

# Integrating Primary Care Practices and Community-based Resources to Manage Obesity

## *A Bridge-building Toolkit for Rural Primary Care Practices*

### **Prepared for**

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AHRQ is the lead Federal agency charged with supporting research designed to improve the quality of health care, reduce health care cost, address patient safety and medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use and access. The information helps health care decision-makers – patients and clinicians, health system leaders, and policy makers – make more informed decisions and improve the quality of health care services.

## Foreword

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I am a practicing family physician, and my clinic schedule is dominated by patients with complex health conditions that are not easily addressed in the routine physician-directed 15-minute office visit. This includes the sixty percent of my patients who are obese or overweight. My perception is that I routinely address weight as a health risk, but I have not assessed whether my actions support this perception. My sense is that although there is an occasional weight loss success story, I am not having much of an impact across my patient population which is reflected in my enthusiasm and approach to obese patients.

The literature confirms that primary care physicians such as me are not doing well in getting patients to lose weight. Obesity is a chronic illness where the social determinants of health have considerable impact. Sharing responsibility and resources for the management of this chronic illness has considerable promise. How do primary care clinicians and their practices find community resources to partner with in improving obesity rates in their communities?

The *Bridge-Building Toolkit*, developed by the Oregon Rural Practice-based Research Network and the Agency for Healthcare Research and Quality for primary care practices to manage obesity, provides tools and concepts that have been informed by the real world of six primary care practices in three rural Oregon communities. The toolkit moves patients from an individual practice-based “rope bridge” to the modern day suspension bridge that is able to support the traffic and weight of an entire population of patients at risk to reach effective community resources.

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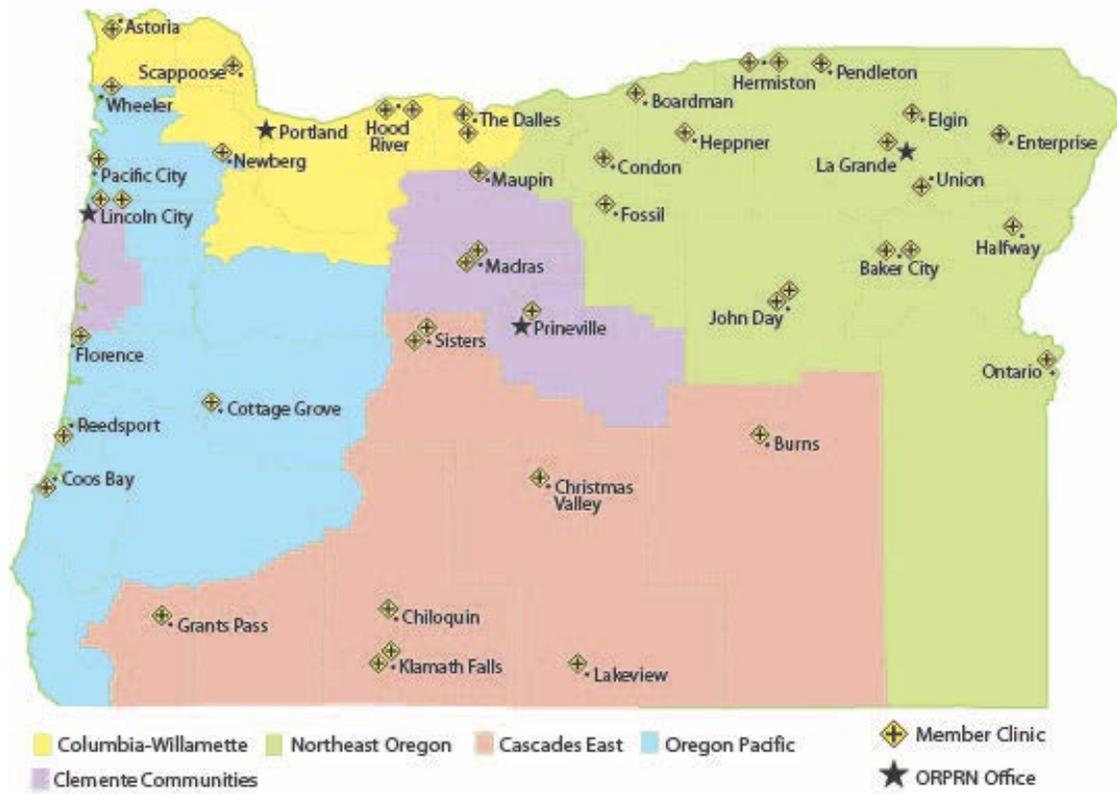
## Oregon Rural Practice-based Research Network (ORPRN)

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ORPRN was established in 2002 with the mission *to improve the health of rural populations in Oregon through conducting and promoting health research in partnership with the communities and practitioners we serve*. In 2010, network membership included 161 clinicians and 49 primary care practices located in 37 rural communities throughout the State of Oregon.

ORPRN is directed by a steering committee of 9 rural Oregon primary care clinicians. The network has its main headquarters at Oregon Health & Science University (OHSU) in Portland, Oregon with five regional offices staffed by Practice Enhancement and Research Coordinators (PERCs) that are distributed across the State. See **Figure 1**.

ORPRN research focuses on chronic disease prevention, practice transformation, and health services research in primary care and community settings. ORPRN also engages in community-based participatory research (CBPR) with our rural clinic and community partners to address the social determinants of health. Find additional information about ORPRN and our research at <http://www.ohsu.edu/orprn/>.



**Figure 1: ORPRN Regions, Primary Care Clinic Members, and Intervention Communities**

## **Suggested Citation**

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## Why Was This Guide Developed?

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Managing and treating obesity is particularly challenging for primary care practices. Although evidence suggests the potential for improving eating and physical activity behaviors by effectively linking primary care practices and community resources, establishing such linkages may be *especially challenging in rural areas*, where limited availability of and access to services may compound standard barriers.

In 2010 the Oregon Rural Practice-based Research Network (ORPRN) received funding from the Agency for Health Care Research and Quality for research into “Integrated Primary Care Practices and Community-based Programs to Manage Obesity.” Over a 2-year period we worked with eight primary care practices and community-based health coalitions in four rural Oregon communities to:

1. Evaluate local clinic and community factors necessary to develop sustainable linkages between primary care and community resources for obesity management, and
2. Design, implement, and evaluate a participatory process using practice facilitation and community-health development principles to achieve these linkages.

We used the findings from this 2-year process to develop this toolkit to help other primary care clinics that want to improve linkages with community-based resources for obesity management. This process highlights strategies to build on the ties that often already exist in rural areas. Although our process is tailored to rural settings, we anticipate that many of the strategies will be beneficial for urban practices and communities to consider. This toolkit offers key steps in our process, providing tools and recommended steps that we encourage you to adapt to fit your local setting.

## Quick Start Guide

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Much has been written about the need for practice transformation and improved connections between primary care and community resources following the Institute of Medicine’s *Crossing the Quality Chasm* report.<sup>2</sup> This toolkit is designed to help you cross a “chasm” in your own community by building bi-directional linkages (a bridge) between your primary care clinic and community-based resources that can help your patients maintain or achieve a healthy weight.

This toolkit describes a series of process steps and provides tools (resources) that will allow you to accomplish the following five tasks.

Task	Chapter	Page Number
<ul style="list-style-type: none"><li>Obtain buy-in from practice clinicians and staff to improve the care you provide to overweight and obese patients.</li></ul>	Chapter 1. Attaining Zoning and Building Permits for the Bridge	3
<ul style="list-style-type: none"><li>Measure and assess your clinic’s current performance in obtaining an accurate height, weight, and Body Mass Index from patients.</li></ul>	Chapter 2. Building and Assessing the Clinic Foundation	8
<ul style="list-style-type: none"><li>Provide brief interventional counseling to patients to determine and enhance their level of readiness to change.</li></ul>	Chapter 3. Getting Patients Excited About Crossing the Bridge	11
<ul style="list-style-type: none"><li>Identify and build relationships with community-based resources to support patient referral.</li></ul>	Chapter 4. Building the Community Foundation	17
<ul style="list-style-type: none"><li>Create a systematic mechanism to refer patients to community-based resources that provides appropriate feedback.</li></ul>	Chapter 5. Crossing the Bridge and Returning	20

We found that when these five tasks are accomplished, a “bridge” will exist between your practice and community-based resources for obesity management and health behavior change. This bridge can help you improve the quality of care and enhance the services your patients receive.

Your clinic may have already accomplished some of these tasks. If so, review the chapter briefly for pointers or skip the chapter and move to a section your clinic is ready to tackle.

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*Like a real bridge, linkages between your clinic and community resources will require continued investments in time and resources once established.*

*This toolkit will help you meet that challenge!*

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## Introduction

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*“Sometimes it is not enough for the doctor to just say “lose weight”; sometimes you have to be shown how to do it.”* Rural Community Focus Group Member

### **A Case Study: Ms. Smith**

Ms. Smith, a middle aged mother of two that you’ve cared for over the past 15 years, is waiting in the exam room for a medication check-up. She’s pre-diabetic, hypertensive, and about 45 pounds overweight, but otherwise healthy. You’ve helped Ms. Smith manage her hypertension with medication over the past 3 years and have warned her about the gradual increase in her laboratory blood sugar levels means. You’ve even tried a little motivational interviewing to see if you could help Ms. Smith think about improving her diet – but she says she’s too busy right now working full time at the school, raising two kids, and caring for her mother who has mild dementia.

You think that many of Ms. Smith’s health issues could be resolved if she were to focus on improving her diet, engaging in regular exercise, and returning to a healthier weight. However, you also realize the sensitive nature of the discussion about obesity. Before entering the exam room you quickly review her medical record. You note that only hypertension is present in the problem list so you add pre-diabetes. You see Ms. Smith was weighed today, but no height was taken and BMI was not calculated. However, your “eyeball test” tells you that Ms. Smith is obese. Just before you knock on the exam door your medical assistant reminds you that you are running behind schedule. You address the main reason for the visit with Ms. Smith (medication check-up) and move on to the next patient.

***What didn’t happen?*** There was no discussion of diet and nutrition as part of Ms. Smith’s visit – despite the clinician’s interest and the patient’s need. National data indicates that conversations around diet and nutrition occur in only 12.2% of visits, and only 8.5% about exercise and 3.7% for weight reduction.<sup>3</sup> This is a missed opportunity to help patients make lifestyles changes that may prevent development of chronic disease and improve management of multiple existing conditions.

