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Background for Strategy

The Clinical-Community Linkages for Prevention strategy has two components: Clinical-Community Linkages and Advancing Public Health, Health Care and Community Linkages with State and Federal Health Reform Initiatives. Grantees are required to progressively work on both components.

Clinical-Community Linkages

The numbers tell the story. In 2009 approximately 63 percent of Minnesotans were overweight or obese, and 17 percent of Minnesotans used tobacco products. The annual obesity-related medical cost is estimated to be $1.5 billion dollars, of which $626 million are Medicaid and Medicare expenditures. Annually, smoking costs Minnesota nearly $3 billion in health care cost. Overweight and obesity also increase the risk of many chronic diseases such as diabetes, heart disease, some cancers and arthritis. This epidemic is placing a huge burden on our health care system and economy. It also underscores the important role of the health care system as a setting for addressing nutrition, physical activity, and tobacco use behaviors.

The U.S Preventive Services Task Force (USPSTF) has made recommendations that include a broad range of clinical preventive health care services such as screenings, counseling, referrals, and preventive medications. Despite the existence of the USPSTF recommendations, patients receive only half of the recommended clinical preventive services overall, and less that 20 percent of recommended counseling or education services.¹ A promising approach to enhancing the delivery of preventive services in clinical settings is for providers to coordinate, cooperate, and collaborate with external nonclinical organizations such as local health departments and community-based organizations that share an interest in improving health and preventing disease and can provide these services.

Primary care practices that attempt to implement guidelines like these face challenges related to available resources, appropriate training, and time necessary to build new capacities for behavioral counseling and follow-up care. Research has shown that practices have the potential to overcome these challenges by combining clinical efforts with community partnerships. When they do, studies show that patients’ health behaviors improve.² Infrastructure support and communication systems must be developed to foster sustainable linkages between practices and local resources. This SHIP strategy allows grantees to develop the support and systems needed for Clinical-Community Linkages for Prevention.

Clinical-Community Linkage Framework

The Etz Bridging Model³ (Figure 1) depicts a “clinic-community linkage.” The bridge has 2 anchors and a bridge span. The anchors illustrate a set of characteristics on the clinic/clinician side that influence the ability to initiate connections to community.
resources, and a set of characteristics on the community resource side that facilitate connections to primary care practices. These attributes can be considered foundational anchors that must be established at each side of the bridge for a clinical-community linkage to be developed. Anchoring characteristics on the clinic/clinician side include the capacity to assess patient risk, ability to provide brief counseling, capacity and ability to refer, and awareness of community resources. Anchoring characteristics on the community resource side include the availability, accessibility, affordability, and perceived value of services provided by the community resource. Strategies created to connect clinical practices and resources can be considered as the bridge span to connect the gap between primary care and community resources.

Figure 1. Bridging Primary Care and Community Resources: Model Elements

Connecting Strategies

1. Steps taken to initiate the bridging process;
2. Primary care practice characteristics (anchor);
3. Resource characteristics (anchor); and
4. Steps taken to make effective use of the bridges, once established.
Advancing Public Health, Health Care and Community Linkages with State and Federal Health Reform Initiatives

Minnesota has been a leader in pursuing policies to improve the health care system. Health Care Homes, also known nationally as Patient-Centered Medical Homes (PCMH), are an important cornerstone of the 2008 MN Health Reform law. The health care home is a transformative change in the delivery of primary care. The health care home concept focuses on a broad continuum of health and incorporates expectations for engagement of the patient, family and community. The aims are to improve the health and quality of life for patients, to connect the health care delivery system with the community and improve population health.

The United States is a recognized leader in many areas, but our healthcare system has been labeled as “broken” by many policymakers and thought leaders. However, with the passage and implementation of the Affordable Care Act (ACA), the U.S. is engaged in significant efforts to transform the healthcare system. A fundamental premise of healthcare transformation is that silos need to be reduced or eliminated and a more integrated and coordinated system must be developed.

In an effort for health care to shift the focus from individual patient care to population health management, the ACA promotes the establishment of accountable care organizations (ACOs). An ACO is a group of coordinated health care providers that work together to care for a designated population. As health systems in Minnesota are developing reforms such as Health Care Delivery Systems, ACOs or Accountable Communities for Health, they should be encouraged to incorporate community-based prevention such as SHIP interventions into their systems. An investment in prevention and coordination with SHIP as part of these overall models can help providers more easily and effectively reach their goals of healthier communities and lower health care costs.

In addition, the ACA regulations require each tax-exempt hospital to do a “Community Health Needs Assessment” every three years. This assessment must include input from the community served by the hospital and from those with expertise in public health. Hospitals must adopt an implementation strategy that addresses the community health needs identified by the assessment. This may free up the hospital’s community benefit dollars, formerly dedicated to charity care, to be used for community prevention initiatives including programs identified in SHIP i.e. National Diabetes Prevention Programs and Diabetes Self-Management Programs, Chronic Disease Self-Management Programs, etc.

Framework
The Expanded Chronic Care Model (Figure 2) represents a framework that can re-orient public health and healthcare services to better address the needs of individuals with chronic disease(s). The framework places greater emphasis on prevention, population health promotion, and the creation of supportive environments that are linked to the
health care system. This enhanced version of the Chronic Care Model includes elements of the population health promotion field so that broadly based prevention efforts, recognition of the social determinants of health, and enhanced community participation can also be part of the work of health care/system teams.

Figure 2. The Expanded Chronic Care Model: Integrating Population Health Promotion


Clinical-Community Linkages Component

The SHIP approach to Clinical-Community Linkages is founded on true collaboration between health care clinics, local public health (LPH) agencies and community-based organizations (CBOs), and healthcare systems. The objectives for this strategy are:

1. Convene and strengthen partnerships between LPH, health care facilities and clinics, health plans/payers, and community-based organizations that are committed to addressing obesity and tobacco use/exposure.

