HEALTHYLIVING
MINNEAPOLIS

COMMUNITY RESOURCES FOR EVERYONE

Clinic Name

Date

Patient Name

My Healthy Living Goals

- ❑ Eat 5 servings of fruits & vegetables each day
- ❑ Exercise at least 30 minutes each day
- ❑ Other _____

Know your BMI

- ❑ Underweight: BMI < 18
- ❑ Normal Weight: BMI 18.5 - 24.9
- ❑ Overweight: BMI 25.0 - 29.9
- ❑ Obese: BMI >=30.0

National Heart, Lung and Blood Institute, NIH guidelines

Clinician Signature

Patient Signature*

**HealthyLiving Minneapolis organizations may tell my health provider(s) about my participation in programs or services.*

Ideas for Healthy Living

- Walk or bike at your local park or trail
- Go to a healthy cooking class
- Get fresh vegetables at your farmer's market
- Join your local fitness facility or sports team
- Take an exercise or dance class

Where to Go

See reverse side for a list of community resources to meet your Healthy Living goals or go to www.MNHelp.Info and search for "HealthyLiving Minneapolis."

Community Resources for Everyone

Healthy Living Minneapolis Network

Call for more details on locations and programs available through HealthyLiving Minneapolis.

Healthy Food:

- ❑ Minneapolis Farmer's Markets – 3-1-1, www.minneapolismn.gov/sustainability/MplsFarmersMarkets
- ❑ Fare for All – 1-800-582-4291, www.emergencyfoodshelf.org/ourfamilyofprograms/ffa

Healthy Eating Classes:

- ❑ Minneapolis Community Education – 612-668-3939, www.mplscommunityed.com
- ❑ Minneapolis Parks and Recreation Centers – 612-230-6400, www.minneapolisparks.org

Exercise:

- ❑ Minneapolis Community Education – 612-668-3939, www.mplscommunityed.com
- ❑ Minneapolis Parks and Recreation Centers – 612-230-6400, www.minneapolisparks.org
- ❑ YMCA of Metropolitan Minneapolis – 612-371-8740 (Downtown), 612-827-5401 (Blaisdell), www.ymcatwincities.org
- ❑ YWCA Minneapolis – 612-230-9622, www.ywca-minneapolis.org

Minneapolis City of Lakes

MINNESOTA'S VISION A Better State of Health

Statewide Health Improvement Program | SHIP

2011, Minneapolis Department of Health & Family Support funded through the MN Department of Health's Statewide Health Improvement Program.

Rx for Healthier Living

IDEAS FOR HEALTHIER LIVING

5 Eat at least 5 fruits and vegetables every day.

2 Limit screen time (for example, TV, video games, computer) to 2 hours or less per day.

1 Get 1 hour or more of physical activity every day.

0 Drink fewer sugar-sweetened drinks.
Try water and low-fat milk instead.

MY HEALTHY LIFESTYLE GOALS

- ☐ Eat _____ fruits and vegetables each day.
- ☐ Reduce screen time to _____ minutes per day.
- ☐ Get _____ minutes of physical activity each day.
- ☐ Reduce number of sugared drinks to _____ per day.

LET'S MOVE!