***Why didn’t it happen?*** There are many reasons why primary care clinicians and staff may not address obesity, exercise, diet, or nutrition during the clinical encounter. Some may include:

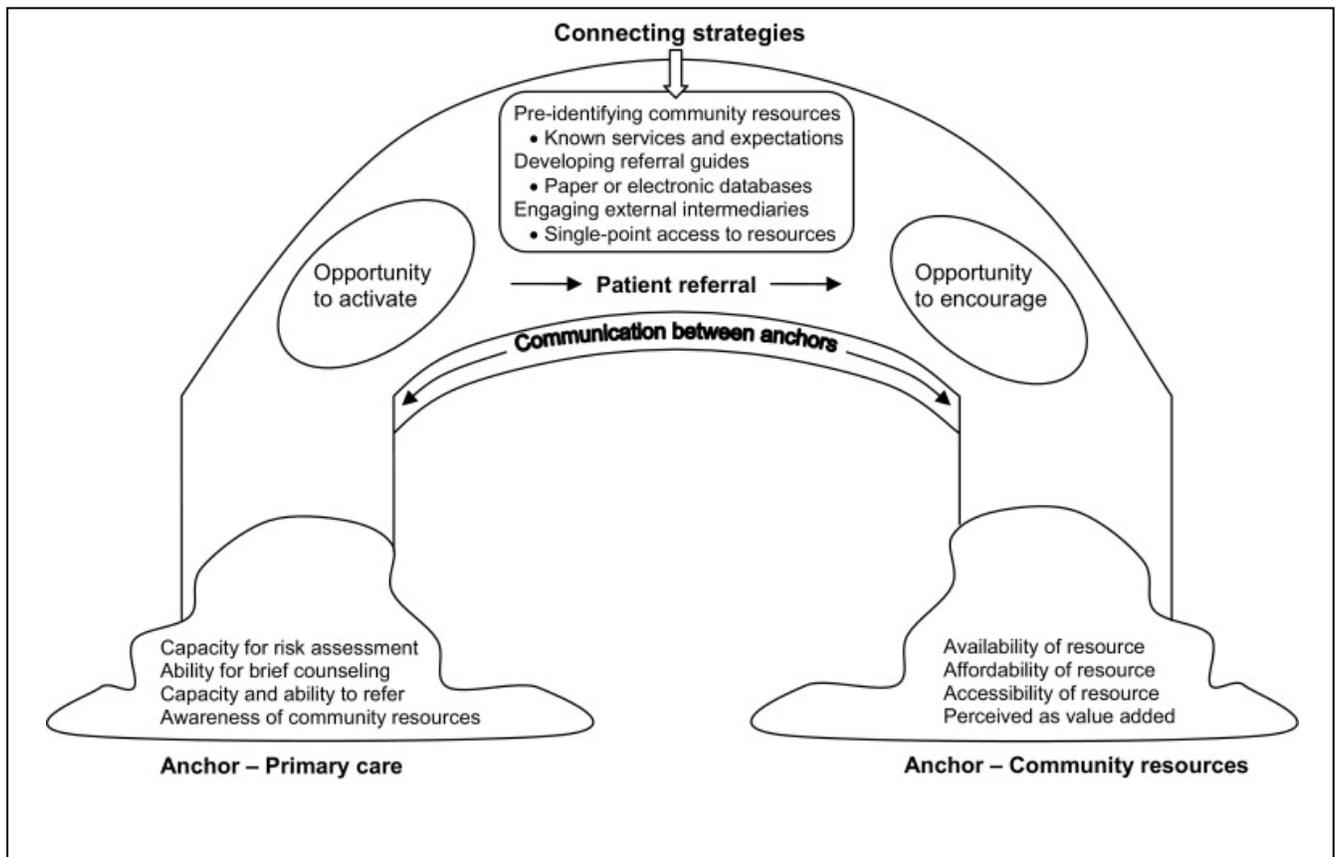
- Not having enough time during the encounter,
- Inadequate reimbursement for health behavior change counseling,
- Thinking that you won’t have an effect on patient behavior,
- Lacking ready solutions to help the patient,
- Fearing that the discussion may lead your patient to seek care from another clinician/clinic, or
- Perhaps you, like 60% of American adults, are overweight or obese.

### **What Can Your Practice Do?**

Primary care is well positioned to coordinate care by identifying patients who need to make health behavior changes (such as around weight management, dietary habits, or physical activity), offering brief counseling, and referring to more intensive counseling and support resources as needed. There is growing evidence that making a referral to community-based resources dedicated to the treatment and management of overweight and obesity may help. This toolkit is designed to help you bridge this gap between primary care and community-based resources.

## Theoretical Framework for Building Clinic and Community Resource Bridges

Etz and colleagues (2009) created the model for bridging the gap between primary care clinics and community-based resources for health behavior change based on findings from the Robert Wood Johnson Foundation Prescription for Health Initiative.<sup>4</sup> Effective linkages (i.e., bridging) requires foundational characteristics in the clinic as well as in the community-based resources – or what Etz and colleagues called “anchors.” Once you’ve built the anchors, you can construct the “deck” of the bridge, which represents the connecting strategies. **Figure 2** summarizes these critical bridging components.



**Figure 2. Bridging Primary Care and Community Resources: Model Elements (Reproduced with permission from Etz et al., 2008)**

This toolkit elaborates on the Etz et al., (2008) model by describing the blueprint our team used to build bridges between rural primary care clinics and community-based resources for obesity management. Throughout this toolkit we present both simple designs and more complex approaches – but all are just sample blueprints. **Many types of bridges can be built with different materials or designs, and you will need to determine the model that works best for your unique clinic and community context.** For example the Brooklyn Bridge, Golden Gate Bridge, and a small bridge crossing a creek all achieve the same goal but have different external structures.

A community focus group member said: “Sometimes it’s not enough to tell someone [to lose weight]; sometimes you have to be shown how to do it.” The same is true with building clinic/community linkages. You have the inspiration – now let’s allocate resources and put in the work!

## Chapter 1: Attaining Zoning and Building Permits

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Before engaging in this bridge building process, it is imperative to examine your clinic's readiness to undertake the project. Start by considering why change is needed from both the clinic and patient perspectives. The obesity epidemic is well documented. The devastating effect of obesity on overall health status is known as well. Diet and exercise are contributing behaviors to preventing heart disease, cancer, stroke, diabetes, mental illness, and overall morbidity and mortality.

Many patients know that being overweight is not good for their health. However, change is hard without the support of family, friends, workplaces, and community. **They need your help.**

As you determine whether your clinic is ready, note that to change an activity of an organization four things should be in place: leadership, data, a process plan, and allocated resources. This chapter deals with **leadership and activities to help attain buy-in from clinic staff.** We emphasize:

- Assessing Clinic Readiness for Change and Leadership Support
- Developing Strategies to Support Process Leadership
- Building Clinic-wide Engagement

This bridge-building project relies on *local knowledge and relationships*. A clinic's staff is generally comprised of community residents and all may have something to contribute to the effort. Sometimes starting to build a change process around a smaller issue can set a strong foundation for future clinic activities. Helping build a bridge may foster positive momentum for practice improvement.

### **Assessing Clinic Readiness for Change and Leadership Support**

Below are some common factors that may positively or negatively affect the process of change in your clinic. They include: low energy level; obesity among clinic staff; multiple contributing factors; fixating on cost; mission statement; collaborative efforts; and clinic spirit. *Clinics should understand, evaluate, and address these factors to help move the process forward.*

**Low Energy Level (Change Fatigue).** Scientific journals call the energy and capacity for a clinic to do something other than maintain the status quo an "adaptive reserve."<sup>5</sup> You can assess this by thinking about the following questions:

- Does the clinic keep abreast of evidence-based medicine standards and make a serious effort at staying educated?
- Is the clinic willing to commit time beyond the basic requirements?
- Is [this] change seen as an opportunity or a threat?
- Does the clinic encourage and embrace new projects, programs, and ideas?
- Are the clinic's decisions and actions proactive or reactive?
- Do you as a leader find your role fulfilling, challenging, and enjoyable?

If you answered negatively to three or more of the questions, ask yourself: Can this bridge-building process serve to re-energize the group and restore enthusiasm? If resources are adequately allocated, it just might!

**Obesity Among Clinic Staff.** In more than 10 years of experience working with rural primary care practices, we have found that clinicians and staff normally reflect demographics and health characteristics of the community as a whole. That means some of the clinic's employees are likely

overweight or obese, and this may present barriers to implementation. You might consider, from an employer human resource perspective, what your clinic can do to encourage increased physical activity and improved nutrition in the workplace. Demonstrating that you are committed to helping your staff live a healthy lifestyle (and achieve a healthy weight in the process) may inspire your patients to do the same.

**Multiple Contributing Factors (It's Outside Our Scope of Practice).** Another sign of inadequate readiness is a group's unwillingness to accept some responsibility for a problem. As the issue of obesity is discussed, do you or your staff look for other conditions or institutions to blame? This might include easy access to fast food restaurants, mass marketing advertising that encourages "supersizing," poor school nutrition programs, the Federal government's farm policies and commodity subsidizations, inadequate parenting, or the time people spend watching screens (e.g., internet, video games, television).

These factors do contribute to the obesity epidemic. But, don't throw up your hands and surrender. As a cornerstone of your community's health system, you can do your part to address the problem. There are many opportunities to get involved in local policies that help contribute to a social environment that supports making the right choices about obesity for your community. As a leader in the local health system, you can do your part within the clinic setting; in addition, many evidenced policies have been identified by the Centers for Disease Control (CDC) that you may support or help implement in the broader context of the obesity issue. A link to the CDC Community Guide is in the resources section.

**Fixated on Cost.** Cost is always an issue, but it is important to stress the potential value of such an endeavor compared with the costs. Your leadership team should ask: What is the cost of building the bridge to community-based resources for obesity management? Time to participate in planning meetings and do the work is one of the most pressing costs – and these costs vary by clinic staff positions. One key opportunity is to match tasks to staff skills and expertise. Staff not directly involved in patient care might fill some of the important linkage roles with limited additional costs. For example, front desk staff may be willing and enthusiastic about identifying, describing, and communicating with community resources.

Opportunity costs are also involved. You could be doing other work to improve patient health behaviors rather than connecting with resources. Each practice will need to consider the costs and benefits of this work and how they align with overall organization goals.

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*When someone says, "It's not the money, but the principle," it's usually the money.*

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**Aligned Mission Statement.** Clinics often have a mission statement that reads akin to: "We provide the highest quality care in a patient-centered, compassionate manner." Providing the highest quality of care and building a relationship with a patient is the intrinsic motivator for most clinicians. This process can help fulfill your mission.

**Building on Other Collaborative Efforts.** Has your clinic integrated mental health services or made connections to dental resources? Does the clinic have a history of collaborating with public health organizations, schools, or human service groups? Is your clinic implementing care coordination as part of your Patient Centered Medical Home (PCMH) initiatives? If so, your clinic already has created

numerous bridges to community-based resources. Developing these relationships demonstrates that you can be successful.

Clinics might also review processes to make referrals to many other subspecialty clinicians and health care institutions. Consider modifying or expanding this process to help facilitate linkages to community-based resources to help patients change their health behaviors and lose weight.

***Clinic Spirit.*** Does your staff seem happy? Is your staff turnover rate high? Clinic spirit can influence the willingness to participate in change activities. Hopefully your staff celebrates holidays, provides cross-coverage so that people may spend time with their family (work hour flexibility), has a respectful climate, and supports honest communication. These factors contribute to the overall spirit of the organization. Job satisfaction in clinics stems from people perceiving that they can influence decisions and relationships with patients and be recognized and valued by their superiors.

The bridge-building process can build on those factors as staffs are often experts on their community. Many staff members have lived in the communities a very long time. They know the patients as “people in the community” whether they are sick at the clinic or well. They understand the challenges of achieving a healthy lifestyle in the local environment. Often, the clinician may be the newcomer. Inviting staff to help implement this toolkit in partnership with clinic leadership may bolster clinic spirit.

### **Developing Strategies to Support Process Leadership for Change**

New ideas or products often need a champion (leader) in order to take hold. A project champion believes in the concept and encourages others to put their efforts behind it. This person must be willing to address the concerns, skepticism, confusion, and perhaps anger that new ideas can generate.

In this guide we call this person the *Clinician Champion* (aka Chief Engineer of Construction). If you are leading efforts to build this bridge, you will need staff input and support. Involving staff in the problem-solving and decision-making is different than telling them what to do. To achieve buy-in, staff must agree that the activity is important, know they will have a role in shaping the response and influencing decisions, and know their specific role in the overall goal is meaningful.

Two common qualities emerge in all definitions of leadership. Leadership involves:

- A group process. In order to lead there must be followers.
- Influence.

The Clinician Champion may need the support of the office manager or clinic administrator to coordinate the process and planning details. Many strategic Clinician Champions may share this toolkit with a staff champion and small group team and say, “We need to do this, and I’d like for you to help me make this happen.” This doesn’t suggest abdication of leadership duties. Instead it recognizes that the Clinician Champion needs partners with connections to both front and back office staff to organize practice change. The Clinician Champion still provides direction and vision for the project, helps design tests for process changes, supports staff as they implement “tests” of change, and encourages organizational changes so that the efforts can be sustained over time.

