapy for Obesity**

Intensive Behavioral Therapy: Medicare’s Obesity Counseling Benefit Webinar Slides (PDF) (https://www.health.state.mn.us/facilities/hchomes/collaborative/lcdocs/webinars/medicareibtwebinar.pdf)
Pediatric Obesity Toolkit for Clinicians
(http://www.mnaap.org/work-groups/pediatric-obesity/)

The Minnesota Partnership on Pediatric Obesity Care and Coverage in conjunction with the Minnesota Chapter of the American Academy of Pediatrics has compiled practical tools, resources and links for Minnesota providers to use in their practice to help assess, prevent and treat childhood obesity.

Older Adults

Evidence-Based Fall Prevention Programs
(https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults/)

Minnesota Area Agency on Aging
(http://www.mnaging.org/Administrator/AAA.aspx)

Evidence Based Falls Prevention
(http://www.ncoa.org/improve-health/center-for-healthy-aging/a-matter-of-balance.html)

CDC Stopping Elderly Accidents, Deaths & Injuries (STEADI)
(https://www.cdc.gov/steadi/index.html)

Tai Ji Quan Moving for Better Balance
(http://tjqmbb.org/)

Physical Activity

Exercise is Medicine® Resources for Health Care
(https://www.exerciseismedicine.org/support_page.php/health-care/)

This website offers ways that health care providers, organizations and systems can integrate the Physical Activity Vital Sign two questions into the patient visit and conclude with an exercise prescription and/or referral to a certified health fitness professional or allied health professional for further counseling and support.

▪ Health Care Providers’ Action Guide (PDF)
(http://exerciseismedicine.org/assets/page_documents/HCP_Action_Guide(3).pdf)

Tobacco

American Lung Association

More information is available from ALA Freedom from Smoking (http://www.lung.org/stop-smoking/how-to-quit/freedom-from-smoking/), including the link to the online program option.
Ask and Act
(https://www.aafp.org/about/initiatives/ask-act.html)

The American Academy of Family Physician’s (AAFP) tobacco cessation program "Ask and Act" encourages family physicians to ASK their patients about tobacco use, then ACT to help them quit. The AAFP website has a variety of evidence-based resources for providers, including information on payment for tobacco cessation counseling.

Minnesota Quitline Network Referral Program
(https://www.health.state.mn.us/callitquits)

Certified Tobacco Treatment Specialist
(https://ndceducation.mayo.edu/)

Connecting clinical staff and providers with the appropriate training to become a Certified Tobacco Treatment Specialist (CTTS) supports tobacco cessation initiatives. CTTSs are trained professionals, available to provide treatment options, such as counseling to individuals that are seeking help to stop using tobacco. The Nicotine Dependence Center Tobacco Treatment Specialist Certification Program at Mayo Clinic is a nationally recognized and accredited training program offered to participants from all backgrounds. The Tobacco Treatment Specialist Certification Program is a five-day long course that focuses on the skills needed to effectively treat tobacco dependence

Freedom from Smoking
(http://www.freedomfromsmoking.org/)

Society for Public Health Education – Smoking Cessation and Reduction In Pregnancy Treatment (SCRIPT)
(https://www.sophe.org/focus-areas/script/)

SCRIPT is an evidence-based program shown to be effective in helping thousands of pregnant women quit smoking. It is designed to be a component of a patient education program for prenatal care providers, and is cited by the Agency for Healthcare Research & Quality’s Smoking Cessation Clinical Practice Guidelines.

State Tobacco Cessation Coverage Database

The American Lung Association has state-specific tobacco cessation coverage information.