America's Move to Raise a Healthier Generation of Kids

www.LetsMove.gov

Patient name

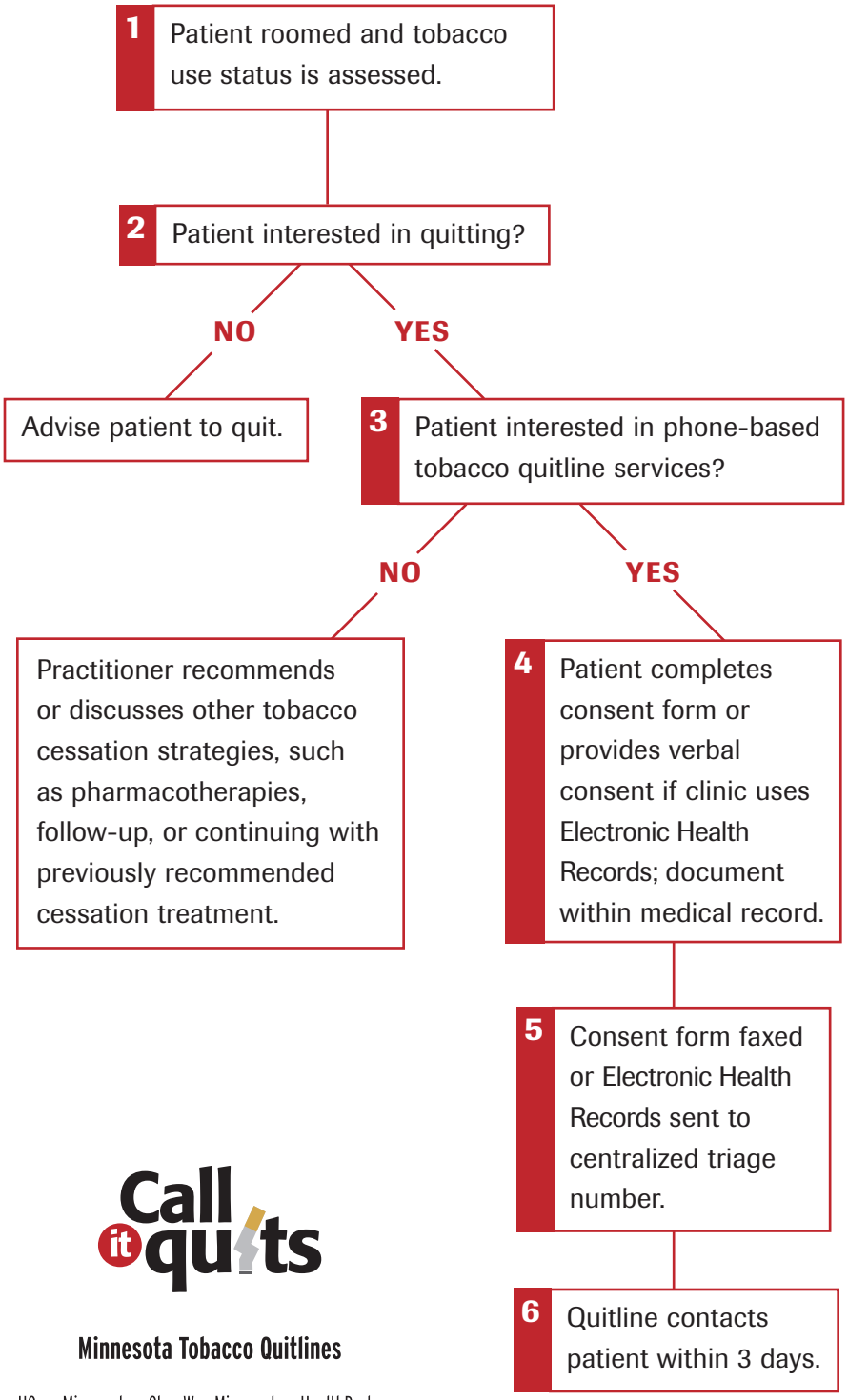
Patient or Parent/Guardian signature

Doctor signature

Date

MN CLINIC FAX REFERRAL PROGRAM

Clinic Fax Referral Process



Call it quits

Minnesota Tobacco Quitlines

UCare Minnesota • ClearWay Minnesota • HealthPartners
Metropolitan Health Plan • Medica • PreferredOne • MMSI
Blue Cross and Blue Shield of Minnesota

Step-by-Step Process

1. Patient visits clinic. Ask patient if he or she uses tobacco.
2. If yes, advise the patient to quit and assess his or her willingness to try.
3. If patient is interested in quitting, briefly explain about the tobacco quitline (free, professionals give practical tips and strategies for quitting, follow-up calls, much better chance of quitting vs. on your own).
4. If the patient is interested in using quitline services, sign him or her up for the program by having the patient complete the middle section of the form. NOTE: Be sure to have the patient sign and initial, giving permission for the quitline coach to call. If your clinic uses Electronic Health Records, create an order for tobacco cessation and obtain verbal consent from the patient; document within medical record.
5. Give the signed form to the designated contact person in your clinic. The contact person will fax the form to the centralized triage number.
6. After the quitline contacts the patient, your clinic will receive a follow up fax providing information on the outcome.

Phone-based tobacco quitline services are available to ALL Minnesotans

F9120 (8/07) This message funded by Blue Cross and Blue Shield of Minnesota, an independent licensee of the Blue Cross and Blue Shield Association.

MN CLINIC FAX REFERRAL PROGRAM

Frequently Asked Questions

Q. What is the MN Clinic Fax Referral Program?

A. The MN Clinic Fax Referral Program allows you to easily refer any of your patients to appropriate tobacco quitline services via a single form. When you advise patients to quit smoking or using tobacco, you can connect them to practical, effective help with this program. A quitline coach proactively contacts your patient who is interested in quitting after you receive the patient's consent to refer him or her to the quitline. The MN Clinic Fax Referral Program is supported by the collaborative, Call it Quits.

Q. What is Call it Quits?

A. Call it Quits is a collaboration among seven of Minnesota's major health plans (UCare Minnesota, HealthPartners, Metropolitan Health Plan, Medica, PreferredOne, MMSI, Blue Cross and Blue Shield of Minnesota) and ClearWay Minnesota (the state-funded quitline for uninsured and underinsured). The goal of this collaboration is to make it easier for you to connect your patients to appropriate tobacco quitline services.

Q. How does the referral program work?

A. As you talk about tobacco use during a clinic visit, you can offer your patient the option of having a quitline coach call as a resource to support quitting. If your patient agrees and signs a consent form, the clinic faxes the information to a centralized triage number. (If your site uses Electronic Health Records you will create an order for tobacco cessation instead of filling out a consent form.) A trained coach from the quitline, appropriate to that patient's health care coverage, will then contact the tobacco user.

Q. Does the patient's health plan affect whether or not I can refer? What if the patient is uninsured?

A. Everyone in Minnesota can take advantage of a quitline that offers personal support – whether or not they are covered by a health plan. The MN Clinic Fax Referral Program connects each referred patient to the appropriate quitline services.

Q. What about confidentiality?

A. Your patient is signing a consent form (verbal okay if your site uses Electronic Health Records) that allows the quitline to contact him or her and to share the intervention results with the clinic. The consent does not authorize release to any other parties. The consent form complies with all HIPAA regulations.

Q. What is the cost?

A. All of the tobacco quitline phone support services are FREE.

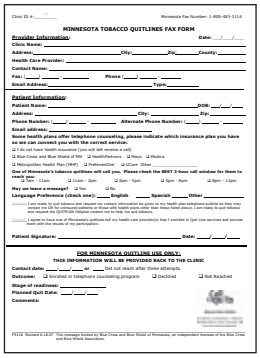
Q. Who do I contact if I have questions?

A. Contact your clinic administrator.

MN CLINIC FAX REFERRAL PROGRAM

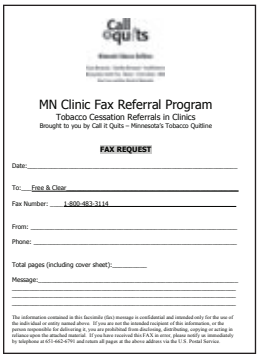
REGISTRATION/ORDER FORM

Starter Kit includes all items below (provided at no charge).


MINNESOTA TOBACCO QUITLINES FAX FORM

Consent Form
(8 1/2" x 11")

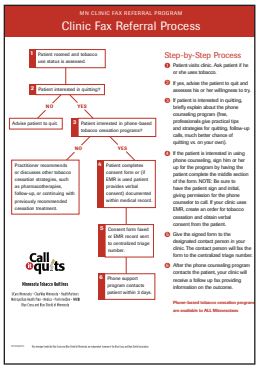
Personalized with your clinic name, address & unique Clinic ID#.


MN Clinic Fax Referral Program
Tobacco Cessation Referrals in Clinics
Brought to you by Call it Quits - Minnesota's Tobacco Quitline

FAX REQUEST

Fax Cover Sheet
(8 1/2" x 11")

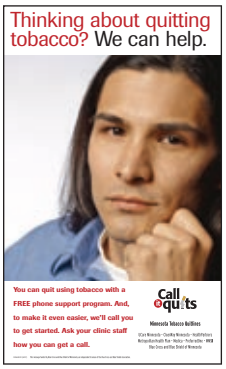
HIPAA Requirement (Clinic may use own Fax cover sheet)


MN CLINIC FAX REFERRAL PROGRAM
Clinic Fax Referral Process

Clinician Fact Sheet
(double-sided, 8 1/2" x 11")

Shows workflow process and answers to frequently asked questions.