### **Building Clinic-wide Engagement (Bridge Building Planning Meeting)**

No construction project gets started without a mandatory public hearing. Similar steps should occur when preparing for clinic changes. Clinic staff meetings often serve this function. In initiating this project, clinics are encouraged to host an informational/engagement meeting with all clinic staff. The goal of this meeting is to seek staff input, to educate staff about the importance of this issue for patient health, to decide to make a change, and to establish a foundation for the project.

This meeting agenda should include the following:

- Overview of the obesity epidemic and associations with medical conditions,
- Project explanation (i.e., to build linkages between the clinic and community-based resources to manage overweight and obesity), and
- Opportunities for staff to engage in a discussion around the topic and project planning.

It may be helpful for the office manager (or designee) to lead a discussion around the questions in **Tool 1**. There are no right or wrong answers. We conducted discussions like this (called focus groups) in preparation for our intervention and building this toolkit. Participants included staff from community-based organizations, community members (patients), and medical clinicians and their staff.

#### ***Findings from Focus Groups with Clinic and Community Partners in Our Intervention***

Two members of our research team conducted hour-long focus groups with clinic staff and community stakeholders. A total of 30 clinic members participated in 6 pre-intervention focus groups, including clinicians ( $n = 10$ ), nurses ( $n = 5$ ), medical assistants ( $n = 11$ ), administrators or managers ( $n = 6$ ), and other clinic administrative staff ( $n = 15$ ). Forty-four community stakeholders representing public health, weight loss agencies, hospital services, and other community-based organizations participated in six focus groups and two individual interviews. Select themes are summarized below and on the next page.

- Clinic and community participants identified overweight and obesity as a significant health issue. They indicated that lower socioeconomic status and limited income present barriers to healthy lifestyles and thus contribute to obesity.
- Weight status was perceived to fall along a continuum, with little distinction between overweight and obese. However, morbid obesity was perceived as distinct. Participants felt that people who are overweight “know it.” A few felt that some people don’t truly recognize their size (i.e., they may believe they are overweight when they are truly obese).

***Findings from Focus Groups with Clinic and Community Partners in Our Intervention, Continued***

- Primary care was seen as a potential resource for weight-related conversations and health behavior change. Both participant groups felt weight was a sensitive subject during patient-clinician conversations. Many found the word “obese” to be offensive. Both clinicians and patients felt that conversations should be framed around promoting healthy lifestyles or healthy eating and not solely weight. Some community members emphasized the importance of paying attention to the emotional and mental issues associated with weight loss – and felt it might be easier to work with a clinician who has struggled with his or her weight.
- Although clinicians felt that they address weight during the clinical encounter, community members reported that clinicians don’t address weight; they address the disease/presenting problem. Clinic staff said it is often the patient who initiates conversations about weight.
- Both groups felt that weight-related discussions don’t take place because of lack of time in the exam room. Community members wondered whether the issue wasn’t discussed because clinicians lacked a ready solution. Many community members and some clinicians felt the topic wasn’t covered because of the potential to lose a patient to another provider given the sensitive nature of the topic. Some clinicians and clinic staff even indicated that patients will seek doctors who won’t talk to them about their weight.
- Participants identified many challenges to health behavior changes and the need for intensive support. A clinician saying, “You need to lose weight,” is not enough; losing weight requires repeated educational messages and may even require showing a patient how to do something. Readiness for behavioral change was perceived by both groups to be highest when a patient was confronted with a chronic disease diagnosis or labeled as “at-risk.”
- Most community members wanted time with their doctor to discuss weight-related behavior change. However, they would be receptive to help from other clinic staff if the handoff was smooth and staff had the training/credentials to provide additional help.
- Clinic staff and community members were receptive to having referrals to community-based resources to support health behavior change. However, both groups recognized that one size doesn’t fit all and that patients need to be matched to the right program. Clinicians called making this match “the art of medicine.”
- While community-based resources would welcome clinician referrals and be willing to provide feedback regarding service utilization to the practice, participants identified the need to raise clinic awareness regarding existing services. Additionally, lack of insurance coverage for these services was seen as a barrier.

## Chapter 2: Building and Assessing the Clinic Foundation

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As described in Chapter 1, the elements for organizational change include leadership, data, a planning process, and resources. This chapter is about **gathering data and measuring your clinic's capacity** for obesity screening, brief counseling, and referral to community resources.

As with choosing the design for your bridge, you should pick the most appropriate performance assessment method for your clinic. The construction workers for the bridge are your clinic staff, and they have technical roles to play in the evaluation and change process. Along with the Clinician Champion, staff may play very specific roles, including:

**Front Office** – Distribute Waiting Room Survey and enter data; present findings.

**Referral Coordinator** – Invite specific community resources to meet clinicians, create a method of communication between clinic and community resources.

**Clinicians/Nursing** – Establish and lead Plan Do Study Act (PDSA) cycles regarding increasing assessment of weight status, documentation of diet and exercise conversation with patient, and establishment of a referral process.

**Medical Assistants** – Create Community Resource Inventory and participate in PDSA cycles.

Below, we describe three process techniques to measure these clinic attributes and provide baseline data against which to benchmark your performance over time. These techniques include conducting one or more of the following:

- 1) Chart reviews or audits,
- 2) Observations of practice flow and organizational behaviors, and
- 3) Patient surveys.

### Chart Reviews or Audits

The purpose of a chart review is to establish a baseline for measurement against implemented interventional changes in screening, counseling, and referrals for obesity. The U. S. Preventive Services Task Force recommends that all patients aged 6 or more be screened for Body Mass Index (BMI). **Table 1** describes BMI and obesity status.

**Table 1. BMI and obesity status in adults**

BMI	Obesity Status
<18.5	Underweight
18.5-24.9	Normal weight
25 – 29.9	Overweight
>30	Obese

BMI is a proxy for human body fat based on an individual's height and weight. BMI is an individual's body weight divided by the square of height and can be determined using online calculators or printed charts. The CDC provides an online tool for calculating BMI, [www.cdc.gov/healthyweight/assessing/bmi](http://www.cdc.gov/healthyweight/assessing/bmi). BMI is not a perfect measure for all people, but it is the most efficient and effective means of screening.<sup>6</sup>

The chart review is designed as a quality improvement effort. By gathering data in the chart review you can determine how well you and your practice are performing (or not performing) certain tasks as reflected in the medical record.

**Tool 2** provides a step-by-step guide to conducting a chart review, including forms, chart audit key terms, and instructions. Note that as electronic health record technology advances, it may be feasible to obtain data on the clinic’s patient panel by running a query.

***Findings from the Chart Audit in Our Intervention***

A total of 891 patient charts were reviewed in the pre-intervention audit using Tool 2. Ninety percent (799) were included in the analysis after meeting inclusion criteria for age, time in practice, etc. Half of the audited charts were female ( $n = 446$ ). When race and ethnicity data was available, 86% of the sample was Caucasian and 64% was Non-Hispanic. A total of 930 charts were audited post intervention and 801 (86%) were included in the final analysis. Demographic characteristics were similar in pre- to post- patient samples.

The number of charts where BMI was not reported or calculable significantly decreased pre- to post-intervention (61% to 32%,  $p = 0.0205$ ). The number of patients with any recorded BMI in the chart significantly increased (24% pre to 65% post,  $p = 0.0403$ ) and the number of patients with no recorded height significantly decreased (67% pre to 35% post,  $p = 0.0068$ ). There was no significant change in the number of patients with any recorded weight (96% pre and post,  $p = 0.8741$ ) or the number of overweight and obese patients with BMI class noted in their chart.

**Pre/Post Comparison of Chart Audit Data Across Our Six Intervention Clinics**

	Pre (N = 799)	Post (N = 801)	P value
Number of patients with any recorded BMI	195 (24%)	522 (65%)	0.0403
BMI not reported or calculable	484 (61%)	253 (32%)	0.0205
BMI reported in audit period per patient, mean (range)	0.5 (0 – 10)	1.0 (0 – 9)	0.0689
BMI class noted in chart			
Overweight	44 (6%)	6 (1%)	No convergence
Obese	98 (12%)	93 (12%)	0.74
Number of documented discussions per patient			
Weight, mean (range)	0.2 (0 – 8)	0.3 (0 – 5)	0.2199
Diet, mean (range)	0.3 (0 – 6)	0.3(0 – 7)	0.9679
Exercise, mean (range)	0.3 (0 – 6)	0.3 (0 – 5)	0.3602

**Observations of Practice Flow and Organizational Behaviors**

Participant observation allows for someone to immerse themselves in the clinic with an eye toward viewing day-to-day activities, language, and workflow. The observer can also look at how interactions occur between different patients, staff members, and clinicians over the course of an intervention. *Observation involves watching, listening, and recording.*

**Tool 3** provides a form that may be used by the observer to conduct clinic observations. We provide prompting questions that might help guide the observer. It may be useful to have an outside observer (e.g., someone who does not work in the practice routinely) conduct the observation. Having a new set of eyes can provide a less biased perception of clinic activities. Consider asking community college nursing students, Cooperative Extension professionals, nurses from the hospital, or medical students. If

clinic staff conduct the observations, it is important to be aware of how past experience may influence their perceptions.

### Patient Survey

It may also be helpful to conduct a patient survey to understand what they know about obesity, their general interest in change, and their knowledge of any community resources. An anonymous survey provides your patients an opportunity to share privately about potentially sensitive topics. If you choose to conduct a survey, you will want to determine:

- 1) who should complete the survey,
- 2) when and how the survey will be distributed, and
- 3) when and how the survey will be collected.

**Tool 4** provides a sample of the survey used in our intervention. You may modify this survey for use in your clinic. This survey collects data on:

- patient perceptions of their health status and current health behaviors,
- current patient efforts on health behavior change for diet and exercise,
- patient-identified community-based resources, and
- patient perceptions of the role of clinicians in weight management.

We suggest collecting the survey from about 50 patients. Larger practices or those interested in a specific population may elect to sample a larger number of patients or those with specific characteristics. We sampled from parents of young adults (12-18 years of age) and adult patients (over 18 years) because this was our target population.

Front office staff is often used to distribute surveys when patients check in. The survey should be distributed to all consecutive patients that meet your target criteria. You may want to develop a script for distributing the survey, for example:

**Front Desk:** Our clinic is working to help our patients maintain or establish a healthy lifestyle. It would be helpful if you could complete this survey so we can better serve all our patients.

**Patient:** I'd be happy to help!

**Front Desk:** Thank you! Please return the completed survey to the medical assistant when you go back to the exam room or to the front desk before you leave today.

#### ***Findings from the Waiting Room Survey Results in Our Intervention***

Of the 384 patients completing our baseline patient survey, almost two-thirds (64%, n = 245) were overweight or obese (BMI > 25 kg/m<sup>2</sup>). The majority of overweight or obese respondents indicated they were currently working on or intended to start losing weight (71%), eating a healthy diet (92%), or engaging in regular exercise (90%).

Although 38% of the overweight or obese patients were “interested” or “very interested” in getting help from primary care to connect with weight management resources only 20% reported that they “frequently” or “very frequently” had conversations with their clinicians about weight-related health behavior change. Patients of all weight categories indicated that primary care played an important role in providing advice on the importance of healthy weight (40%), screening for weight status (34%), asking about interest in losing weight (34%), and assisting with weight loss plans (34%).

## Chapter 3: Getting Patients Excited About Crossing the Bridge

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Nobody likes to be told to do something because it is “good for them.” From their first steps, children challenge their parents and they get better at it as the years progress. Still, like a parent to a child, there is an obligation to deliver a consistent message backed up by role modeling and examples of others who have overcome or are trying to overcome the barriers presented.