2. Enhance methods for screening and documentation of Body Mass Index (BMI) and tobacco use and exposure status.

3. Provide technical assistance to clinicians and clinic staff on effective practices and approaches for addressing BMI status and tobacco use and exposure with patients, including motivational interviewing and goal setting.
4. Identify, catalogue and make available to clinicians, clinic staff and patients community resources that address behaviors related to nutrition, physical activity, and tobacco use and exposure. This may include uploading resources to a statewide online database and integrating resources into electronic medical record (EMR).

5. Create or strengthen system of referral to in-house or community resources.

6. Develop or enhance a follow-up system.

7. Promote usage of existing billing codes for reimbursement of services provided related to the SHIP strategy, Clinical-Community Linkages for Prevention (i.e., counseling, nutrition education, follow-up care).

The Clinical-Community Linkage component includes the following steps:

- Assess and plan to increase access to evidence-based lifestyle change and prevention programs.
- Facilitate infrastructure development to increase access to evidence-based lifestyle change and prevention programs in the health care facilities and in the community.
- Partner with local clinics to support the implementation of evidenced-based clinical guidelines and the clinical system process of Screen, Counsel, Refer, and Follow-up**.
- Support the use of health care extenders (i.e. health educators, community paramedics, nutritionists, etc.) to improve engagement of disparate populations in evidence-based lifestyle change and prevention programs.

**Origin

The SHIP clinical system process of Screen, Counsel, Refer, and Follow-up was adapted from evidence-based guidelines and recommendations, including:

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

Please also see Appendix B: References for supporting literature, Appendix C: Talking Points for Prevention in Health Care, and Appendix D: Terminology and Abbreviations.
**Priority Populations**
The populations for the Clinical-Community Linkage strategy include patients, regardless of age, who are identified as being overweight or obese and or using/being exposed to tobacco. Priority patients within these population include patients who are uninsured or on Minnesota Health Care Programs such as Medicaid, Medicare, or MNCare, pregnant women to include breastfeeding education and, adults with mental illness and adults over the age of 60.

**Scope of Component**
The approach to the Clinical-Community Linkage component is founded on true collaboration between health care clinics, local public health (LPH) agencies and community-based organizations (CBOs). In relation to the Bridging Model, the collaboration is the bridge span strengthened by the grantee; the strategy steps of Screen, Counsel, Refer, and Follow-up ensure that Primary Care anchor has a strong foundation; and the step of Creating/Identifying Resources (availability, affordability, accessibility) ensures that the Community Resources anchor has a strong foundation.

**Phased Approach**
During the application process, applicants will place themselves in one of the following three phases. The evaluation expectations, grant monitoring milestones and level of training and technical assistance will vary for each phase. Please read through this Guide for details to help you determine which phase is the most appropriate to begin activities.

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Partnerships and Planning</th>
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<tr>
<td>Applicants have limited partnerships within the strategy work. They are just beginning to address health inequities within their community. The focus is on planning, assessing and engagement and they will likely begin with a more step-by-step approach. The choice of phase doesn’t necessarily reflect experience. Applicants may choose this phase if they are starting work in a new community or a new setting within a content area that is already familiar to the grantee. The level of technical assistance and support for this phase is significant and will be provided in a timely fashion. This phase is intended to be short-term; exact details will be negotiated in final work plans.</td>
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<th>Phase 2</th>
<th>Growth</th>
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<td>Applicants have strong partnerships and consistent experience within this content area and setting. They will build on existing partnerships and expand to additional sites, addressing health inequities and supporting policy development and regional efforts. Training and technical assistance needs should be able to be met through regular contact with an assigned Community Specialist, consultation with MDH content experts and regularly-scheduled trainings.</td>
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<th>Phase 3</th>
<th>Innovation and Promising Practices</th>
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</thead>
<tbody>
<tr>
<td>This allows for innovation by grantees and their partners, addressing cutting edge policy, systems and environmental change. The strategies selected will or have decreased</td>
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health inequities. Potential is high for new models and learning. Minimal formal technical assistance is planned for this phase but will be delivered as needed.

**Phase 1: Partnerships and Planning**
Those that select Phase 1 will develop relationships among health care providers and community leaders; build partnerships; and identify gaps and resources that facilitate active referral of patients to local resources which increase access to high quality nutritious foods, opportunities for physical activity, tobacco use cessation and evidence-based self-management programs.

**Phase 2: Growth**
Those in Phase 2 have demonstrated they have at least one partnership in place and have conducted an environmental scan of the local resources. The grantee will support infrastructure development to increase access to evidence-based self-management programs in the community; support the SHIP model of Screen, Counsel, Refer and Follow-up with additional health care partners; and support the implementation of evidence-based clinical guidelines.

**Phase 3: Innovation and Promising Practices**
In Phase 3, grantees will identify additional health care partners in their community to address health disparities.

**Activities**

**Planning and Assessment**
Planning and assessment are critical aspects of SHIP as they prepare both grantees and community partners for implementation of evidence-based strategies. SHIP grantees must complete the two processes described in this section (Process 1: Community Linkages and Process 2: Clinical Linkages) prior to implementation of the Clinical-Community Linkages for Prevention strategy steps.

**Process 1: Community Linkages**

1. Organize a SHIP health area advisory committee
The purpose of an area advisory council is to allow health care and community conversations on what works, address common issues or concerns related to implementation, and strengthen the relationship between community referral organizations and clinics through collective problem-solving. Members may include (but are not limited to): representatives from the Community Leadership Team, clinician champion from local clinics, clinic representative (clinic manager), LPH staff, health educators, and patients and representatives from select community-based organizations (that offer resources for nutrition, physical activity, and tobacco via referrals), depending on the area capacity. *A grantee would not have to organize a new council or committee if a similar committee already exists and could complete the following activities:*

i. Identify potential partner groups and send letter of invitation.
ii. Add new SHIP partners as recruitment proceeds.
iii. Propose dates for meetings.
iv. Upon assessing availability, schedule regular meetings (every month or every-other month).