Patient Take Away
(double-sided, 3 1/2" x 8 1/2")



Poster
(11" x 14")

Reorders:

Clinic ID#_____

❑ Consent Form (.pdf file)

❑ Fax Cover Sheet (.pdf file)

❑ Patient Takeaway (F8662) Qty: _____

❑ Poster (F8563) Qty: _____

Clinic Information:

Clinic Name and Site: _____

Address: _____ City: _____

County: _____ ZIP: _____

Contact Name (Clinic Admin): _____

Phone: ( ) _____ Fax: ( ) _____

E-mail Address: _____

Clinic Type: ❑ Medical ❑ Dental ❑ Behavioral Health ❑ Public Health ❑ Other

Send to:

Fax form to: (651) 662-2375

Mail form to: Blue Cross and Blue Shield of Minnesota
S113
P.O. Box 64560
Eagan, MN 55164-0560

For more information, contact Kim Winter at (651) 662-6879, kim_winter@bluecrossmn.com.

Call it quits

Minnesota Tobacco Quitlines

UCare Minnesota • ClearWay Minnesota • HealthPartners
Metropolitan Health Plan • Medica • PreferredOne • MMSI
Blue Cross and Blue Shield of Minnesota

X16675R01 (12/07) This message funded by Blue Cross and Blue Shield of Minnesota, an independent licensee of the Blue Cross and Blue Shield Association.

Clinic ID #:_____ Minnesota Fax Number: 1-800-483-3114

MN CLINIC FAX REFERRAL PROGRAM
MINNESOTA TOBACCO QUITLINES FAX FORM

Clinic Information: **Date:** ___/____/____

Clinic Name: _____

Address:_____ **City:**_____ **Zip**:_____ **County:**_____

Health Care Provider: _____

Contact Name: _____

Fax: (_____) _____ - _____ **Phone** (_____) _____ - _____

Email Address:_____ **Type:**_____

Patient Information:

Patient Name: _____ **DOB:** ___/___/____

Address: _____ **City:** _____ **Zip:**_____

Phone Number: (_____) _____ - _____ **Alternate Phone Number:** (_____) _____ - _____

Email address: _____

Some health plans offer telephone counseling, please indicate which medical insurance you have so we can connect you with the correct service:

❑ I do not have medical insurance (you will still receive a call)

❑ Blue Cross and Blue Shield of MN ❑ HealthPartners ❑ MMSI ❑ Medica

❑ Metropolitan Health Plan (MHP) ❑ PreferredOne ❑ UCare Other _____

One of Minnesota's tobacco quitlines will call you. Please check the BEST 3-hour call window for them to reach you:

❑ 7am - 11am ❑ 11am - 2pm ❑ 2pm - 5pm ❑ 5pm - 8pm ❑ 8pm - 11pm

May we leave a message? ❑ Yes ❑ No

Language Preference (check one): _____ English _____ Spanish _____ Other _____

(initial)_____ I am ready to quit tobacco and request my contact information be given to my health plan telephone quitline so they may contact me OR for uninsured patients or those with health plans other than those listed above, I am ready to quit tobacco and request the QUITPLAN Helpline contact me to help me quit tobacco.

(initial)_____ I agree to have one of Minnesota's Quitlines tell my health care provider(s) that I enrolled in quitline services and provide them with the results of my participation.

Patient Signature: _____ **Date:** ____/____/____

(or parent/personal representative optional)

FOR QUITLINE USE ONLY:

THIS INFORMATION WILL BE PROVIDED BACK TO THE CLINIC

Contact date: ____/____/____ **or** ____ Did not reach after three attempts.

Outcome: ❑ Enrolled in telephone counseling program ❑ Declined ❑ Not Reached

Stage of readiness: _____

Planned Quit Date: ____/____/____

Comments:

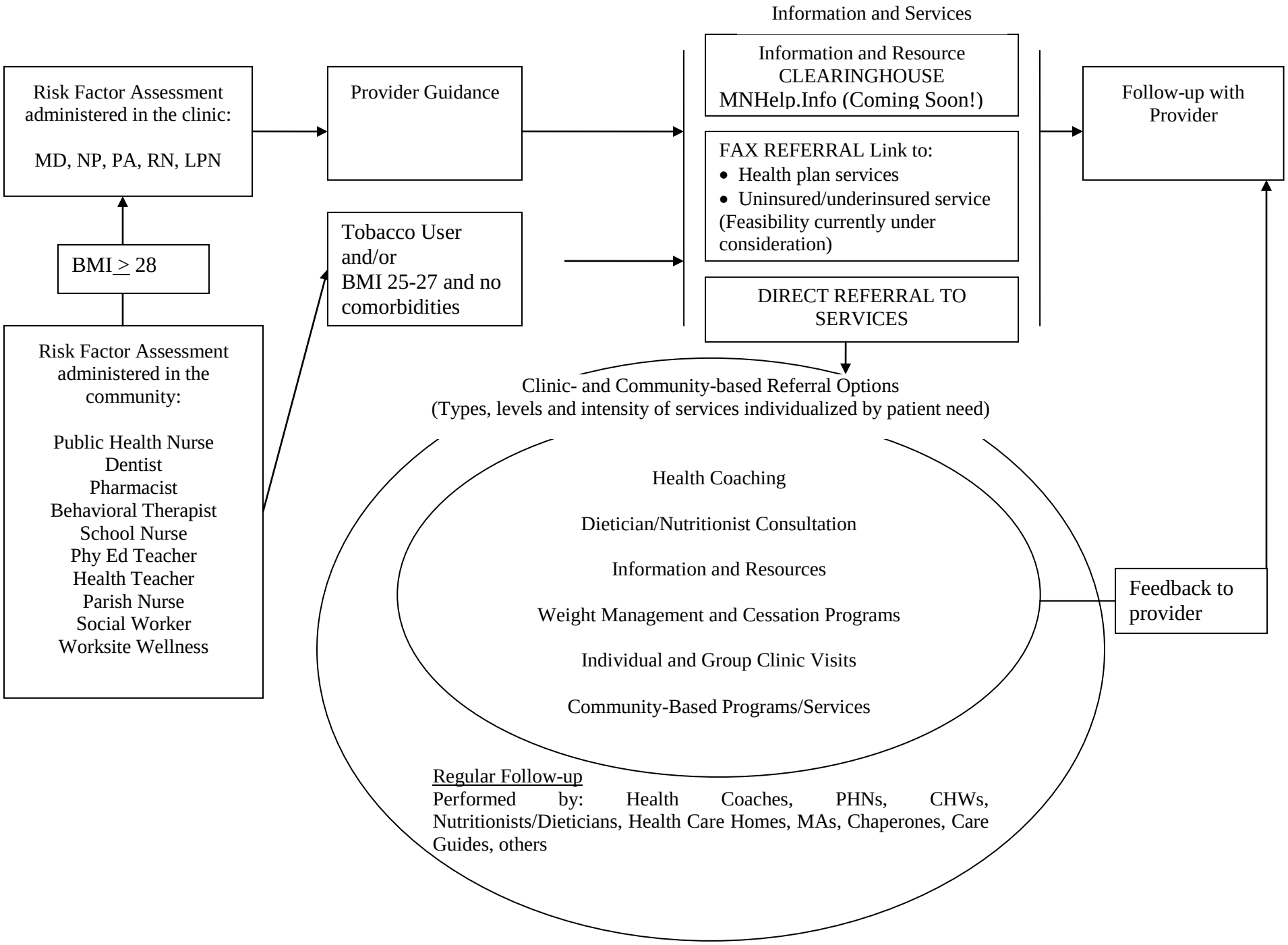
Call it quits

Minnesota Tobacco Quitlines

UCare Minnesota • ClearWay Minnesota • HealthPartners
Metropolitan Health Plan • Medica • PreferredOne • MMSI
Blue Cross and Blue Shield of Minnesota

F9118 Revised 8.1.07 This message funded by Blue Cross and Blue Shield of Minnesota, an independent licensee of the Blue Cross and Blue Shield Association.

Minneapolis SHIP Health Care Referral and Follow-Up Model



Referral/Follow-up Model Comparison Grid

Referral/Follow-up Model	Description	Pros	Cons	Cost/Reimbursement	Current Usage Demographics	Literature Support
Phone Wellness/Health Coach Models						
MN Fax Referral Program	Call It Quits Fax Referral program is a fax referral program for registered clinics to refer clients to phone counseling services. Providers fax the referral to the main triage center where the helpline is managed and the referral is directed to the appropriate health plan services, uninsured patients are directed to Quitplan services. The corresponding health plan vendor or Quitplan contacts the patient to offer phone counseling services. Call It Quits is a group of representatives from health plans, MDH and the quit lines that meet quarterly.	• Patient does not have to make the next step to call the Quitline • Providers do not have to rely on the patient to make the next step • Providers do not have to keep track of quit line phone numbers to give to patients • Referral can be automated into clinic systems (referral systems, decision models, etc)	• Many registered clinics are not actively referring through the fax referral program • Clinic may still need to designate a staff person to process fax referrals	• Estimated cost for development is approx. $200,000. Ongoing administrative costs approx $40,000 per year. • Administrative cost to the health plans is $6-10 per referral. • Cost per enrollee is $150-300 and determined by health plan services. Cost is covered by health plans or Clearway and includes cost of medication. • Clinics can receive up to $15,000/year in pay for performance for referrals	• Insured and uninsured Minnesotans addicted to tobacco, majority English or Spanish speaking • Approx. 3000 individuals in Minnestota were referred in 2009. • In 2009, 71 out of 186 registered Henn Co clinics referred patients. Of patients referred in Henn Co Clinics in 2009, 24.9% enrolled (208 pts enrolled / 834 pts referred). % quit? • According to SHAPE, in 2006, approx. 191,878 individuals in Henn Co smoked, which accounts for 17.1% of Henn Co population.	Charles J Bentz, et al. "The Feasibility of Connecting Physician Offices to a State-Level tobacco Quit Line" Am J Prev Med 2006;30(1)). The study describes an effort in Oregon to link provider offices with state quit lines. Since referral quitlines have been shown to be effective in assisting patients with tobacco cessation, the study sought to show that providers and phone counseling could work in tandem. The authors found that linkage of provider offices was feasible and potentially cost effective; however, they also recognized limitations in the state quitline model such as higher levels of integration with pharmacotheraphy potentially provided by plan-sponsored quit lines. Shelley and Cantrell. "The effect of linking community health centers to a state-level smoker's quitline on rates of cessation assistance." Hlth Serv Research 2010; 10(25). The study provided a training with providers at intervention sites in which they taught providers how to refer patients to the state fax referral system. At intervention sites, use of the fax referral system promoted greater adherence to asking, assessing, advising and assisting related to tobacco use. Intervention training and use of the fax referral system also resulted in greater rates of referral to the fax helpline over time as well as likelihood of offering nicotine pharmacotherapy. Lawrence C An et al. "A Randomized Trial of a Pay-for-Performance Program Targeting Clinician Referral to a State Tobacco Quitline" Arch Intern Med 2008; 168 (18). The authors of this study found that pay for performance could be used successfully with clinics to promote referrals of patients to fax referral lines for tobacco cessation. Of note, the study stratified by past involvement of clinics with quality improvement activities and found (1) little or no difference between intervention/control clinics with high past QI activity and (2) relatively large differences between intervention/control clinics with low past QI activity.