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*Sometimes, just telling someone they need to stop smoking, eat better, or exercise more doesn't get the results we seek.*

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### Obesity Screening

As mentioned above, the first step in screening for obesity, according to the U.S. Preventive Services Task Force, is measuring the Body Mass Index (BMI) of every patient aged 6 and greater.<sup>6</sup> In our intervention, practices found that the standard of obtaining height, weight, and BMI from patients at every visit was the easiest change to implement. Although some staff or clinicians may argue that BMI measures are not perfect, they are the clinical standard in many cases. Heavily muscled people often have BMI's in the overweight or obese range. These patients may need another tool to assess their weight status such as waist circumference or percentage of body fat.

Clinicians sometimes say their “eye ball” is enough. However, the BMI provides you with an objective measure of obesity status rather than a subjective assessment. Weight is often gradually gained or lost. If BMI is recorded at every visit, it will be more likely that you will catch these changes and be able to praise patients (for weight loss) or provide additional interventions (for weight gain).

Using the results from your chart reviews and observations in Chapter 2, have the Clinician Champion and Intervention Team discuss the protocols in place at your clinic to obtain an accurate weight and height on each visit. **Tool 5** is a worksheet that considers elements and personnel required for obesity screening. The worksheet and suggested protocol in **Tool 6** will help you frame the issue in a logical way.

The Institute for Healthcare Improvement uses the Model for Improvement as the framework to guide quality improvement. The Model for Improvement is a process that allows you to decide what you want to do, implement it, measure to see if it worked, and then to make adjustments based on testing your change strategy. Links to the Model for Improvement as well as a YouTube video on the Plan-Do-Study-Act (PDSA) cycle are listed in the resource section.

### Documenting Weight Status and Addressing It with Patients

Once an accurate BMI is obtained, clinics are encouraged to note weight status in the problem list (e.g., overweight or obese) and to address the condition with the patient at each visit. You may wonder: “Will that make any difference?” A study published in 2011 in *Archives of Internal Medicine* found that patients who had been told by a clinician that they were overweight were more likely to perceive themselves as overweight and to have attempted to lose weight in the past 12 months.<sup>7</sup> That is a step in the right direction. Once a problem is acknowledged, brief counseling can begin. Two frameworks for approaching this counseling are the Five A's and Motivational Interviewing (MI).

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*Overweight individuals were twice as likely to have tried to lose weight during the previous year if a physician had told them they were overweight.*

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**Five (or Six) A’s and Motivational Interviewing for Health Behavior Change Counseling**

**The Five (or Six) A’s.** The Five A’s are: Ask, Advice, Assess, Assist, and Arrange. The 5 A’s have been linked to higher motivation to quit smoking among tobacco users. Now, they are being applied to weight loss. **Table 2** provides a description and examples for each of the 5 A’s.<sup>8</sup>

**Table 2. Descriptions and Examples of the Five A’s**

<b>“A”</b>	<b>Description</b>	<b>Example</b>
<b><u>A</u>sk</b>	Clinician <i>asks</i> the patient about weight, nutrition, and exercise.	“Do you exercise?” “What do you typically eat for breakfast?”
<b><u>A</u>dvice</b>	Clinician provides the patient with clear, strong <i>advice</i> .	“You need to get 30 minutes of exercise a day, 5 days a week.” “I think you need to lose about 20 pounds.” “Because of your diabetes and hypertension, it is really important that you exercise.”
<b><u>A</u>ssess</b>	Clinician verbally <i>assesses</i> patient’s readiness to change.	“Is attaining a healthier weight something you might want to do in the near future?” “Do you see yourself getting more exercise in the coming months?”
<b><u>A</u>ssist</b>	Clinician <i>assists</i> by providing brief counseling or self-help materials	“What might get in the way of your plans to exercise three times a week?” “How are you feeling about being able to make this change?” “Is your family supportive of your attempts to eat better?”
<b><u>A</u>rrange</b>	Clinician <i>arranges</i> for follow-up with health care professional or community-based resource	“I will make a referral to (Community-Resource), they have an excellent program to help you attain a healthier weight.”

A recent study titled: “Do the Five A’s Work When Physicians Counsel About Weight Loss?”<sup>8</sup> found that physicians consistently *ask* and *advise* patients to lose weight, but often stop there. When physicians *arranged* for follow-up, patients had a significant increase in weight loss compared to patients whose physicians did not. Moreover, physicians that both *assisted* and *arranged* saw improvements in their patients’ dietary fat intake. Using the Five A’s approach can support patient weight loss efforts in primary care (e.g., increasing patient motivation, confidence, and likelihood of change).

**Motivational Interviewing.** Motivational Interviewing (MI) is defined as a collaborative, person (patient)-centered form of guiding to elicit and strengthen motivation for change. MI focuses on exploring and resolving ambivalence and centers on motivational processes that facilitate change within the person. MI has evolved over the last two decades. Studies find that MI is efficacious in helping patients make behavior change.

MI is about getting your patient to proceed with a change. It begins with allowing them to commit to a change by having them verbally describe their reasons why the change is good for them. They need to have confidence that they can indeed change. It includes you and the patient establishing a plan that will work for that person. (Don’t forget to document the plan in the chart notes). It needs to be a realistic plan that you believe the patient can achieve so when you speak with

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*Recently a sixth “A” indicating “applaud” was added to the 5A’s. It is important for clinicians to recognize even small changes in patient behavior and to acknowledge these changes.*

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them next time you can boost their confidence (*applaud*) in a genuine way. Lastly, you should support their autonomy as they progress with proper affirmation and recognition, and help when they slide.

In theory, this sounds right, but how do you actually carry out this conversation? There is an acronym to help you remember. It is **OARS** and represents:

- **OPEN-ENDED QUESTIONS**
- **AFFIRMATIONS**
- **REFLECTIONS**
- **SUMMARIES**

**Open-Ended Questions.** Open-ended questions are those that require the receiver to respond with more than a yes or no answer. They elicit responses that reveal the thought patterns and knowledge of the speaker. They also allow the clinician to say which behavior needs to be changed in a less direct manner. These questions get the conversation focused on “change.” Think about the difference between the first closed-ended question and some of the open-ended questions that follow:

<b>Closed Example 1.</b> “You need to achieve a healthier weight. Are you ready to start a diet and increase exercise?”	No.
<b>Open Example 1.</b> “You need to achieve a healthier weight. What are you already doing to be healthy?”	Well....
<b>Open Example 2.</b> “What is working for you around diet and exercise? Why might you want to make a change in diet and exercise?”	What works for me is....
<b>Open Example 3.</b> “If you decided to try and achieve a healthier weight, how would you go about doing it? What are the three most important benefits you see in making this change?”	I think I could try and .....

The following sets of open-ended questions are from Miller and Rollnick, who pioneered Motivational Interviewing and “Change Talk.”<sup>9</sup> These questions may help patients identify the harms of not changing behavior or the advantages of change. **Table 3** provides examples of these types of questions.

**Table 3. Two Types of MI Questions That Support Change Talk**

Questions requiring answers that are <i>disadvantages to maintaining the status quo</i> .
<ul style="list-style-type: none"> <li>• What concerns you about your weight?</li> <li>• What makes you think you need to do something about your weight?</li> <li>• What hassles have you experienced in relation to your weight?</li> <li>• How has your weight stopped you from doing what you want to do in life?</li> <li>• What do you think will happen if you don’t change anything about your weight?</li> </ul>

<p>Questions that require answers that <i>focus on the advantages of change.</i></p> <ul style="list-style-type: none"> <li>• How would you like things to be different?</li> <li>• What would be good things about attaining a healthier weight?</li> <li>• What would you like your life to be like five years from now?</li> <li>• What are the main reasons you see for making a change?</li> </ul>
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Gauging the patient’s sense of confidence in their ability to make a change is also a part of the MI conversation. *Some clinicians like to establish a numerical value to write in the chart.* The question would be:

On a scale from 1 to 10 with 10 being extremely confident, how confident are you that you can (be specific) exercise 30 minutes a day 3 times a week?

Not Very									Very
1	2	3	4	5	6	7	8	9	10

This will give you a sense of the patient’s optimism about change. *The following open-ended questions may also be used to measure the confidence and optimism about the change.*

- If you decided to make a change in diet and exercise, what would you do to be successful?
- What do you think would work for you if you decided to change your diet or exercise more?
- When else in your life have you made a significant change like this? How did you do it?
- What personal strengths do you have that will help you achieve a healthy weight?

*Lastly, here are some open-ended questions that will gauge the patient’s intention to change.*

- What are you thinking about your eating and exercise habits at this point?
- What do you think you might do?
- What would you be willing to try?
- What do you want to have happen?

**Affirmations.** Making an affirming statement can help build the relationship of trust between you and the patient through this change process. An affirming statement confirms that you want the patient to succeed. Affirmations include:

- Commenting positively on a patient attribute. “You have demonstrated a strong commitment to others.”
- Making a statement of appreciation. “I appreciate your being honest with me about how your spouse is going to make this change difficult for you.”
- Catching your patient demonstrating a positive behavior. “You’ve been very consistent with your approach to eating breakfast every day.”
- An expression of hope, caring, or support. “With both our efforts we will get your weight to a healthy level.”

**Reflections.** Reflective statements let the patient know not only that you are listening but that you are hearing what they are saying. Empathy is demonstrated through reflective statements. Empathy means understanding, not necessarily agreeing with, the patient’s statement. Reflective statements are not questions that require the patient to answer. They restate what the patient says and selectively reinforce change talk. Further, they put the patient in a more active role when discussing behavior change. By making a reflective statement and then stopping, the other person is then “expected” to

uphold their end of the conversation and make a statement rather than simply answering an open-ended question. An example may be:

“So, you say your children won’t eat vegetables, and they are expensive, but you feel you can prepare them for yourself.”

**Summaries.** The 15-minute visit does not allow for extensive conversation after the physical exam and dealing with the presenting problem. It is important to be able to wrap up the visit and still make the patient feel as if you are not giving them the brush off. First, recognize that patients understand you are trying to serve many others. It is okay to discuss time limitations up front. So a smooth summary statement will not come as complete surprise to them or an abrupt shift in conversation.

Summary statements can be accomplished by *collecting material that has been offered by the patient into a conclusive statement*. For example:

“You’ve expressed concern about your weight, hypertension, and family health habits.”

Then *move to an action step*. If the patient seems to be saying the same thing over and over, link their last statement with something discussed earlier and then move to action. Transitional statements help you move to action after drawing together what has happened during the encounter. An example is:

“Let me summarize and see if I missed anything.”

Then *move to your goal setting action*.

“We’ve talked about a lot of things today; if you had to pick one to work on, what would it be?”

### **Goal Setting to Support Health Behavior Change**

Included in the resource section are two video links that reflect the actions described in the prior narrative. This [5:26 minute video](#) provides a good short overview from Dartmouth University defining the five principles of MI. There is no actual patient-clinician demonstration of MI in this video, but rather it describes the principles:

- Express empathy.
- Develop discrepancy.
- Avoid arguing.
- Roll with resistance.
- Support self-efficacy.

Ultimately, *the entire conversation detailed above is to establish a mutually acceptable established goal and objectives between you and the patient*. A goal is a statement of long-term desires. To achieve the goal, several objectives (short-term limited-duration activities) may be needed. One of those objectives leading to the goal of achieving a healthy weight might be to use the services of a community-based organization dedicated to improving diet or increasing exercise.

After listening to the patient describe what they think might work and considering your knowledge of community resources, if you can suggest a resource that you feel meets their needs, *make the referral*.

Some clinicians allow the patient to choose. After your summary statement, you might want to say:

“Our clinic has created a community resource inventory. We think these are resources that can help you. The medical assistant is going to share it with you. Before you leave, I’d like for you to tell me which resource you’d like me to refer you to.”

**Documenting Brief Counseling and Patient Goals**

To remind you of the goals and where the patient decided to go, it is imperative that you document the discussion and record it in your chart notes. **Tool 7** is a guide for documenting the discussion.