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

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

2. **Engage community stakeholders**

   A. Develop a list of key community stakeholders and community agencies to conduct assessment—if applicable, consider getting contacts from an inventory of existing programs.

   B. Conduct Community Stakeholder Engagement through key informant interviews to solicit community and culturally relevant feedback on 1) community resource access, barriers, and needs; 2) needs and preferences for a referral/resource system; and 3) developing relationships among health care providers and community leaders to build partnerships for active referrals.

   C. Compile document of key findings and recommendations.

   D. Get feedback from area health advisory committee.

**Potential Milestones**
• List of stakeholders assembled
• Key informant interviews completed and information summarized
• Key findings and recommendations from community/stakeholder engagement activities are incorporated into work plan

Resources
• Referral and Resource Key Informant Interview Themes, Minneapolis SHIP 2010 (Appendix X)

3. Identify resource gaps and barriers to referrals

A. Work with partner clinics to assess clinics to identify current clinic-specific referral resources through general assessment processes such as clinic assessment, provider surveys, provider focus groups and patient surveys.

B. Identify gaps in community and clinic based programs at individual clinics through assessment.

C. Obtain feedback from providers on current referral process and needs

1) To identify opportunities for process improvement within the clinics; and
2) To inform the development of a broad-based referral directory. Discuss when to implement a quality improvement cycle for adapting clinic processes (i.e. before or after formal referral system is developed). To be conducted after the initial Clinic, Provider, and Patient Surveys are complete and before intervention implementation.

Potential Milestones
• Clinic-specific resources identified and list developed
• Community-specific resources identified and list developed

Resources
• Health Care Provider/Staff Focus Groups: Informed Consent and Questions (Appendix J).
• Americans in Motion—Healthy Interventions (AIM-HI). Offers resources for family physician practice staff who want to serve as role models for patients. See page 7, step 3 of the AIM-HI Practice Manual for information on adjusting office processes and procedures.
• Healthy Ohio Program - Creating Healthy Communities Checklist: Health Care Setting Checklist, pages 9-18.
  http://www.healthyohioprogram.org/~media/HealthyOhio/ASSETS/Files/cr
4. **Compile an inventory of existing resources and populate resource database (detail below)**

A. Research and compile existing clinical, community and self-management resources through research, interviews, and assessments.

B. Develop an internal database or list to organize resources.
   i. Consider using MNHelp.Info inclusion criteria
   ii. Consider limiting your list by your jurisdiction or area served by clinics
   iii. Be sure to include programs in your area
   iv. Collect key data points identified in patient and staff/provider assessments (e.g. cost, location, etc.)

C. Ensure the statewide resource database (MNHelp.Info) is populated with compiled resources.
   i. Familiarize yourself with key features of resource database MNHelp.Info.
   ii. Complete MNHelp.Info excel template with compiled resource information.
   iii. Submit MNHelp.Info excel resource spreadsheet to MNHelp.Info. Note that MNHelp.Info will: determine taxonomy and terms; send each agency an email indicating that their organization has been invited to be listed in the database; and provide instructions on how to log-in and enter/update agency and program information.

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

- List of resources for referrals is developed and sent to MNHelp.Info (and other clearinghouses such as United Way 211 and if applicable, county or health system/clinic websites)
- Resource database is populated

Resources

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

5. Create a community action plan to support resource infrastructure development

Using results from the assessments, grantees will work with area health advisory council or committee to determine which evidenced-based lifestyle program(s) they would like to establish in the community and who would sustain it. The following are MDH-approved programs for adults:

- Diabetes programs (i.e., National Diabetes Prevention Program, I CAN Prevent Diabetes, Diabetes Self-Management Program) – modest 5-10 percent weight loss by increased physical fitness, improved diet, increased self-monitoring and self-care
- Chronic Disease Self-Management Program – demonstrated increase in physical activity and healthy eating
- Other evidence-based programs identified for specific populations, e.g., pediatrics, patients with mental illness, older adults – approval from MDH is required if SHIP funding is to be used to establish the program

A. Outline priorities and focus areas with planning group.

B. Create overall action plan with timelines for addressing priority(ies). The action plan is to 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.
Resources for Adult Programs

  [http://www.mnhealthyaging.org/FindAClass.aspx](http://www.mnhealthyaging.org/FindAClass.aspx)
- Minnesota Arthritis Program [http://www.health.state.mn.us/divs/hpcd/arthritis/text/mnarthritis.htm](http://www.health.state.mn.us/divs/hpcd/arthritis/text/mnarthritis.htm)

Resources for Pediatrics Program

- Action Plan templates
  - Minneapolis SHIP Resource and Referral Network Clinic Action Plan template (Appendix M)
  - Clinic Action Plan Tracking Tool (Appendix N)
  - Carver-Scott Health Care Action Plan template (Appendix O)

Process 2: Clinical Linkages

1. **Recruit clinic partners**

   Grantees will provide information to clinics and other health care sites about SHIP and the Clinical-Community Linkages for Prevention strategy. Outreach should include information on how prevention can fit in with the clinic or health care system’s current or changing workflow processes.

   A. Obtain a list of clinics in the community.
      
      i. Engage existing network of partners (first or second round SHIP partners).
ii. Consider approaching local Health Care Home clinics.

B. Contact clinic staff or clinicians, if possible, to schedule in-person meetings.

C. Review the measures clinics are responsible for reporting related to weight and tobacco use assessment, counseling, and referral services.

D. Present SHIP materials, clinic tools, and clear vision: “This is what SHIP can offer you....”
   i. Develop a plan/training to educate clinicians and clinic staff about the Clinical-Community Linkages strategy and objectives.
   ii. Include materials/handouts, food and refreshments.