Minnesota Tobacco Quitlines	Minnesota's tobacco phone counseling programs can be accessed by calling the corresponding health plan toll free number or by calling Quitplan. Quitplan services are funded by Clearway MN and provides service for anyone not covered by a health plan. Quitplan will triage callers to their corresponding health plan tobacco counseling program. Each health plan provides their own phone counseling and tobacco cessation services. Quitplan also offers options for in-person counseling and online self management.	• Providers have one phone number to give patients for tobacco cessation resources, regardless of insurance provider or status • Patients have access to a phone number for tobacco cessation services outside of their clinic	• Patient must make the first contact • Providers do not receive follow-up information on patient referrals to the phone line	• Cost per enrollee is $150-300 and determined by health plan services • Clearway is unable to provide cost per uninsured/underinsured because budget for helpline services includes a variety of things, including cost of NRTs, etc.	• Insured, underinsured, and uninsured Minnesotans addicted to tobacco, majority English or Spanish speaking • Specific usage demographics available through each health plan • Clearway is unable to provide usage demographics for the purpose of this comparison grid	Telephone counseling has been shown to be an effective means of tobacco cessation. The US Department of Health and Human Services taskforce on tobacco use recommends that telephone counseling be used, if possible, as a supplement to care provided in a clinical setting. The taskforce also recommends that practical (problem-solving) advice be given and follow-up interventions be scheduled.
Phone Based Health Coaching	Phone based health coaching or disease management coaching services are provided by most health plans in Minnesota for some of their members. Health coaches provide phone based motivational messages on health and wellness, self-management skills, education, and resources.	• Health plan members can access individualized health coaching services and resources outside the clinic setting • Patients can call their health plan to see what health and wellness services are available to them	• Only available to some members, mainly self-insured employer groups • Cost, quality, and services differ across health plans and members	• Free to eligible health plan members • Cost to health plans and employers?	• Insured, mainly self-insured employer group members • % insured that have access?	Telephone counseling has been shown to be effective for improvement of fruit and vegetable intake and reduction of dietary fat intake. It has likewise been shown to be effective for increasing levels of physical activity. Telephone counseling has been shown to be effective when delivered by a range of professionals, from masters level public health students to nurses and registered dieticians.
Electronic Linkage System (eLinkS)	Electronic decision support and referral system for providers to assess, counsel and refer. The system refers to a community based counselor that contacts the patient for group counseling, telephone counseling, or computer care. The counselor can enter progress notes into an electronic system that updates the EMR.	• Electronic system is all encompasing of the 5A's and provides clinical decision support and tools for the provider • The system provides an array of counseling options for patients	• Referrals and enrollment in counseling significantly decline when patients are asked to pay for counseling services. • New services would need to be created to support this model	• The cost of developing the actual system is not specified. The counseling cost was covered by grant funding.	• The initial medical practices that implemented the system are only using the system for telephone tobacco counseling since other counseling services are not funded.	http://www.innovations.ahrq.gov/popup.aspx?id=2121&type=1&name=print