Some patients may acknowledge that they need to get healthier. They may not want to go to a community resource but will say they want to “try on their own.” They may say they want to walk along the pathways near the river or use the track three times a week. They say they’ll only have one dessert with dinner and start the day with breakfast. That is fine. The important thing is to establish goals with the patient around diet and exercise and document the discussion and goals in the medical record.

**Findings on Changes in Documented Discussions on Weight Status in Our Intervention.** The number of patients with any documented discussions on weight (16% to 22%,  $p = 0.1312$ ), diet (23% to 24%,  $p = 0.9104$ ), and exercise (24% to 23%,  $p = 0.3393$ ) did not change significantly across all six intervention clinics. However, there was significant improvement in documentation of these discussions by individual sites.

**Pre- and Post- Changes in Any Documented Discussions on Weight, Diet, and Exercise by Clinic**

Clinic	Weight			Diet			Exercise		
	Pre	Post	p-value	Pre	Post	p-value	Pre	Post	p-value
One	14%	9%	NS	14%	19%	NS	9%	9%	NS
Two	35%	42%	NS	57%	9%	<0.001 (-)	58%	25%	<0.0001 (-)
Three	7%	18%	0.0109 (+)	23%	30%	NS	14%	29%	0.0037 (+)
Four	4%	15%	0.0190 (+)	6%	18%	0.0091 (+)	4%	21%	0.0021 (+)
Five	25%	27%	NS	30%	35%	NS	26%	44%	0.0028 (+)
Six	12%	23%	0.0039 (+)	16%	24%	0.0045 (+)	13%	29%	0.0002 (+)

Definitions: + = Increased, - = Decreased, NS = Not Significant

## Chapter 4: Building the Community Foundation

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There is an old marketing model concept called AIDA. The acronym stands for Awareness (Attention), Interest, Desire, and Action. To embrace a new idea or purchase a product you first must be aware that it exists. Once you know something is available, you either have an interest in it or not. Some products that are offered you know about but don't need or want. If you are interested, you need desire. Desire reflects the attributes of the product you are aware of and have an interest in. These could include cost, quality, style, etc. Action is the decision to purchase or embrace the idea.

Are there commercial weight loss programs in your community? Does your hospital have diabetic dietary counseling? Are there weight management resources with an evidence base of success? It is important to refer your patients to programs that are affordable and evidence based, and that meetings are at a time and location mostly accessible to your patients. You will want to learn more about each program before you take the Action step in the model of referring a patient across the bridge. That is what this chapter is about.

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*Create an inventory of the community-based resources in your area that appeal to your patient population and that you would feel comfortable telling them to use.*

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### Identify Community Resources

Referrals require two decisions. The first is to refer or not, and the second is to whom. Many variables overlap and complicate the decisions. These variables can be attributed to the clinician, the community, and the patient.

For the clinician, the variables include the formal training or the ability to handle the situation within the clinic, the scope of practice of the clinic itself, and knowledge of and involvement in community social and human service-based organizations.

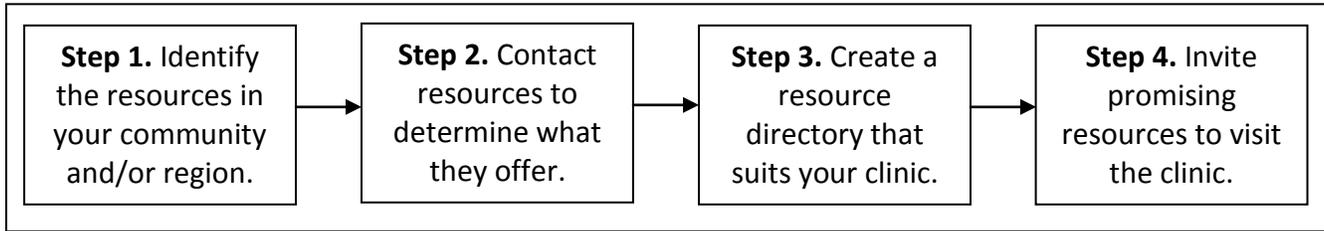
Community variables include the presence (or lack of) an appropriate organization, cost, accessibility, and expected value achieved by the user.

The last and most important set of variables relates to the patient. Clearly one size does not fit all when it comes to increasing physical activity and improving nutrition. Some patients wouldn't like a support group; others would shun any on-line resource; cost is a serious factor for some and not for others; and people need resources that fit their schedules. There is an aquatic-based exercise program endorsed by the National Arthritis Foundation. If you had a 30-year-old male patient who was obese presenting with joint pain in hips and knees, this might be a good program for him, correct? It allows for exercise and weight loss in the water, thus minimizing some pressure on his joints due to his increased weight status. But, it might not really be helpful. Why? When this was explored in one of our pilot communities, we learned that the typical user is a woman more than 70 years of age. Thinking you might know these programs is not the same as really exploring each using a systematic approach.

### A Step-By-Step Process to Learn About “the Other Side of the Ravine”

In our intervention the community and clinic partners developed a process to identify community-based-resources and to prepare a resource guide for use by primary care clinics. This process used four key steps and resulted in the creation of a community resource inventory form. An example of a

completed inventory form appears in **Tool 8**. These steps are summarized in **Figure 3** and details appear below.



**Figure 3. Steps in Learning About Community-based Resources for Weight Management**

**Step 1. Identify the resources in your community and/or region.** Work with your staff to determine what’s out there already by looking for existing inventories (Approach A), brainstorming resources lists (Approach B), and scouring the phone book/online directories (Approach C). Combined, these three approaches should give you a comprehensive list of current community resources.

- **Approach A.** Someone already may have done this work for you. Determine if a resource inventory or directory already exists in the community. Check with your local health department, the hospital’s education department, senior citizen centers, community action agencies, parks and recreation departments, or Cooperative Extensions. Consider if a modification of an existing directory will work for you.
- **Approach B.** Ask your staff to brainstorm a list of the community-based resources. It is important to use a group process for this step to minimize the chances of missing resources.
- **Approach C.** Look in the Yellow Pages or online under headings such as weight loss, nutrition, exercise, gyms, pools, sports, etc. Supplement the list your staff has created. Moreover, should you choose to conduct a survey of patients (Chapter 2), an open-ended question in the survey allows them to identify community-based resources.

**Step 2. Contact resources to determine what they offer.** Divide the list among staff members equally and ask them to contact each resource. Use or modify the attached form to collect common information from all the resources. It is often best to conduct these reviews in person. The ability to actually see the resource and not rely on a web site or professional photos to determine its cleanliness, professionalism, and value is critical. When contacting the resource, say:

“Good Morning (afternoon), I’m (name) calling from the (name of clinic), here in (name of community). We are starting a program to help our patients achieve a healthy lifestyle through improved diet and increasing physical activity. One way we intend to do this is to refer some of our patients to community resources like yours. We are building a resource directory of all the resources here in (name of the community) that help with diet and exercise. We’d like to learn more about (name of resource) and perhaps build a relationship with your organization. Who should I speak to?”

Then try to establish a time to meet and send them an advance copy of the form so they are better prepared to answer your questions. When conducting the interviews, it is helpful to make notes about your perceptions about how hard or easy the organization was to work with. Did they return messages? Were they on time for the appointment? Would you want to invite this person to make a presentation to your clinicians?

**Step 3. Create a resource directory that suits your clinic.** Once you have a list of all the resources (step 1) along with details about service availability and costs (step 2) you'll want to compile the information into a directory format that fits your office. It may be a three ring binder or a word document icon on the desktop of each computer screen. It might be 3x5 cards for each resource with a map and contact information on the reverse or a referral link in your electronic health record. Many approaches can work – chose what's best for your practice.

**Step 4. Invite promising resources to visit the clinic.** Once you've created your resource list, review it as a practice and invite the most likely referral organizations to visit your clinic. Evidence suggests that visits similar to pharmaceutical detailing are effective to inform clinicians about the community program. Studies indicate that the clinician's top concerns were cost to the participant, credibility of the resource, and convenience. Help the community resource prepare by prompting them to be timely and efficient and to leave behind program materials.

Don't forget to ask the community resource if they are willing to provide a discount or incentive to the patients you refer. If they agree, determine how the resource would want to be informed. They might want a note (your Prescription Pad; or use the sample provided in **Tool 9**) or they may say the patient needs to tell them, "Dr. (name) from the (group) sent me."

***Findings From Referrals to Community-based Weight Management Resources in Our Intervention.***

There was considerable variability in referral patterns by practice. The greatest number of referrals was made to CHIP (28%), Tomando Control (18%) and Living Well (17%). In most practices, only a subset of clinicians distributed pre-referrals surveys, a proxy for making referrals. For example, one clinician made 97% of the referrals at Clinic Two, 75% at Clinic One, and 78% at Clinic Three. Clinic Five did not to track referrals by provider but documented that 82% of the referrals were completed by the clinic at large.

**Referrals to Community-based Weight Management Resources, n (%)**

Clinic	Resource								
	WW	CHIP	WW & CHIP	TOPS	Living Well	Tomando Control	Patient Choice	Other	Total
One	1 (4)	13 (52)	0 (0)	1 (4)	0 (0)	0 (0)	5 (20)	5 (20)	25 (20)
Two	0 (0)	21 (62)	13 (38)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	34 (28)
Three	0 (0)	0 (0)	0 (0)	1 (2)	21 (42)	22 (44)	0 (0)	6 (12)	50 (41)
Four	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Five	1 (7)	0 (0)	0 (0)	2 (14)	0 (0)	0 (0)	2 (14)	9 (4)	14 (11)
Six	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Total	2 (2)	34 (28)	13 (11)	4 (3)	21 (17)	22 (18)	7 (6)	20 (16)	123 (100)

Abbreviations: WW = Weight Watchers, CHIP = Coronary Health Improvement Program, TOPS = Take Off Pounds Sensibly.

## Chapter 5: Crossing the Bridge and Returning

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The bridge is built. Now comes the part where your patient-centered interactions result in the patient going to a community-based resource that fits their need.

### Get Patients Ready to Use Community Resources

Even healthy people who are not overweight or obese can establish a self-management goal around diet and exercise, which should be reflected in their medical record. This would also apply to people who have managed to reduce their weight but may have gained the weight back after a year. Being focused on healthy living applies to all the patients.

Start by making patients aware that you plan to speak to them about diet and exercise. This can happen in any number of ways.

Your appointment personnel can prompt the patient that you are interested in having a brief discussion about diet and exercise at the next visit. Patients will feel more comfortable with the conversation if they know it is coming and they can prepare in advance. Here is a brief script for the scheduler to use.

“Mr. Clemente, the (name of group) is committed to helping all of our patients achieve a healthy lifestyle and to start we are focusing in on diet and exercise. I just wanted to give you a head’s up that (name of clinician) will likely ask you about your goals in this area during your visit. You might want to think about little ways you can improve your diet and increase exercise before coming in.”

**Tool 10** (brochure) and **Tool 11** (poster) can be customized with your particular information and clinic logo. The brochure may also be put in mailings to patients for other routine services such as billings, test results, and other communications. In deciding whether to include a brochure, remember to consider whether extra postage is required when the brochure is added to the mailing.

If the clinic staff is participating in attaining a healthy lifestyle, you might want to profile them on a poster in the waiting room. Have the staff member share their diet and exercise goals, which community-based resource they are using and how they are progressing. Personal stories and testimonials resonate well with consumers. And, while your staff may not be celebrities, they are known to the patients. This will also help build relationships between patients and caregivers. Further, it sends the message that you all understand the struggles and that you are all in this together.

Knowing you are not alone in the struggle is important. Your clinic may want to make a poster for the waiting area indicating the number of people who have connected with a resource. This may be a “thermometer” like those used by fundraising organizations. Setting a goal and tracking it in a transparent way will encourage staff and patients.