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

Potential Milestones
- List of potential partners (clinics) generated
- List of potential clinician champions generated
- Information on clinic measures gathered
- Training planned and scheduled
- Grantee-clinic partner commitment agreement signed, with each party’s role delineated

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

2. Establish clinic-specific planning groups

Grantees will facilitate the formation of clinic-specific planning groups which have been shown to markedly increase the success of implementation and sustainability. Grantees may also consider using an area advisory committee to provide guidance, oversight, and coordination of SHIP Clinical-Community Linkages for Prevention strategy within their region.
A. Facilitate the formation of clinic-specific planning groups. The purpose of each planning group is to determine priorities, provide input on the planning and implementation of the strategy steps, and assist with evaluation activities. Members may include (but are not limited to) clinician champion, clinic manager, TA providers, medical assistants, nurses, quality improvement staff, health educators, nutritionists, community health workers, and other partners.

i. Ask clinic administration to identify and confirm group members.
ii. Schedule meetings, ideally monthly or more often to track progress, conduct assessment and develop clinic action plan.
iii. Utilize the first or second meeting to provide a general overview of SHIP and the SHIP Clinical-Community Linkages for Prevention strategy steps, including a suggested timeline and plan.

3. Collect baseline assessment data from clinic partners

Grantees will conduct baseline assessments of clinic partners to determine:

- Organizational readiness to change
- Quality improvement culture
- Current systems, practices, measures, and documentation related to:
  - screening for BMI and tobacco use/exposure
  - screening for nutritional and physical activity behaviors (optional for new grantees or grantees who have not addressed the Clinical-Community Linkages for Prevention strategy)
  - addressing BMI and tobacco use/exposure
  - referring to community resources

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

B. Conduct baseline assessment with each clinic partner to determine current systems, practices, and measures (if any) related to the Clinical-Community Linkages for Prevention strategy.

C. Collect and manage data.

Potential Milestones
- Baseline assessment conducted

4. Analyze baseline assessment data

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

A. Analyze data.
B. Organize findings in a useable format.
   i. Create presentation of clinic assessment, patient and provider survey results (to be presented at collaborative or meeting with clinic to determine protocols/process for referrals at that clinic).

C. Share findings with clinic planning group.
   i. Conduct Staff/Provider Focus Groups to get more clarity on clinic/provider survey results and ascertain further feedback from providers on current referral processes and needs.

D. Based on findings, determine priorities. Incorporate findings into action plan or work plan.

**Potential Milestones**
- Baseline data generated and analyzed
- Process flow chart of current clinic practices developed
- Staff/Provider focus groups conducted
- Findings shared with planning group
- Priorities/focus areas determined

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

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

A. Outline priorities and focus areas with planning group.

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

C. Create overall action plan for addressing priorities, including timelines.

D. Develop clinic-specific action plans.
   i. Map out readiness to change and ensure the plans are based on addressing the clinic partner’s needs.
   ii. Map out the clinic patient flow goal and ensure plans are largely based on how to get to that revised clinic flow.
   iii. Include a budget (for purchase of new items such as BMI posters).

E. Indicate technical assistance needs.

F. Pilot plans and revise accordingly using PDSA tool (see Resources below).

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

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

After completing or updating the planning and assessment phase, grantees will continue to work with the community to build infrastructure where needed and support their clinic partners by:

1. Based on gaps identified in the environmental scan of evidence-based lifestyle change programs such as the Diabetes Prevention Program (DPP), Chronic Disease Self-Management Programs (CDSMP), pediatric weight management programs and tobacco cessation programs, support infrastructure development to increase access to evidence-based programs in the community.

2. Support the implementation of evidence-based clinical guidelines by health care providers for adults and children where applicable; ICSI Guidelines: Healthy Lifestyles, Preventive Services for Adults (Hypertension, lipid, tobacco use screening and brief intervention), Preventive Services for Children and Adolescents, Prevention and Management of Obesity (Adults). Other Guidelines may include but are not limited to: American Academy of Pediatrics’ Bright Futures, Academy of Breastfeeding Medicine.

3. Support the SHIP clinical system process of “Screen, Counsel, Refer and Follow-up,” by providing direct technical assistance or by offering trainings such as motivational interviewing, health coaching, tobacco cessation specialist certification or other types of training.

The grantees will be required to complete the baseline data collection survey for each of the clinic partners. MDH will provide an electronic link to access the survey. To review the SHIP 2.0 baseline data collection survey, check the Health Care section from the following link [http://www.health.state.mn.us/healthreform/ship/evaluation2.html](http://www.health.state.mn.us/healthreform/ship/evaluation2.html).

Step 1: Screen

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

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

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

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

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

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

Implementing Step 1: Screen

1. Develop new screening process (measurement, documentation and clinic flow)
   
   A. Determine if clinic needs additional lifestyle risk measurement tools and/or questions to add to their current intake forms.
B. Consider needs of Step 2 (address risks) and Step 3 (refer to resources) when developing documentation—insure documentation is used as a flag/trigger for addressing risks and referring to resources.

C. Develop new forms (paper and/or electronic) to gather the required information.

D. Diagram the revised clinic process flow including:
   i. Which staff accomplish each part of the process
   ii. Existing or new tools (forms, reminders, etc.) used throughout process

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

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

Resources
- Your BMI Handout (Appendix S)
- AIM-HI Fitness Inventory (includes a total of 19 questions covering activity, healthy eating and emotional well-being): http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/aim/fitnessinventory.Par.0001.File.dat/FitnessInventory.pdf

2. Pilot new process

   A. Conduct a pilot to test the new process (for example, one or two clinicians for a day or two) using a Plan, Do, Study, Act model for quality improvement.