Referral/Follow-up Model Comparison Grid

Referral/Follow-up Model	Description	Pros	Cons	Cost/Reimbursement	Current Usage Demographics	Literature Support
Internal Care Coordination and Referral Models						
ICSI Diamond Initiative	Evidence based collaborative care model for primary care management of adults with depression. Patients are screened for depression by provider and referred to care coordinator for enrollment in DIAMOND if meet eligibility criteria. Trained care coordinator (MA, LPN, RN, Social Worker, Dietician, CHW) provides follow-up, monitoring, and assistance with resources for depression, chronic conditions and community resources.	• Weekly follow-up by care coordinator • Consulting psychiatrist to review care coordinator caseload and advise primary physician regarding changes in treatment • Coverage of services by single DIAMOND billing code, fees negotiated by health plan and medical group, paid monthly • Model proven to lower health care cost and provide financial benefits by getting employees back to productive work	• Some clinics report that this is an expensive program for clinics to absorb even with reimbursement by health plans	• Reimbursement fees negotiated between health plan and medical group and paid on a monthly basis • Costs to run the program are estimated at roughly $50 - 70 per patient per month • The program costs the medical group to implement in the first year. The second and third year, it is close to cost neutral. The fourth year, there is cost savings of roughly $400 per patient per year. This is "total cost of care" dollars (like ER and hospitalizations, etc.) - not direct dollar savings to the medical group.	• As of March 2010, 85 DIAMOND family practice clinics in MN • Enrollees are adults with a diagnosis of major depression with a PHQ-9 score of 10 or above	Care coordination has also been found to be an effective avenue toward improvement of patient outcomes in primary care settings at least when aimed at improving care for depression. In a 2002 article, investigators published the results of an RCT which showed that among 18 clinics, introduction of a patient care manager (usually a mid-level provider such as a nurse or psychologist -- application of the IMPACT model of care) to coordinate patient care significantly improved patient outcomes. Later meta analyses of generalized collaborative care models suggest that these improvements are appreciable in both the short and long term. Studies have also shown that this model of care management and coordination is effective in 'actual practice' -- i.e. the study reviewed results of a program implemented at several Kaiser Permanente clinics.
Health Care Home	Health Care Home (HCH) is a primary care approach for coordination of chronic conditions involving providers, families, and patients. Each clinic will provide coordination of care and services for patients with severe chronic conditions. Payment models have recently been developed in MN for reimbursement of care coordination for providers.	• Clinic reimbursement for care coordination and management of chronic, severe, and complex conditions requiring care coordination • Many clinics already planning to be HCH for patients with chronic conditions, so fits with ICSI guidelines	• Self-insured and Medicare are not payers for HCH •Only required for chronic, severe, and complex conditions • Currently not for prevention, only severe chronic conditions	• With an average of 200 case management patients, reimbursement will equal approx $75,000/year.	• Patients with severe, chronic conditions requiring case management	
Community Health Worker	Community Health Worker's (CHWs) main role is to reinforce disease related education given by a provider and provide referrals and outreach. CHWs help patients improve appropriate access and usage, promote healthy behavior, prevent and manage disease and chronic conditions, and comply with care mandates.	• CHWs can work under MD, RN, APRN, Dentists, CPHRN, and soon MH providers • Referral and scheduling to other services can result in decreased no shows and cancellations • Competent in language, culture, and community	• CHW reimbursement is currently only available for DHS (MHCP) enrolled providers working with DHS (MHCP) enrolled CHWs • FQHCs cannot bill for CHW services based on financial status • There are currently no contracts for billing with commercial insurance or home health services • Community based organizations and home health cannot currently access funding • CHWs cannot treat, assess, give medication, or provide primary teaching	• CHW reimbursement is about $25/hour	• MHCP enrolled clinics with MHCP enrolled CHWs • Currently 17 registered CHWs billing through 12 different provider sites • MHCP covered patients, generally low income and needs based	Models of patient counseling based on brief interventions by physicians have included community health workers whose roles are to provide "booster" phone calls. In this way, 3-5 minutes of physician counseling followed by a CHW booster phone call have been shown to increase physical activity by 30 minutes/week among intervention groups. Additional studies have shown CHWs to be effective in other domains, such as infectious disease.
Licensed Dietician or Nutritionist (enrolled with MHCP)	(see also billing matrix) The role of the dietitian includes health teaching and case management for clients who have been referred by a prescribing health care provider. May be employed by hospitals, public health, clinics, or an individual physician.	• MHCP Reimbursable Services include evaluation, follow-up, and group counseling prescribed by a physician. Billing codes are: 97802, 97803, 97804, G0270, and G0271. • Eligible recipients are MA, GAMC and MNCare clients.	• Reimbursable only when prescribed by a physician, advanced practice registered nurse, clinical nurse specialist, nurse practitioner, nurse midwife, or physician assistant. • MNT services may be provided in a physician's office, clinic, or outpatient hospital setting. Medical necessity must be documented in the recipient's medical record. ·May not be available at all public health agencies.			Significant research supports the effectiveness of licensed dieticians' and nutritionists' counseling efforts toward increasing fruit/vegetable intake among clients. Effective interventions have been shown to include not only face to face counseling, but also telephone counseling, web-based counseling and community based multi-component interventions.
Physicians and weight loss services	(see also billing matrix)	MHCP Reimbursable Services covers physician visits, medical nutritional therapy, mental health services, and laboratory work provided for weight management. Services must be billed by enrolled providers on a component basis with current CPT codes. For medical nutrition therapy assessment/intervention performed by a physician see "Evaluation and Management" or "Preventive Medicine" service codes 99201 - 99499.				Studies have shown that providers who offer brief counseling or motivational interviewing for patients (3 - 10 minutes during and office visit) are able to alter patient behaviors -- e.g. diet, physical activity levels and tobacco cessation.
External Care Coordination and Referral Models						
Public Health Nurse	The role of the Public Health Nurse (PHN) includes disease investigation, health teaching, and case management among individuals and families who are members of vulnerable populations and high risk groups. In every setting, the PHN focuses on the prevention of illness, injury or disability, the promotion of health, and maintenance of the health of populations. (see also billing matrix)	• MHCP Reimbursable Services, in the clinic or home setting, include health promotion and individual and group counseling (S9123.22; S9445/S9446), nursing assessment and diagnostic testing (S9123.22; T1015), medication management (S9123.22; T1015), and nursing treatment (S9123.22; T1015). • Medica is interested in exploring this option. • PHNs are competent in language, culture, and community.	• PHN reimbursement is currently only available for MHCP clients. • Private health plans (i.e. BC/BS) do not recognize Public Health Nurse Clinics (PHNC) as a provider.	• Amount billed to PHNC for T1015 is $15 per 15 minutes. Reimbursed at $12.56 per 15 minutes.	• MHCP clients (MSHO/MSC+) • Low-income • Pregnant women and children (WIC) • All children ages 3-6 (ECS) • High risk population groups	Studies of public health nursing and case management programs have been shown to be effective in a variety of areas. Strong support exists for nurse-led case management models, showing cost effectiveness (by reduction of need for acute care or additional follow-up care) and effectiveness -- e.g. reduction of low birth weight and caesarian section rates in nurse-led perinatal case management studies. Effective strategies for reduction of racial and ethnic disparities have been found to be: Multifaceted Programs, A Focus on Cultural Relevancy, Nurse-led Programs.
Community Health Educator Referral Liaison (CHERL)	CHERLs serve as community based self-management support for patients. The CHERL provides telephone based support to patients including motivational interviewing, connection to resources, and follow-up with referring primary care provider. The CHERL also helps clinics improve processes to screen, assess, and refer patients; develops relationships with community organizations; and fills gaps when there is a lack of resources. The CHERL can be a nurse, health educator, dietician, or other allied health professional.	• CHERL provides one phone number or one fax number for providers to use as a referral resource • The CHERL supports the clinic in making referrals, patients in completing referrals, and creates connections with community resources • The CHERL can be a number of types of providers				http://www.genesys.org/Internet/Web/CherlWeb.nsf/0/D6F1029D52FC564B85257516005CA8CB http://www.innovations.ahrq.gov/content.aspx?id=2244