### Receiving Feedback from the Resource

As part of the community inventory listing (**Tool 8**), we encourage clinics to develop a process to close the feedback loop. **Tool 12**, the community resource punch card, provides an example of one method to obtain feedback on service usage. As obesity increases health expenditures, some health insurance companies are covering or heavily subsidizing the costs for some identified diet and exercise programs. Weight Watchers tracks the attendance at their sponsored group meetings. Curves for Women has an

electronic bar code admission card and a method of reporting back to insurers the utilization of those enjoying the benefit. Other private gyms may also have those tools.

For those small independent businesses not affiliated with a franchise, you may need to create some tools to allow the feedback that the patient has made the connection with the resource. Some have elected to establish a faxing system where the clinic faxes the referral and the community resource faxes a form back that the patient has used the service. Others have created punch cards to indicate the number of times the patient has been served. Tool 16 is a sample punch card. The patient can bring the tally back at their next visit. Lastly, some other resources have agreed to call the clinic to let you know your patient has connected. This does not need to be a complicated process. Your goal is to simply know that the patient followed through with your referral.

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*Patients trust your judgment. A good match between an individual's characteristics (age, gender, activity interests) and the community resource (group format versus one-on-one, intensive versus casual) will help achieve desired results and may contribute to longer lasting change.*

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Remember that patients trust your judgment. The services provided by the community resource will be a reflection of you and the clinic. Don't forget when the patient returns to the practice to ask them about their experience. You'll likely hear, without asking, about the negative experiences and complaints. It is important to gain knowledge of the positive experiences as well, so that you may try to direct the right patients to a resource that works better for them. A good match will last longer and achieve the desired result of a healthier lifestyle.

**Community Resource Referral Rates in Our Intervention.** A total of 137 patients received referrals to community-based weight management resources during a 6-week intervention period, and 81 (59.1%) were completed. Two clinics did not distribute any surveys; three sites distributed more than 25 pre-referral surveys with completion rates of 55.5%-80.7%. A total of 39 post-referral surveys were completed (48.2% response rate).

**Table 10. Pre/Post Patient Surveys Distributed by Practice and Completed by Patients**

Clinic	Consented/ Pre-Survey Distributed	Returned Pre-Survey	Pre-Survey Completion Rate <sup>a</sup>	Returned Post-Survey	Post-Survey Completion Rate <sup>b</sup>
One	26	21	80.8%	13	61.9%
Two	34	27	79.4%	19	70.4%
Three	59	23	39.0%	6	26.1%
Four	0	0	N/A	0	N/A
Five	18	10	55.6%	1	10.0%
Six	0	0	N/A	0	N/A
Total	137	81	59.1%	39	48.2%

<sup>a</sup> Pre-survey completion rate is equal to percent of returned out of distributed pre-surveys.  
<sup>b</sup> Post-survey completion rate is equal to percent of returned post-surveys out of returned pre-surveys. Only individuals completing pre-surveys received post-surveys.

## Chapter 6: Reflections on the Critical Elements for Successful Bridge Building

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We used a cross-case comparative analysis to explore elements that appeared to be important in a clinic's ability to build linkages with community-based resources for weight management. These items are summarized below.

- *Leadership Support and Alignment with Organization Priorities* – Leadership support was critical for project success. Clinics where there was clear buy-in from the management and resources allocated to support project activities experienced greater success. Notably, these clinics tended to align and enfold the goals of this research project with larger clinic/system initiatives. Further, they allocated resources (time, esteem) so that ancillary staff could help develop and implement project interventions. As such, these sites were able to negotiate the challenges of practice change (e.g., implementing new electronic health record systems, personnel changes) while still making progress on their goals to improve obesity treatment.
- *Clinician and Staff Champions* – Although a project may be initiated with the support of organizational leadership, having clinician and staff champions was critical for success. A champion does the actual work of moving the project forward by tracking progress of the intervention, calling meetings, reminding other staff about the project, and supporting implementation of clinic change processes. Champions are more effective if they have support from clinic leadership. If a champion is no longer involved, or is called to address other priorities, a project may wither. In our intervention turnover of key clinicians and staff limited participation at several sites. At one practice, a single nurse acted as a champion to advocate for collecting and calculating BMI rates at every patient visit. However, without clinic leadership support this small change didn't translate into larger project goals.
- *Known and 'Owned' Resources* – Clinician and staff knowledge of and experience with community-based resources to address behavioral health issues was limited, but critically important. Clinicians and clinical staff were more likely to refer patients to resources that they were familiar with. In one county the clinicians referred the majority of their patients to the Coronary Health Improvement Program (CHIP, 52% of Clinic One referrals; 100% of Clinic Two referrals). Lead clinicians in each practice led these groups; noting efficacy and familiarity with the program's philosophy of lifestyle change as the reason for almost exclusive referral. Program referrals were often triggered by a patient's negative lab tests, and attendees are there to improve health, rather than just lose weight. Similarly, staff at Clinics Three and Five work with, teach, and have participated in the Living Well program and its Spanish-language version Tomando. Clinic staff referred patients to these resources because they believed them to be of high quality, offering patients tools on healthy lifestyles rather than quick fixes. Although practices received an up-to-date inventory of community resources with information regarding hours, cost, type of program, clients served, history, and effectiveness, personal experience with the community resource appeared to be a stronger predictor of referral patterns.

- *Referral Support by Care Managers and/or Community Health Workers* -- Having staff available to implement the intervention and follow through on project activities was a key element of success. Although all clinics received a stipend for participating in the project, few used these resources to hire additional staff. Instead, existing staff frequently took on project activities. Having staff with allocated time to approach patients, provide information on the referral, and do follow up was critical to intervention success. In the clinic with the highest number of referrals, a community health worker was dedicated to working with patients who were flagged by physicians as needing a referral to a community-based resource. That person went so far as to go to the homes of patients to follow up on referrals. Once this workflow was put into place the number of referrals made by the clinic in the intervention period dramatically increased. At Clinic One, the regional practice facilitator assisted the clinic staff in approaching patients and offering referrals, as well as attended the Coronary Health Improvement Program to follow up with patients. Without this additional support by a person with dedicated time, these activities would not have been accomplished.
- *Practice Stability/Capacity for Change Management* – All clinics participating in this project faced considerable changes during the course of the study. Five of the six clinics changed electronic medical record systems. Two clinics changed ownership, becoming part of hospital systems. All experienced changes in staffing, including clinicians leaving the practice or changing their practice focus and bringing new clinicians on board. Office managers transitioned at four of the clinics at least once during the study. Frequently other urgent clinic issues took focus away from achieving the study goals. Changes in leadership, staffing, and operations are magnified in small, rural primary care clinics, and these clinics often have limited capacity to absorb change. Some practices handled this better than others, having either adaptive reserve to juggle many change processes at once or having management capacity to keep the project on staff radar despite changes. This capacity had profound implications for project implementation.
- *Adequate Time and Practice Facilitation.* A 12-month intervention to improve linkages between primary care practice and community-based resources to manage obesity simply lays the foundation. Addressing this problem requires support from individual clinics, the community, and health systems. The use of practice and community facilitation was critical to engaging these diverse partners. We used a participatory approach supported by practice facilitators and practice-based research network staff to engage clinics and community-based health coalitions as partners. Our staff played a critical role in helping clinics identify members of the implementation team, outline intervention plans, and implement and refine the interventions through continuous quality improvement cycles. Additionally, the team helped mobilize community partners to identify resources, conduct outreach visits, and share the list of resources with clinic partners. Thus the research team and regional practice facilitators became a critical part of the intervention.

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9. Miller WR, Rollnick S. *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press; 1991.

## Resources

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1. Worksite Wellness  
<http://public.health.oregon.gov/PreventionWellness/HealthyCommunities/HealthyWorksites/Pages/index.aspx>
2. CDC Community Guide Link  
[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm?s\\_cid=rr5807a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm?s_cid=rr5807a1_e)
3. Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change*. 2nd ed. New York: Guilford Press; 2002. An authoritative text on Motivational Interviewing.
4. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles  
<http://www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx>
5. 8:07 minute video on Plan Do Study Act  
<http://www.youtube.com/watch?v=xzAp6ZV5ml4>
6. 5:26-minute video overview of Motivational Interviewing  
<http://www.youtube.com/watch?v=ziH33JqCGAU&feature=related>  
*This 5:26-minute video about smoking is a nice demonstration of the steps to eliciting behavioral change. There is an excellent summary of at the end of the video about how the clinician handled the conversation. Can you see the five principles below in action?*
  - Express empathy.
  - Develop discrepancy.
  - Avoid a.
  - Roll with resistance.
  - Support self-efficacy.
7. 6:33-minute video: The Effective Physician. Motivational Interviewing Demonstration  
<http://www.youtube.com/watch?v=URiKA7CKtfc&feature=related>  
University of Florida Department of Psychiatry

## **Tool 1. Staff Meeting Discussion Guide**

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### **Intro Activities**

- Welcome participants
- Identify the purpose of the meeting: discuss current process for weight.
- Address ground rules:
  - There are no right or wrong answers.
  - Only one person speaks at a time.
  - Respect others' opinions.

### **Leader Facilitation Instructions**

Encourage all staff members to participate in the discussion. If body language indicates agreement, ask for clarification. If the leader hears something that feels controversial, he or she should ask how others feel about it.

### **Potential Questions and Follow-up Prompts**

- What is your perception of overweight and obesity as it relates to our patients and this community?
- Tell me about your perceptions of the effect of obesity on the health status of our patients.
- What generally triggers the discussion regarding obesity?
  - How do you broach the subject of obesity with our patients?
- Think about the typical flow of patient care at this practice. Can you identify some of the factors/processes that help you care for patients who are obese?
  - How do we currently screen for obesity (i.e., BMI? Waist Circumference? Eye ball?)
  - How do we know when a patient is ready to do something about their weight?
  - How do we counsel patients who are obese?
  - How might these approaches be different for children, adults, and older adults?
- Can you describe some of the factors/processes that make it challenging to care for our obese patients?
  - What are some of the sensitivities involved in talking about obesity?
- How do we care for patients who are not ready to do something about their weight?
- What community resources are available outside the practice to help patients?
  - What resources do you know of that you, your family, or friends use for weight management?
  - What were their experiences?
  - How would you describe the relationships between our clinic and these organizations?
  - What features would you look for in these resources when choosing to refer a patient?

## Tool 2. Chart Audit Form and Instructions

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### (Clinic Name) Chart Review: Screening for Overweight and Obesity

1. Audit Period \_\_\_\_\_

2. Patient ID: \_\_\_\_\_ 3. Clinic ID: \_\_\_\_\_ 4. Assigned PCP ID: \_\_\_\_\_

#### *Patient Demographics*

5. Date of birth: \_\_\_\_\_ 6. Gender:  Male  Female

#### *Medical History*

7. Which of the following conditions can you confirm for this patient? (Check all that apply.)

<input type="checkbox"/> Arthritis - <b>circle:</b> Osteo or Other	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Asthma	<input type="checkbox"/> Overweight
<input type="checkbox"/> Cancer - <b>specify type(s):</b>	<input type="checkbox"/> Obesity
<input type="checkbox"/> Coronary Artery Disease (CAD)	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Depression	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes - <b>circle:</b> Type 1 or Type 2	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Dyslipidemia - <b>circle:</b> hyper or hypo	<input type="checkbox"/> <b>None of the conditions listed</b>
<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> <b>Other weight related - specify:</b> _____

**Weight Management During Audit Period**

8. Total Visits During Audit Period: \_\_\_\_\_

9. Weight Management Tracking

Visit #	1	2	3	4	5	6	7
Date (mm/dd/yy)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Height (in inches)	Y1 ___ N2						
Weight (in lbs)	Y1 ___ N2						
BMI	Y1 ___ N2						
Other weight measures?	Y1 ___ N2						
Weight discussed? (Circle 1, 2, 3, 4)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Diet discussed? (Circle 1, 2, 3, 4)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Exercise discussed? (Circle 1, 2, 3, 4)	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Weight Management Referral?	Y1 ___ N2						
Other relevant information							

**Instructions for Filling Out the Chart Audit**

- Audit period.** Check pre-intervention or post-intervention as appropriate to the audit period you are using.
- Patient ID.** This should be a unique id number that cannot be linked back to an individual patient. Choose the number and enter.
- Clinic ID.** This should be a unique id number. Choose the number and enter.
- Assigned PCP ID.** This is the PCP that is designated as the primary clinician for that patient. This should be a unique id number. Choose the number and enter.
- Date of birth.** Enter patient DOB as mm/dd/yy.