   B. Review pilot results and change process based on what you’ve learned.

   C. Re-pilot and re-evaluate the process until it works smoothly.

Potential Milestones
- Pilot is conducted
- Process is finalized
Resources
- MDH PDSA Storyboard Template (Appendix T)
- MDH PDSA Worksheet (Appendix U)
- RWJF Post Practice Assessment Instrument: http://www.prescriptionforhealth.org/results/NCObservationInstrumentFU.doc

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

Potential Milestones
- Training completed

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

Potential Milestones
- New process implemented for entire target clinic population

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

Potential Milestones
- Chart audit conducted monthly
- Chart audit shows consistent implementation of the process
Step 2: Counsel

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

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

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

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

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

Implementing Step 2: Counsel

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

   A. Diagram current process, compare to evidence-based recommendations, and identify gaps.

   B. Develop and diagram revised process that will support counseling, incorporating feedback from clinic planning group.

   C. Identify and obtain resources and tools needed for revised process.

   **Potential Milestones**
   - Process outline revised into a swim lane diagram (see Resources below) based on clinician and staff feedback in order to delineate clinician and staff roles

   **Resources**
   - MDH SHIP QI Collaborative Monthly Report Forms and Storyboard Template.
     - MDH PDSA Storyboard Template (Appendix T)
     - MDH PDSA Worksheet (Appendix U)

2. Train staff on new counseling process

   A. Identify training needs, which may include the following:

      - Motivational Interviewing Techniques
      - Documentation training
      - Role Training and Talk-back Session

   B. Arrange sessions to cover all clinic team members.
C. Complete sessions and administer post-test to evaluate learning.

**Potential Milestones**
- Training completed

**Resources**
- Sue Eckmaahs, Motivational Interviewing Trainer: [http://www.eckmaahs.com/home](http://www.eckmaahs.com/home)
- Collaborative Decision-Making and Brief Interventions (Appendix W)

3. Implement new counseling process

A. Create action plan to implement new process.

B. Create, run, and evaluate new process using pilot test and/or Rapid Cycle PDSAs.

C. Develop prompts for staff and clinicians and provide incentives for clinicians/staff who implement new process correctly and consistently.

D. Embed new process in paper chart or EMR.

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

**Resources**
4. Evaluate implementation of new process

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

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

   C. Share progress with clinicians.

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

**Potential Milestones**

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

**Resources**


**Step 3: Refer**

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

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

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

Clinicians must use their roles as clinicians, community leaders and health advocates to convey a clear, strong, personal message about the advisability and benefits of health behavior change (complimenting Step 2). In addition, they must provide a referral to community-level resources appropriate to their patients’ health conditions, current health status, and degree of motivation and document it in the medical record. An effective system of referral of patients to resources focused on nutrition, physical activity and tobacco cessation will require a high level of communication and coordination. A system must be in place at the clinic to document the referral in the medical record and if necessary, involve the health care team to carry out different components of the referral process (e.g. locating and selecting a resource, tracking referrals, arranging transportation, etc.). Clinics should be able to provide patients with handouts, links, or contact information to resources before they leave the clinic, to increase the likelihood that patients will follow-through. Additionally, scheduling referral appointments, utilizing referral forms or electronic referrals, and developing relationships with resource agencies for a warm hand-off will help facilitate follow-through by the patient.

**Outcome**
Referral to resource is documented.

### Implementing Step 3: Refer

1. **#1: Engage Community Stakeholders**
2. **#2: Inventory Existing Referral Resources**
3. **#3: Establish Clinic-Specific Referral Resources and Partnerships**
4. **#4: Develop New Process for Referrals**
5. **#5: Train Clinicians and Clinic Staff on New Process for Referrals**
6. **#6: Implement Referral Process and Resource Database**
7. **#7: Evaluate Implementation**
1-3. Identify resource gaps and develop referral partnerships

A. Work with partner clinics to identify current clinic specific referral resources through assessment (general clinic assessment, provider survey and focus group, patient survey).