Referral/Follow-up Model Comparison Grid

Referral/Follow-up Model	Description	Pros	Cons	Cost/Reimbursement	Current Usage Demographics	Literature Support
Other Agency Specific Models						
Allina Robina Care Guide	Non-clinical care guide in clinic to help patients with congestive heart failure, diabetes, and hypertension. Care guide meets with the patient to go over the provider orders, prioritize provider instructions, set measureable clinical goals (e.g. BP level) and sign a contract to reach those goals. Administrative duties only, meet with patient, follow-up with them over the phone, help locate resources as necessary. May be part of the overall medical home model in future for Allina.	• Pilot study found increase in reaching clinical goals for blood pressure, heboglobin A1C, eye exam, microalbuninuria test, ACEI and ARB use, LDL, and smoking. Findings were the same across age, sex, race, insurance, education level, language, care guidke, and pre-existing views of care. • Cost savings of care guide as compared to ED Visits or hospitalization.	• Model is focused on chronic disease management and clinical goals. Not sure if this is translatable to behavior change and goals for physical activity and nutrition.	• Grant funded pilot study. Cost for each patient is $384/year.	• Currently piloted at one urban Allina medicine clinic with 332 patients with hypertension, diabetes, and congestive heart failure. • To be expanded to 5 additional Allina clinics (urban/rural/suburban) in summer 2010 with a randomized controlled trial of patient education only versus patient education plus care guide.	• Chronic Care Model (Wagner, Seattle) • Teamlet model (bodenheimer, San Francisco) • 15 medicare demonstration projects
Cultural Wellness Center Health Navigator	Health navigators have familiarity with the community and cultrually specific approaches to build capacity of a person to go to resources and negotiate the system. Health naviagators focus on wellness of an individual and helps patients understand the system to know where to go for help.	• Focuses on wellness and buildling capacity for patient to find resources in the future • Culturally specific approach	• Specific activities of this model are unclear	• Cultural Wellness Center contracts with hospitals		
HCMC Chaperone Model	Follow-up care model at HCMC within the Cardiology group. HCMC chronic disease patients receive a chaperone which is a lay staff person (not necessarily a nurse or MA) call the patient to follow-up with them regarding appointments and follow-up care. This model has not been proven yet, but is promising. Additionally, it is being used for for titrating drugs, etc...however, it is also being used for secondary prevention (as these patients have already had heart attacks), so they are using it for physical actiivty, smoking cessation, etc.	• Less burden on medical staff to follow-up with patients on next steps and appointments. Lower cost for folllow-up using lay staff. • Secondary prevention model around risk factors could potentially be translated to primary prevention.	• Model is for chronic disease patients and has not been applied to other populations • Chaperone provides limited assistance with finding and contacting resources, mainly provides reminders and information to patient.	• HCMC cardiology group attempting to get funding for through grants.	• HCMC cardiology chronic disease patients.	
Primary Care Access Initiative Project (HCMC and St. John's)	DHS funded project at HCMC, St. John's, and St. Joe's to connect patients in the Emergency Department to primary care clinic "home" that is culturally appropriate, etc. ED refers patients who present with non-emergent medical or dental needs to the PCAI staff which is on site during most day and eventing hours. Care navigation program uses a software program to connect patients to primary care, provides assistance and enrollment for NHCN, apply for MHCP if approprate, patient leaves the ED with an appointment, some outpatient care navigation, follow-up with no show appointments and reconnect people, work with community partners to refer to appropriate resources.	• Good model for referral, care navigation, and follow-up	• Model is hospital based to divert people from the ED to primary care so the software program may not be translatable to community resources.	• DHS funded from November 2008 to June 30, 2010. Portico is working on plans for sustainability of the program.	• ED patients at HCMC, St. John's, and St. Joe's with primary care needs for medical and dental. About half of the patients served are uninsured and about half are enrolled in MHCP. • 70-75% single males, 19-47, unemployed, uninsured.	
Philly Health Community Health Information and Resource Specialists (CHIRS)	The Philly Health Info Internet Portal is a multifaceted web portal of quality health and medical information available to residents of Greater Philidelphia. The portal was piloted as part of STEPS project in which health information and resource kioks were integrated into delivery of primary care services. The kiosk at each clinic is staffed 16 hours per week by a trained community resident to provide patients with health information and community resources. The kiosk and web portal are available for patient use when it is not staffed, but the patient does not receive assistance.	• The community residents manning the kiosk are aware of relevant behaviors and cultural norms (as residents themselves) • The model of using a community resident to provide health information and resources decreases the demand on trained health professionals to provide this service	• Kiosk is only staffed16 hours per week at each clinic • The relationship of the community resident and the health care professional is not clear • Although trained, the expertise of the community resident may not be appropriate for some health referrals	• Costs related to equipment and supplies (computer, printer, literature) • Clinics had barriers in creating and maintaining infrastructure for additional computers, internet and • Volunteers were plentiful, but they did not always keep constantly busy and were not always available when needed (limited hours)	• Was initially implemented in 6-10 clinics, not sure of long term kiosk use	http://www.thefreelibrary.com/Philly health info: the college of physicians of Philadelphia's ...-a0131499689 Kenyon, Andrea. (2005, January 1). Philly health info: the college of physicians of Philadelphia's regional community health information project The Free Library. (2005). Retrieved October 05, 2010 from http://www.thefreelibrary.com/Philly health info: the college of physicians of Philadelphia's ...-a0131499689

Miscellaneous Notes from Literature Review

A review of dietary interventions among 92 individual studies found that behavioral change was most likely to occur among participants when two common programmatic threads were present: goal setting and small group therapy

Among all 4 risk domains targeted by SHIP -- tobacco, diet, physical activity and alcohol -- a common theme in the literature seemed to be that behavioral change was best accomplished through face-to-face counseling or motivational interviewing.

The most extensive research on behavioral change therapies have been conducted for tobacco cessation. In that domain, multiple clinician types have been found to be effective-- e.g. physicians might initiate intervention with brief discussion and prescription of pharmacotherapy after which non-medical professionals follow up with counseling. Researched strategies from most to least effective are: group behavioral therapy, pharmacotherapy, intensive physician advice, individual counseling, nursing interventions and tailored self-help programs.

Native American Community Clinic

Your name:_____

Lifestyle Assessment How are you doing?

Check the boxes that are true for you.

Be Active	Eat Healthy	Manage Stress	Be Tobacco Free
			
☐ I walk ____ minutes, ___ times a week. ☐ I spend ___ hours a day watching TV, video games, or on the computer. ☐ I do yard or house work ____ times a week. ☐ I exercise at the gym or at home ____ times a week. ☐ Other activity (describe): _____ **How am I doing:** __ I'm doing great. I don't need help. ___ I'm ready to be more active and would like help. ___ I'm not sure I'm ready to be more active, but I'm ready to talk. ___ I'm not interested at this time.	☐ I eat ____ servings of fruit or vegetables every day. ☐ I eat fast food or restaurant meals ___ times a week. ☐ I eat junk food (chips, cookies) for snacks or meals ___ times a day. ☐ I drink ___ sugary drinks (pop, juice, energy drinks) each day. ☐ I eat when I am not hungry for emotional reasons ___ times a week. **How am I doing:** ___ I'm doing great. I don't need help. ___ I'm ready to eat better and would like help. ___ I'm not sure I'm ready to eat better, but I'm ready to talk. ___ I'm not interested at this time.	☐ My physical or emotional health kept me from doing my usual activity ___ days in the past week. ☐ Feelings of stress, sadness, or anxiety affected my ability to enjoy and manage my life ___ days in the past week. ☐ I participated in a spiritual or cultural activity that gave me emotional strength ___ times in the past month. **How am I doing:** ___ I'm doing great. I don't need help. ___ I'm ready to manage stress better and would like help. ___ I'm not sure I'm ready to manage stress better, but I'm ready to talk. ___ I'm not interested at this time.	☐ I smoke ___ cigarettes a day. ☐ I live or work in a place where others smoke cigars, cigarettes, or a pipe (outside of ceremonial use). ☐ I am trying to quit. ☐ I am trying to cut down. ☐ I worry about gaining or am gaining weight since I quit/cut down. **How am I doing:** ___ I'm doing great. I don't need help. ___ I'm ready to cut down/quit smoking and would like help. ___ I'm not sure I'm ready to cut down/quit smoking, but I'm ready to talk. ___ I'm not interested at this time.