6. **Gender.** Check male or female.
7. **Medical history.** Check all conditions that the patient has listed in their medical record. For certain conditions document where additional information is required:
- Arthritis – circle osteo or other
  - Cancer – specify type(s)
  - Diabetes – circle Type 1 or type 2
  - Dyslipidemia – circle: hyper or hypo (note hyperlipidemia, hypercholesterolemia are types of dyslipidemia)
  - Other weight related – specify.

### *Weight Management Tracking During Audit Period*

8. **Total visits.** Write the total number of visits during the audit period here. If there are more than 7 visits during the audit period add a new sheet and continue to track.
9. **Weight Management Tracking**
- **Height, Weight, BMI.** If these are obtained, circle “Y” for yes and record the value using the units designated (height = inches; weight = lbs.). If these are not obtained circle “N” for no in the appropriate cell.
  - **Other weight measures:** Some clinics may use alternate means to record weight status such as Body Fat Percentage (BFP), Abdominal Circumference (AC), or Growth Curves (GC). If this is the case, circle “Y” for yes and indicate type. If not circle “N” for no.
  - **Weight, diet, exercise discussed.** Please circle the appropriate response as follows:
    - **1 = Documented present, current.** Chart indicates that the topic was discussed.
    - **2 = Documented not present.** Chart indicates that the topic was NOT discussed.
    - **3 = Not documented/unknown.** Chart makes no indication if topic was or was NOT discussed.
    - **4 = Documented present, historical.** Chart indicates that topic may have been discussed years ago (i.e., appears in history).
  - **Weight management referral.** If yes, circle “Y” and indicate the name of the organization or individual to which the patient was referred. If no circle “N”.
  - **Other relevant information.** Document anything noteworthy or unclear here, or indicate where this is documented.

### Tool 3. Clinical Care Observation Guide

**Goal:** Observe the practice workflow. Identify if there are gaps in care delivery or systems in place that facilitate obesity screening.

#### Potential Observations of Interest:

- What does the clinic waiting room look like?
- Are there posters highlighting the importance of healthy behaviors?
- Are there materials that patient can read to learn more or evaluate their personal health behaviors?
- Is there any space in the clinic for a patient education area?
- What happens to the patients at clinic check in?  
Are they greeted pleasantly?  
Does the front desk pass out any intake information? Is this different for new versus established patients?
- What steps does the clinic take when rooming a patient?  
Is height and weight a standard step in rooming?  
When are height and weight taken at a clinic?  
How are height and weight taken (are shoes removed?)
- Does the clinic provide counseling to patients who need assistance with health behavior change?  
Who provides this counseling – the clinician? Medical assistant? Nurse care manager? Social worker?  
When does this counseling occur?  
How does this counseling occur?  
Does the clinic seem interested in expanding its staff's ability to provide brief counseling?
- How does the clinic referral process work?  
Is there a difference between specialty care referrals and lab referrals?  
Is someone in the clinic responsible for scheduling patient referrals? Is there a designated referral coordinator or is this the medical assistant's responsibility?  
Does a patient receive a referral sheet, and is it their responsibility to make appointments?  
Who tracks to see if referrals were completed? Does anyone in the clinic make reminder calls if a referral was not completed?  
Has the clinic made any changes to their referral process in the last year?  
Does the electronic health record (if present) make referral tracking more streamlined?
- Any other observations that seem relevant to the way obese and patients at risk for obesity may be managed at the clinic.

## Tool 4. Patient Waiting Room Survey

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Our practice is interested in the health habits of patient as part of a quality improvement project. We appreciate your taking 5 minutes to answer these questions about yourself. Please do *not* put your name on this survey. Completing this survey is voluntary.

**For each question please check or circle the response that is most appropriate for you.**

*Thank you!*

### Section 1: Health and Health Behaviors

1. Would you say that in general your health is:

<sub>1</sub> Poor      <sub>2</sub> Fair      <sub>3</sub> Good      <sub>4</sub> Very Good      <sub>5</sub> Excellent

2. How many of the past 7 days did you follow a healthful eating plan? \_\_\_\_\_ Days

3. In a typical *day*, how many servings of fruit and vegetables do you eat?

*A serving is 1 banana, one apple, ½ cup of fruit juice, ten baby carrots, or one tomato.*

a. Fruit = \_\_\_\_\_ servings per day

b. Vegetables = \_\_\_\_\_ servings per day

4. In the past *month*, how common was it for you or anyone in your family to go hungry because there was not have enough money for food?

<sub>1</sub> Very Common      <sub>2</sub> Somewhat Common      <sub>3</sub> Neutral      <sub>4</sub> Uncommon      <sub>5</sub> Very Uncommon

5. Which statement best describes your usual exercise routine (by regular exercise, we mean spending at least 30 minutes on an activity that increases your heart rate outside of work-related activities, such as brisk walking, jogging, swimming, playing soccer or other sport or aerobics) (choose one):

- <sub>1</sub> I do not exercise regularly.
- <sub>2</sub> I exercise 1-2 times per week.
- <sub>3</sub> I exercise 3-5 times per week.
- <sub>4</sub> I exercise more than 5 times per week

6. Which statement best describes routine physical activity you undertake as part of your work (by routine physical activity as part of your work, we mean spending at least 30 minutes on an activity, such as digging, heavy lifting, heavy yard work) (choose one):

- <sub>1</sub> My work does not involve routine physical activity.

- <sub>2</sub> My work involves physical activity 1-2 times per week.
- <sub>3</sub> My work involves physical activity 3-5 times per week.
- <sub>4</sub> My work involves physical activity more than 5 times per week.

7. Do you have a disability that affects your ability to be physically active?

- <sub>1</sub> No      <sub>2</sub> Yes

8. Are you currently making efforts to:

	Yes, I have been for <i>more than 6 months</i> .	Yes, I have been for <i>less than 6 months</i> .	No, but I intend to in <i>the next 30 days</i> .	No, but I intend to in <i>the next 6 months</i> .	No, and I do <i>not</i> intend to in <i>the next 6 months</i> .
a. lose weight?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
b. make healthy food choices?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
c. be physically active on a regular basis?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Section 2: Weight Status**

9. When you consider your current body weight, do you consider yourself to be:

- <sub>1</sub> Very Underweight      <sub>2</sub> Somewhat Underweight      <sub>3</sub> A Healthy Weight      <sub>4</sub> Somewhat Overweight      <sub>5</sub> Very Overweight

**Section 3: Community Weight Management Resources**

10. Are there places in your community or nearby to assist **adults** with weight loss (e.g., diet programs, physical activity centers, etc.)?

- <sub>1</sub> No
- <sub>2</sub> I don't know/unsure
- <sub>3</sub> Yes. Please specify what/where:

11. Are there places in your community or nearby to assist **kids** with weight loss (e.g., diet programs, physical activity centers, etc.)?

<sub>1</sub> No

<sub>2</sub> I don't know/unsure

<sub>3</sub> Yes. Please specify what/where:

--

12. Considering where you live, how easy is it for you to find locations to:

	Very Difficult	Somewhat Difficult	Easy	Very Easy
a. get fruit to eat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
b. get vegetables to eat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
c. obtain fast food?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
d. exercise in a gym?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
e. play at a park?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
f. use walking trails or bike paths?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**Section 4: Primary Care and Health Behavior Change**

13. In the last **year**, how often has your primary care clinician talked with you about your:

	Never	Rarely	Sometimes	Frequently	Very Frequently
a. weight?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
b. diet?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
c. physical activity?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

14. Would you be interested in getting help from your doctor/clinic to connect with resources for weight management in your community?

<sub>1</sub> Not Very Interested

<sub>2</sub> Somewhat Interested

<sub>3</sub> Interested

<sub>4</sub> Very Interested

<sub>5</sub> Not Applicable

15. What factors would affect your willingness to access resources for weight management in your community or nearby?

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> Cost                         | <input type="checkbox"/> <sub>5</sub> Family Support  |
| <input type="checkbox"/> <sub>2</sub> Time                         | <input type="checkbox"/> <sub>6</sub> Friend Support  |
| <input type="checkbox"/> <sub>3</sub> Transportation               | <input type="checkbox"/> <sub>7</sub> Clinic Support  |
| <input type="checkbox"/> <sub>4</sub> Quality of Resource          | <input type="checkbox"/> <sub>8</sub> Confidentiality |
| <input type="checkbox"/> <sub>9</sub> Other. Please specify: _____ |   |

16. What role should your doctor/clinic play in supporting weight loss efforts? **(Check all that apply.)**

- <sub>1</sub> No role. This is not a responsibility I expect from my doctor.
- <sub>2</sub> Screen patients for weight status during clinic visits.
- <sub>3</sub> Ask patients about their interest in weight loss during clinic visits.
- <sub>4</sub> Advise patients about the risks of overweight and obesity.
- <sub>5</sub> Assess patients' willingness to make weight related health behavior changes.
- <sub>6</sub> Assist patients in developing weight loss plans.
- <sub>7</sub> Arrange referrals with community resources for weight management.
- <sub>8</sub> I don't know/unsure.
- <sub>9</sub> Other. Please comment:

**Section 5: Demographics**

17. Are you male or female? <sub>1</sub> Male <sub>2</sub> Female

18. What is your age? \_\_\_\_\_ Years of Age

## **Tool 5. BMI Protocol Template**

---

**BMI Screening Goal** (Example: Our clinic will obtain BMI at each visit for patients between 6 and 90 years old.)

**Clinic Resources** (Example: Scales are located in each exam room to facilitate privacy of data collection. There is also a back-up scale for larger patients located in the procedure room. BMI charts for children and adults are posted on the wall to the right of each scale. In addition, a shortcut to an online BMI calculator has been placed on the desktop of each computer.)

**Weight Protocol** (Example: Weight will be taken at each visit for children and adults between 6 and 90 years of age. Patients will not be required to remove all clothing prior to obtaining weight due to time constraints.)

**Height Protocol** (Example: Medical assistants will measure patient height at every visit for children and adolescents between 6 and 18 years old, and annually for adults unless requested by patient. For adult patients, the annual height measurement will be transferred onto the current visit for 1 year or until the next annual measurement is due.)

**BMI Calculation Protocol** (Example: Medical assistants will calculate BMI using the wall mounted chart or electronic resource for each patient. Values for height and weight will be used according to the described protocol. Medical assistants will record BMI in the patient chart as appropriate for the current visit.)

**Protocol for Addressing Overweight/Obesity in Patients** (Example: Medical assistants will flag clinicians for patients with a BMI > 25 or BMI >30 by starting a community-based resource referral form. Clinicians will document overweight or obesity as a medical condition on the patient's problem list. Medical assistants and clinicians will address weight status according to the "Weight Protocol".)

**Additional Notes:**

## **Tool 6. Worksheet: Establishing Protocols for BMI Screening**

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### **Planning:**

Who: Project Team (to plan); Clinic-wide (to implement and refine)

What: Standardize protocol for obtaining BMI at each patient visit

When: TBD

Materials:

- BMI chart(s)
- Clinic chart audit data
- Clinic observation notes
- Resource: Mapping Clinic Flow Template
- Resource: BMI Screening Protocol Template

### **Project Team Meeting Agenda (Part 1)**

- Review data from chart audit and observation notes.
- Outline current BMI screening process.
- Identify challenges to obtaining BMI at each visit.
  - a. Height not obtained?
  - b. BMI not calculated?
  - c. Scale in “wrong location?”
- Draft BMI screening protocols.
- Develop and Implement Plan-Do-Study-Act (PDSA) cycle to test.