B. Work with partner clinics to establish clinic-specific referral resources as described in the table below:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Type of Referral Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinic-based</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Train clinicians to offer on-site</td>
</tr>
<tr>
<td></td>
<td>tobacco cessation classes such as</td>
</tr>
<tr>
<td></td>
<td>Freedom From Smoking; offer</td>
</tr>
<tr>
<td></td>
<td>clinician or pharmacist</td>
</tr>
<tr>
<td></td>
<td>cessation counseling; other</td>
</tr>
<tr>
<td></td>
<td>clinic-based tobacco cessation</td>
</tr>
<tr>
<td></td>
<td>counseling off-site</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Internal or external clinicians</td>
</tr>
<tr>
<td></td>
<td>such as a health coach or physical</td>
</tr>
<tr>
<td></td>
<td>therapy; conduct on-site</td>
</tr>
<tr>
<td></td>
<td>group exercise classes utilizing</td>
</tr>
<tr>
<td></td>
<td>Kinesiology Interns from your local</td>
</tr>
<tr>
<td></td>
<td>University</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Internal or external clinicians</td>
</tr>
<tr>
<td></td>
<td>such as RD or health coach; provide</td>
</tr>
<tr>
<td></td>
<td>nutrition classes on-site utilizing</td>
</tr>
<tr>
<td></td>
<td>RD, UMN Extension, or RD interns</td>
</tr>
<tr>
<td></td>
<td>from your local University</td>
</tr>
<tr>
<td>Weight and Chronic Disease</td>
<td>Internal or external clinicians</td>
</tr>
<tr>
<td>Management</td>
<td>such as RD or clinical weight</td>
</tr>
<tr>
<td></td>
<td>management, offer prediabetes (I</td>
</tr>
<tr>
<td></td>
<td>Can or YDPP) or chronic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Referral Resource</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Enroll in or improve referral processes</td>
</tr>
<tr>
<td></td>
<td>for MN Clinic Fax Referral Program; MN</td>
</tr>
<tr>
<td></td>
<td>QuitPlan services</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Public or private health clubs (YMCA,</td>
</tr>
<tr>
<td></td>
<td>YWCA), Community Education and Parks</td>
</tr>
<tr>
<td></td>
<td>and Recreation exercise classes, local</td>
</tr>
<tr>
<td></td>
<td>parks and trails, sports leagues, etc.</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Nutrition classes through Community</td>
</tr>
<tr>
<td></td>
<td>Education, Parks and Recreation</td>
</tr>
<tr>
<td></td>
<td>programming and UMN Extension; farmer’s</td>
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<tr>
<td></td>
<td>markets, Fare for All and other places to</td>
</tr>
<tr>
<td></td>
<td>access healthy foods</td>
</tr>
<tr>
<td>Weight and Chronic Disease</td>
<td>Public or private weight management</td>
</tr>
<tr>
<td>Management</td>
<td>classes such as Weight Watchers,</td>
</tr>
<tr>
<td></td>
<td>prediabetes classes (I Can or YDPP),</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Referral Resource</th>
<th>Self-Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Online tobacco cessation tools through</td>
</tr>
<tr>
<td></td>
<td>QuitPlan, their health insurer, etc.</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Exercise videos, exercise tutorial hand-</td>
</tr>
<tr>
<td></td>
<td>outs on how to get small bouts of</td>
</tr>
<tr>
<td></td>
<td>exercise, or home exercise equipment (hand</td>
</tr>
<tr>
<td></td>
<td>weights, exercise ball, etc.)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Informational handouts on eating well,</td>
</tr>
<tr>
<td></td>
<td>recipes, food logs, etc.</td>
</tr>
<tr>
<td>Weight and Chronic Disease</td>
<td>Educational information and tips on</td>
</tr>
<tr>
<td>Management</td>
<td>losing weight</td>
</tr>
</tbody>
</table>
C. Develop clinic specific list of selected resources and informational hand-outs.

D. Create partnerships/relationships with the most relevant and important community resource agencies and create a warm hand-off process with a referral form.

   i. Conduct community agency assessment (see Evaluation Tools).
   ii. Facilitate partnership meetings, presentations, or conversations between providers and community agencies.

B. Identify gaps in community and clinic based programs at individual clinics through assessment.

C. Develop new resources to address gaps at individual clinics via additional clinical, community and self-management resources.

   i. Identify clinics and agencies that are best-suited to offer programs on-site and facilitate implementation (e.g. I Can Prevent Diabetes and CDSMP).
   ii. Facilitate partnerships or conversations between clinic and community agencies to offer new or additional programming in the community for referral.

D. Work with clinic to develop a plan for sustaining partnerships and making updates/changes to referral resource system.

Potential Milestones

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

Resources

- Resource List Examples (Appendix II)
- Warm Hand-off Process Map (Appendix JJ)
- Referral Form Examples
  - Healthy Living, Minneapolis (Appendix KK)
  - Lifestyle Action Plan, Hennepin County (Appendix LL)
4. Develop new process for referrals to clinical, community and self-management resources

A. Familiarize yourself with existing clinic referral systems and coordination models (CHW, EMR, warm hand-off, etc.) and assess feasibility for use with partner clinics based on clinic assessments.

B. Determine current referral process at the clinic and address barriers.
   i. Use clinic assessment and staff/provider surveys and focus groups to determine current process for referrals, e.g. where resources are and what processes are required. For example, if your organization refers patients to an outside source, what are the criteria for referral?
   ii. Ascertain data specific to registration in the Call It Quits Fax Referral System and the number of providers that actively refer patients.

C. Determine how to integrate resources into clinic process (how to link patients with these resources).
   i. Map out current clinic processes for referral (PA, tobacco, HE).
   ii. Make changes to map ideal process and tools necessary (provider conversation, responsible referral person, assessment tools, readiness tools, clinic decision support/EMR integration).
   iii. Create a warm hand-off process and referral forms (see Additional Resources under step 5 for examples).
   iv. Conduct clinic process changes for referrals (PDSA, lean management, etc.).
   v. Conduct Plan-Do-Study-Act cycles (PDSAs) to make desired changes.
   vi. Finalize ideal process for referrals in clinic.

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

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

5. Train staff on new referral process

A. Present new process to clinic staff and get input.
B. Conduct provider/staff training on clinic referral process/protocols, available resources and how to use the “Power User” features of MNHelp.Info to access saved favorites list (Saved Plans), conduct keyword searches and create printable directories (Saved Directories).

C. Work with individual partner clinics on saving favorite resources, integrating into referral processes, and provide staff/provider training.

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

6. Implement new referral process and resource database

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

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

**Resources**
- SHIP Health Care Provider Toolkit for Obesity and Chronic Disease Prevention. Initial toolkit to contain brief (1-2 pages) information on referral resources to include: 1) Evidence based community interventions (reimbursement), 2) list of current referral databases/directories, and 3) select other resources from ICSI guidelines or otherwise. To access this toolkit, please contact SHIP Health Care Strategy Coordinator Cherylee Sherry, MPH, CHES at Cherylee.Sherry@state.mn.us
- Referral and Prescription Forms:
  - Let’s Move (Appendix PP)
  - AIM-HI Prescription (Appendix QQ)
  - Parks Prescriptions:
  - Prescribing Public Lands for Health
    http://www.youtube.com/watch?v=ZfiT7kH_KQY
  - Exercise is Medicine:
7. Evaluate implementation of new referral process and resource database

A. Conduct baseline assessment of number of referrals and track increase (including the Call It Quits Fax Referral program).