3/19/10

Native American Community Clinic

What's the big deal about my weight?

Serious Health Conditions Related to Being Overweight:

- Diabetes, type 2
- High blood pressure
- Heart disease and stroke
- Elevated LDL "bad" cholesterol and triglycerides
- Cancer (colon, breast, uterine, and prostate)
- Osteoarthritis (knees, hips)
- Sleep apnea and other respiratory problems
- Gallbladder disease
- Low-back pain
- Depression and low self-esteem
- Social discomfort

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

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

Native American Community Clinic

My Action Plan

I (my name) _____ and my provider, _____
agree I will do this in the next _____weeks/months:

Follow-up appointment or call date: _____

My BMI _____ **My Weight today:** _____ **Date:**_____
□ **My weight loss goal:** _____ **by**_____ **(**___ **pounds per week)**
□ **My weight maintenance goal:** _____
□ **My next office visit/phone call:** _____

1. Choose one thing to do better	2. Check one NEW thing to do or do better. (Small steps make a BIG difference.)		3. Describe what you will do:
Be Active 	□ Walk___minutes, ___ x per week □ Get up and move for 10 minutes, ___ times a day □ Move when watching TV or a movie, walk, dance, stretch, jump rope	□ Use the stairs and add more steps to and from the car, store, school □ Limit screen time (TV, computers) □ Do more of what you love (dancing, hiking, sports) □ Other:	**What?** **How much?**
Eat Healthy 	□ Eat a healthy breakfast □ Limit the size of food servings □ Cut down or stop sugary drinks □ Eat out less: ___ times/week □Eat lean meat: fish, chicken, turkey	□ Eat more fruits or vegetables □ Eat more whole grains and beans □ Eat less junk food (chips, desserts, fried foods) □ Decrease fat in diet (cheese, dressing, mayonnaise) □ Other:	**When?** **How often?**
Manage Stress 	□ Limit junk food, alcohol, tobacco □ Stretch, deep breathe, meditate, pray □ Take time every day to relax: read, walk, play music, do beading, sew □ Get help from a mental health provider or trusted friend.	□ Stay in touch with friends and family □ Sleep 7–9 hours at night □ Talk or write about my feelings □ Talk with my doctor if pain or sadness interfere with sleep, daily life, or enjoyment □ Other:	**How sure are you that you can do this?** |_____|_____| Not sure bit sure Very sure **What might stop you from doing this?**
Be Tobacco Free 	□ Avoid places or situations that make me feel like smoking. □ Cut down to ___ cigarettes per day. □ Set a firm quit date □ Learn to manage my stress better	□ Try nicotine replacement to reduce my cravings □ Get help from my doctor and/or a quit program. □ Other:	**Who can help you do this?**

Your signature: _____ **Date** _____ **Provider signature** _____ **Date** _____

Native American Community Clinic

Where You Can Get Help…This is where you can get help to make small steps.

4. If you chose to do this:	5. Choose at least one thing you are willing to try out for _____weeks.	6. What I will do next:
Be Active 	□ **Running Wolf Fitness Center** 612-721-6631, Ext. 214 □ **NACC Walkers** 612-872-8086, Ext. 124 (Adrienne Voorhees) Wednesdays and Fridays from 9:30–11:30 a.m. at MAIC Gym. Lunch provided. □ **Midtown YWCA** □ **Other:**	
Eat Healthy 	□ **NACC Nutrition Service** 612-972.8086, Ext. 112 (Shannon) □ **Living in Balance** at NACC: 612-872-8086, Ext. 116. Six-week lifestyle class □ **Other:**	
Manage Stress 	□ **NACC Counseling Services** 612-238-0747 □ **Living in Balance** at NACC: 612-872-8086, Ext. 116 (Connie) Six-week lifestyle class. Incentives and food provided. □ **Running Wolf Fitness Center** 612-721-6631, Ext. 214 Tai Chi and Yoga classes offered. *(See monthly class schedule.)* □ **Other:**	
Be Tobacco Free 	□ **Mashkiki Waakaaigan** 612-871-1989 □ **Minnesota Quit Plan** 1-888-354-7526 □ **Indigenous Peoples Task Force** 612-870-1723 □ **Inter-Tribal Elders Services** 612-724-6499 Elder health advisors are available for support. □ **Other:**	

Minnesota's Vision A Better State of Health Statewide Health Improvement Program | SHIP

Hennepin

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

AIM-HI FITNESS PRESCRIPTION

Patient name:_____ Date:___/___/_____

	Physical Activity	Healthy Eating	Emotional Well-Being
Opportunity (What do I want to do?)			
Goal (My target)			
Dose (How much, how often?)			
Benefits (What's in it for me?)			

Personal Goal(s):_____

☐ Use the Food & Activity Journal and bring it back to the next visit.

For more information visit www.familydoctor.org.

Next follow-up visit scheduled for:_____

Physician signature: _____

Patient signature: _____

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

AIM HI
Americans In Motion - Healthy Interventions

AAFP Catalog Order #1997

YOUR PERSONALIZED FITNESS PRESCRIPTION

Just like any other prescription, individuals should know what is being prescribed, why, how to take it and any side effects or warnings. With this in mind, consider these points.

BRAND NAME: Fitness

GENERIC NAMES: Physical activity, healthy eating, emotional well-being

INDICATIONS: Effective for treating low energy, stress and boredom; prevents undesired weight gain; helps manage a healthy weight; helps improve long-term health conditions like high blood pressure or high cholesterol; helps prevent potential chronic health problems like diabetes and heart disease.

BENEFITS: Increased energy, manage or maintain weight, more mindful decision-making, improved eating habits and appetite, better self-image and confidence, improved sense of well-being.

SIDE EFFECTS: Be in charge of your life; feel stronger, healthier and more youthful; have a more positive outlook; find balance in all areas of your life; develop lasting, long-term changes for improved health.

PRECAUTIONS: Talk to your family doctor before making any major changes.

DOSAGE: Start small, increase slowly and repeat often. Adjust to fit your needs.

WARNING: Likely to become habit-forming when used regularly!

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