### **Project Team Meeting Agenda (Part 2)**

- Review PDSA cycle and refine BMI screening protocols as needed.
- Conduct additional PDSA cycles as needed and refine protocol.
- Develop plan to spread protocol across practice.

### **Project Team Meeting Agenda (Part 3)**

- Review protocol spread – Where is it working really well? When is it not working?
- Refine protocol.
- Develop follow-up Plan-Do-Study-Act (PDSA) interventions as needed.

## Tool 7. Documenting the Conversation in Your Charts

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### *Documenting and Tracking Weight Management Discussions – How to Capture Brief Counseling and Referral in Your Chart Notes*

This worksheet is designed to help your clinic document brief counseling and referral for patients who experience challenges with weight management. Ideally patients identified as overweight or obese (BMI > 25 < 30 or BMI > 30, respectively) would have the following documented in their chart at each visit:

- Diagnosis/listing of weight management, obese, overweight in the patient’s problem list (use the “appropriate” code determined by your practice).
- Indication that brief counseling around diet, exercise, weight management occurred during the encounter (use motivational interviewing approach).
- Documentation of referral to external resource or that referral to resource was declined.
- Plan for “next steps” related to healthy lifestyle maintenance/change.

### **Consider These Steps as You Refine the Documentation Process**

- Explore the current lay of the land:
- What is the current format of your chart notes – do clinicians/staff tend to use text or templates?
- What do chart notes look like when you see a patient with weight issues?
- Discuss if there are opportunities for improving documentation of screening, problems, brief counseling, and referrals.
- Determine a strategy for modifying existing templates or refining encounter text to capture the key elements.
- Pilot test and refine your process!

### **Example Chart Notes for your Clinic’s Use**

Chart notes are often structured based on personal preference and/or the formatting capabilities of your Electronic Health Record. The two examples below (template and text format) provide learning models depicting how you might document brief counseling and referral for weight management. These models are provided as a “straw man” and clinics are strongly encouraged to discuss and refine according to local preferences and protocols.

**Template Format** – I discussed health consequences of weight including (diabetes, knee OA, hypertension, heart disease, etc.). We discussed (check all appropriate):

Weight     Yes    No

Diet     Yes    No

Exercise     Yes    No

We discussed referral to community resources for weight management:  Yes    No

The patient expressed a desire for referral:  Yes    No

I referred the patient to:

Weight Watchers    TOPS    CHIP    Other (specify): \_\_\_\_\_

***Text Format***

*At-the-point example* – Discussed weight, diet, exercise with patient in relation to health conditions. Used motivational interviewing to illicit change talk and established initial goals with patient, including: walking daily to mailbox, reducing soda from 40 oz. daily to 20 oz., eating dinner at table 1 night per week.

After discussing patient preferences I referred [him/her] to [Weight Watchers, TOPS, etc] for additional follow-up. Patient plans to return in 2 months for follow-up appointment.

*Another example* – CC: Here for an annual check-up

Subjective: Susan is a 40 year old computer programmer who is here after a three-year hiatus from health care as she now has a job and health insurance. She is doing well overall. She is taking vitamins but no prescription medications. She realizes her weight is up from 3years ago but it has been a stressful time. She does not exercise but is thinking about getting back to this. Her exercise of choice is walking. Susan has started to watch her intake of sugar. She does not smoke and has one alcohol drink a month. She is single and has her own apartment. She is in a monogamous relationship and is thinking that she would like to have a family. Family history notes that an older sibling has weight issues and that Susan has a maternal aunt who developed breast cancer at age 51.

Objective: Ht. 70 inches; Wt. 294; BMI 42.3; BP 124/78; P-76

Gen app-comfortable, overweight

Assessment: Major health issue is obesity.

Plan: Discussed the importance of a healthy diet and exercise.

She feels she can get her weight down to 250 over the next 12 months.

She agrees to get a lipid and blood glucose check.

She is aware of the health hazards of obesity—including diabetes, knee osteoarthritis, and heart disease.

Susan will send a progress note in 6 months regarding her weight. If she is not making any progress, she agrees to connect with Weight Watchers.

## **Tool 8. Sample Community Inventory Form**

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**Name of Organization:** Basic Yoga Studio

**Address:**

**E-mail:**

**Phone:**

**Website:**

**FAX:**

**Primary Contact Person:**

**AVAILABILITY - Program Description – Purpose or Mission Statement Included:** Therapeutic Yoga. “Do No Harm.”

**Description of Typical User:** People who want to make a change in their life and are willing to be responsible for and committed to their health needs.

**ACCESSIBILITY - Hours of Operation:**

Basic Yoga (for new and returning students): Tuesday and Thursday: 10-11:15 am and 6-7:15 pm.

Gentle Basic Yoga (student specific, modified poses): Tuesday and Thursday: 3-4:15 pm.

Private instruction is available.

**Physical Barriers:** Stairs.

**AFFORDABILITY - Fee (Cost) – Including Potential Discounts for People We Refer– Scholarships:**

10 classes for \$80

10 classes for \$75 for seniors over 55 years

Drop-in fee: \$10/class

**Accepted Insurance:** None.

**CONTINUITY - Funding source, years in operation:** Client funded. Instructor has been teaching in area since 2001.

**QUALITY - Evidence of Effectiveness:** Some clients are referred by their physician and by word of mouth. Classes continue to be full. There is scientific evidence supporting the benefits of yoga on health.

**Methodological Approach:** Clients receive instruction and then are expected to perform.

**FEEDBACK - How will organization let clinics know the client has been served?**

Basic Yoga Studio is willing to fill out any appropriate forms, although must be client initiated due to HIPPA concerns.

**Tool 9. Sample Prescription Pad**

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Phone: 541-322-7430  
Fax: 541-322-7467  
E-mail: [livingwellinfo@dschts.org](mailto:livingwellinfo@dschts.org)  
Web: [www.livewellco.org](http://www.livewellco.org)

---

**R<sub>x</sub> Put Life Back in Your Life!**

Client Name \_\_\_\_\_

Phone/E-mail \_\_\_\_\_



*I agree to receive a call from the Oregon Tobacco Quitline and/or a Chronic Disease Self Management Program.*

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Provider Name \_\_\_\_\_

- \_\_\_\_ Live Well with Chronic Conditions (6 weeks)
- \_\_\_\_ Tomando Control de Sa Salud - Spanish version (6 weeks)
- \_\_\_\_ Positive Self Management Program (HIV) (7 weeks)

Weekly workshops that teach practical skills for living a full, healthy life despite ongoing health issues.

- \_\_\_\_ Oregon Tobacco Quitline  
Personalized help to quit tobacco.  
1-800-QUIT-NOW (1-800-784-8669)  
[www.quitnow.net/oregon](http://www.quitnow.net/oregon)
- 

**PLEASE COMPLETE FORM AND FAX OR MAIL TO**

**FAX: 1-541-123-4567**

**Living Well Central Oregon  
Deschutes County Health Services  
1234 NE Courtney Drive  
Bend, OR 97000**



## Project Overview

Our clinic is participating in a national research project to connect clinics with community resources to support healthy living around diet and physical activity. The goal of the project is to help patients achieve and sustain healthy diet and exercise behaviors.

Patients invited to participate will receive a referral from their doctor to a local resource for physical activity or weight management. Participants will be asked to complete two surveys over 4 months. For more information, contact the Oregon Health & Science University Investigator Lyle J. Fagnan, M.D., at 503-494-4365.

IRB #: 00006936

## Community-based Resources

(Clinic to choose community resources with contact information to be listed below)

### Diet:

- XXX
- XXX

### Physical Activity:

- XXX
- XXX

### Smoking Cessation:

- XXX
- XXX

### Emotional Health:

- XXX

### Diet and Physical Activity:

- XXX
- XXX

**Ask your health care team for more information.**

[Clinic Logo]

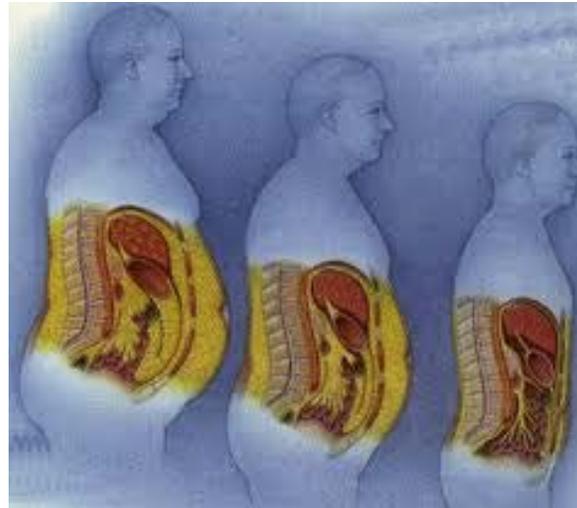
# Healthy Living for Life





## What is "Health"?

More than a focus on weight – our clinic is interested in promoting healthy lifestyles that encompass diet, exercise and social well-being for all patients. Good health may be achieved by following current recommendations for good health. The USDA recommends 35 minutes of moderate-intensity exercise a day and a diet full of fruits, vegetables and whole grains.



## How do you know if you need to make a change for a healthier lifestyle?

Making changes can be difficult. Your health care team can help you make these changes by referring you to places in your community that specialize in healthy eating and active living changes.

Your health care team will talk to you about your views on your goals for achieving this healthy lifestyle.

## What is Body Mass Index (BMI)?

Your health care team will measure your weight and height to calculate your BMI. This ratio of height to weight is used to identify possible weight problems. BMI is generally classified into four categories. If your BMI is:

- **Less than 18.5**, it falls within the "underweight" range.
- **18.5 to 24.9**, it falls within the "normal" weight range.
- **25.0 to 29.9**, it falls within the "overweight" range.
- **30.0 or higher**, it falls within the "obese" range.

## Why does BMI matter?

- Obese and overweight describe ranges of weight that are *greater* than what is considered healthy.
- Underweight describes a weight that is *lower* than what is considered healthy.

If your BMI falls outside of the "normal" weight range, you may want to talk to your health care team about how you might achieve a healthier body weight. Patients who are overweight or obese may be more likely to be at risk for heart disease, type 2 diabetes, high blood pressure and even cancer.

**For a list of resources available in your community, see the back page of this brochure.**

## Additional Resources

- Oregon Rural Practice-based Research Network Website: [www.ohsu.edu/orprn](http://www.ohsu.edu/orprn)
- Oregon Health & Science University Website: [www.ohsu.edu](http://www.ohsu.edu)
- Agency for Health Care Research & Quality Website: [www.ahrq.gov](http://www.ahrq.gov)
- United States Department of Agriculture Website: [www.usda.gov](http://www.usda.gov)
- U.S. Food & Drug Administration Website: [www.fda.gov](http://www.fda.gov)

# Healthy Living for Life

Your health and quality of life are important. Physical activity and diet are associated with good health and can prevent or improve conditions such as heart disease, type 2 diabetes, high blood pressure and even cancer.



[Clinic Name] is participating in a project to support healthy lifestyles. We may talk with you about your diet and exercise goals. Our clinic can help support your goals by referring you to community-based resources that specialize in healthy eating and active living changes.

Ask your health care team how they can help you start making a change today, or support your current changes for a healthy life.

[Clinic name, logo and contact information]

## Tool 12. Sample Punch Card

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[Clinic Logo]

[Clinic Name]

This is how many times I visited:

---

(referred resource)

---

(Name)

*Get a punch for each visit.*