B. Collect outcome and process measures and report progress towards goal and aims.

C. Review ongoing clinic progress and provide updates to clinic staff and providers at meetings.

D. Assist clinic to conduct continuous quality improvement to increase referrals to resources.

*Potential Milestones*
- Assessment tools completed
- Survey/ focus group of clinic staff completed

**Step 4: Follow-Up**

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

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

As relationships and communication between clinicians, in-house and community resources, and patients grow, clinics should implement systems that ensure consistent follow-up between medical visits to assess participation in programs to which patients were referred. This allows the clinician to assess progress, learn about and resolve barriers, and suggest additional or different activities. Community organizations should be encouraged to play a role in following-up with patients by communicating outcomes with clinics. Clinics can arrange partnerships with agencies to take on the responsibility of the referral by reporting back to the clinic via a referral form.
Clinical-Community Linkages for Prevention – last updated 6/2013

**Outcome**
Clinics/community organizations track patient access and utilization of referral resources. Patient follow-up is completed with evidence documented of patient utilization of referral and/or behavior change.
- **Definition of Policy for Follow-Up**: Relationship between clinics and referral entities grows; communication infrastructure is established and allows feedback on referrals to flow between clinicians and clinical, community and self-management resources.

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

**Implementing Step 4: Follow-Up**

1. Develop new process for tracking referral utilization and behavior change (for each type of referral utilized for the clinic)
   - **A.** Review survey feedback on clinic referral process completed in step 3.
   - **B.** Incorporate clinic needs assessment and build on existing referral work plan. Types of referrals may include:
     i. Clinical referrals (e.g., case manager, dietitian, health coach, physical therapy)
     ii. Community referrals
     iii. Non-profit organization referrals (e.g., YMCA, health plan)
     iv. Private organization referrals (e.g., Weight Watchers)
     v. Self-management resources or programs (e.g., home-based exercise handouts, personal diet or exercise regimen)
Potential Milestones
- Clinics have incorporated activities into their action plans for increasing follow-up on referrals for at-risk patients
- Follow-up process training complete for clinic staff and use integrated into practice within 6-12 months

Additional Resource
- See Step 3 Referral Resource Lists

2. Create necessary forms to support referral follow-up tracking process (or electronic eLinks system can be used for electronic referral from EMR or MNHelp.Info)

A. Assist with chart flag/ pop-up and or clinician note template for referral follow-up creation.

B. Conduct a trial or pilot follow-up call/discussion interview model.

C. Conduct follow-up process PDSA review and make necessary changes.

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

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

3. Implement referral follow-up process

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

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

4. Evaluate referral follow-up process

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

B. Review ongoing clinic progress and provide updates to clinic staff and providers at meetings.
C. Assist clinic to conduct continuous quality improvement on referral and follow-up process.

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

*Potential Milestones*
- Evaluation of first 6 months of follow-up process completed

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

**Sustaining Long-Term Change**

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

*Potential Milestones*
- Policy written
- Policy shared

**Resources**
- Chapter 7. The Evidence for Evidence-Based Practice Implementation, Marita G Titler [http://www.ahrq.gov/professionals/clinicians-provider/resources/nursing/resources/nurseshdbk/TitlerM_EEBPI.pdf](http://www.ahrq.gov/professionals/clinicians-provider/resources/nursing/resources/nurseshdbk/TitlerM_EEBPI.pdf)

**Innovations or Promising Practices**
The following are examples of Innovations or Promising Practices for the Clinical Community Linkage strategy:
1. Support the use of health care extenders (i.e. health educators, community paramedics, 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.

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

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

**Advancing Public Health, Health Care and Community Linkages with State and Federal Health Reform Initiatives Strategy**

As MDH considered revisions to the SHIP 3.0 menu of health care strategies, staff took into consideration how the health care scene has changed since the inception of SHIP when the original health care strategies were developed. These changes include:

- Development of health care homes within primary care clinics. They are intended to incorporate clinical preventive services for persons with chronic and complex conditions;
- Maturing of Minnesota’s health reform strategies that are having an impact on changing clinical practices to achieve improved health outcomes (e.g. public reporting; transition from volume-based reimbursement to reimbursement for outcomes; etc.);
- Increased awareness of evidence-based chronic disease self-management programs, although not always accessible in some communities;
- Enactment of federal health reform, which has included a focus on prevention as well as the emphasis on clinical and community linkages;
- Recent CMS award of the 3-year State Innovations Model (SIM) grant to Minnesota, which among other actions, intends to support the building of Accountable Communities for Health in 15 communities. This represents an opportunity for LPH to serve as a catalyst in bringing together citizens to shape the future system of care in their communities.

**Scope of Component**

To purposefully insert the expertise of LPH into the health reform discussions at the community level in order to bring added value to the overall goals of improved population health.
Phase 1: Planning and Assessment
- Partner with local hospital(s) in conducting their community needs assessments

Resource
Association for Community Health Improvement (ACHI) http://www.assesstoolkit.org/
Models of Community Engagement
http://www.health.state.mn.us/communityeng/intro/models.html

Phase 2: Growth
- Reach out to local certified health care home clinics or clinics working to obtain health care home certification to participate on clinic’s community health team

Resources
MDH Health Care Homes http://www.health.state.mn.us/healthreform/homes/
MN Community Health Worker Project
http://www.health.state.mn.us/ommh/projects/chw.html
MN Community Health Worker Alliance http://mnchwalliance.org/
Hennepin Tech Community Paramedic Program
http://www.hennepintech.edu/customizedtraining/cts/44#&panel1-1

Phase 3: Innovation and Promising Practices
- Act as a catalyst in bringing together citizens and organizations to shape the future system of health care in the community.
- Grantees will create an action plan for the activity (s) they intend to address.

Resources
Minnesota Area Health Education Centers
http://www.mnahec.umn.edu/regions/home.html

Accountable Communities for Health – To be selected in 2014
http://www.health.state.mn.us/healthreform/sim/minnesotaaccountablehealthmodels ummary.pdf

Requirements

The grantees will be required to:

- Work on both strategy components
- Complete the baseline data collection survey with each of the clinic partners. MDH will provide an electronic link to access the survey. To review the SHIP 2.0 baseline data collection survey, check the Health Care section from the following link
  http://www.health.state.mn.us/healthreform/ship/evaluation2.html.


• Use evidence-based programs when assisting to build infrastructure for referrals. The following evidence-based community interventions have been proven effective in promoting the skills needed to build self-efficacy in self-management of health behaviors. These programs include:

  o Lifestyle Balance programs (i.e., Diabetes Prevention Program or I CAN Prevent Diabetes) – modest 5-10 percent weight loss by increased physical fitness, improved diet, increased self-monitoring and self-care
  o Chronic Disease Self-Management Program – demonstrated increase in physical activity and healthy eating
  o Arthritis Self-Management Program – demonstrated increase in physical activity and healthy eating
  o Matter of Balance – demonstrated increase in physical activity
  o Arthritis Foundation Exercise and Warm Water Exercise programs – increased physical activity
  o Tobacco cessation Quit Lines (i.e. MN Clinic Fax Referral Program)

• Participate in regular learning meetings established by MDH. The meetings are yet to be determined.
• Participate in monthly conference calls which will be separated into those new to health care and those who have been working on health care in SHIP 2.0.

**Recommended Partners and Potential Responsibilities**

*Minnesota Department of Health (MDH)*

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

*Local Public Health (LPH) (referred to in this document as “grantees”)*

- Recruit health care partners.
- Conduct baseline assessment, analyze results and share findings with planning groups.
- Develop or identify resources that support strategy implementation including surveys, clinician materials, EMR measures, sample policies, etc.
- Work with clinic partners to identify or develop in-house, home-based and community-based referral resources.
- Identify and/or develop referral and follow-up processes.
- Offer technical assistance and on-site training for clinic partners as needed.
Clinic Partners (For SHIP 3.0 health care partners will be referred to as “clinic partners,” whether it is technically a clinic or a health care site.)

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

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

**Clinical-Community Linkage Strategy:**

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

Community-Based Partners

- Community programs and resources that can assist patients in reaching their goals and/or provide social support for lifestyle change. This could include groups such as YMCA, YWCA, church groups, youth centers, senior centers, commercial gyms, community education programs, Minnesota Extension Programs, Area Agencies on Aging, programs designed for individuals with particular chronic conditions such as I/We CAN Prevent Diabetes Program, Chronic Disease Self-Management Program (CDSMP), Arthritis Foundation exercise programs and warm water exercise, extension education efforts, walking groups, etc.
- Community-based health or social service coalitions such as local breastfeeding coalitions, ATOD, Obesity Prevention, Tobacco Cessation, others.
Training and Technical Assistance
See the separate SHIP 3 Guide to Training and Technical Assistance for an overall picture of training and technical assistance.

Grantees will be required to participate in monthly conference calls which will be separated into those new to health care and those who have been working on health care in SHIP 2.0.

MDH will provide technical assistance for the infrastructure development of the following programs: I Can Prevent Diabetes and the Chronic Disease Self-Management Program.

Grantees can make requests for training and technical assistance through the TA request process (see the SHIP 3 Guide to Training and Technical Assistance).
Appendices

The following appendices can be accessed at:
http://www.health.state.mn.us/healthreform/ship/Implementation.html under “Health Care Appendices by Topic.”

A: 5A Concepts and SHIP Prevention in Health Care Steps
B: SHIP Prevention in Health Care References
C: SHIP Prevention in Health Care Talking Points
D: SHIP Prevention in Health Care Terminology and Abbreviations
E: Sample Recruitment Letter
F: Sample Recruitment Information - Overview of the Strategy
G: Dr. Neal Holton and Dr. Sofi Ali’s PowerPoint Presentation
H: UDS and HEDIS Measures
I: Minneapolis MGI Health Care Work Group Model
J: Health Care Provider/Staff Focus Group – Informed Consent
K: NACC Mpls-Hennepin Sample Policy
L: Anoka County Public Health Nursing Breastfeeding Sample Policy
M: Minneapolis SHIP Resource and Referral Network Clinic Action Plan template
N: Clinic Action Plan Tracking Tool
O: Carver-Scott Health Care Action Plan template
P: SHIP Lifestyle Risk Tool
Q: Health Behavior Assessment
R: 5-2-1-0 Healthy Habits Survey
S: Your BMI Handout
T: MDH PDSA Storyboard Template
U: MDH PDSA Worksheet
W: Collaborative Decision-Making and Brief Interventions
X: Referral and Resource Key Informant Interview Themes
Y: MNHelp.Info Inclusion Criteria
Z: Resource Database Attributes and Values
AA: MDH SHIP Guide 2008 List of Evidence-Based Resources
BB: MNHelp.Info SHIP Information Sheet
CC: MNHelp.Info Excel spreadsheet template
EE: MNHelp.Info PowerPoints-MHI Provider Portal Instructions
FF: MNHelp.Info Saved Plans Guide
GG: MNHelp.Info Keyword Search Guide
HH: Resource and Referral Network Aggregate Baseline Assessment Findings
II: Resource List Examples
JJ: Warm Hand-Off Process Map
KK: Referral Form Examples - Health Living Minneapolis
LL: Referral Form Examples - Lifestyle Action Plan (Hennepin County)
MM: Referral Model Grid
NN: Health Care Referral and Follow-Up Model Map
OO: MN Tobacco Fax Referral Process
PP: Referral and Prescription Forms - Let's Move
QQ: Referral and Prescription Forms - AIM-HI

References

4 Prevention Institute, How Can We Pay for A Healthy Population? Innovative New Ways to Redirect Funds to Community Prevention, January 2013
7 Barr VJ, et al. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Hospital Quarterly. 2003. Vol 7(1); 73-82.