Community Connections

Linking Primary Care Patients to Local Resources for Better Management of Obesity

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Contract No. HHSA290-2007-10008

Prepared by:

The State Networks of Colorado Ambulatory Practices and Partners (SNOCAP-USA)
Elizabeth E. Stewart, Ph.D., M.B.A., Healthy Living & Sunflower Trails Sunflower Foundation: *Health Care for Kansans*
Neta Taylor-Post, H.B.O.R., B.A., YMCA of Greater Providence
Laura Nichols, M.S., SNOCAP-USA
Elizabeth W. Staton, M.S.T.C., SNOCAP-USA
Andrew Schleuning, B.S., Kansas City University of Medicine & Biosciences

AHRQ Publication No. 14-0030-EF
March, 2014

Acknowledgements

The State Networks of Colorado Ambulatory Practices and Partners (SNOCAP-USA) and the YMCA are grateful to the primary care practices that participated in the pilot project and freely shared their experiences for the benefit of other practices. Participating in a formal quality improvement project takes time and commitment, and the authors wish to extend their thanks to each practice for its hard work and willingness to participate in the evaluation.

This toolkit is based on research conducted by SNOCAP-USA under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. HHSA 290-2007-10008). The findings and conclusions in this document are those of the authors, who are responsible for the content, and do not necessarily represent the views of AHRQ. No statement in this report should be construed as an official position of AHRQ or of the U.S. Department of Health and Human Services.

Suggested citation:
Stewart EE, Taylor-Post N, Nichols L, Staton EW, Schleuning A. Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity. Rockville, MD: Agency for Healthcare Research and Quality; March 2014. AHRQ Publication No. 14-0030-EF.

Contents

Figures

Appendixes

List of Tools:

Chapter 1. Introduction

The Scenario

Phones are ringing nonstop in the background, and someone in the waiting room is crying. The recently "upgraded" electronic health record (EHR) system is frozen. As a practice manager, you're trying to keep everything under control.

A physician comes out of the exam room 20 minutes behind and frustrated. "Where do we keep those forms on the Food Pyramid?" she almost shouts.

"I think they're in that drawer in Room 3, but that room is occupied."

A medical assistant passing by adds, "Plus I think those are the old ones, not that the new pyramid we're supposed to use."

"Forget it," the physician says, deflated. "My patient is 100 pounds overweight and a food pyramid is not going to help. Besides, I'm too far behind to start anything."

As you watch her walk away, defeated, you think— there has got to be a better way-–a better way to help our patients who struggle with excess weight, a better way to provide assistance in such a time-crunched environment, a better way to, overall, tackle the lifestyle issues see daily even at 10 a.m. on a Monday morning.

The Solution

In a perfect world, the next step would be as simple as writing a referral to an inexpensive and credible community resource—a resource specifically designed to assist and support patients in their efforts to make healthy lifestyle changes—and providing feedback to the physician about the patient's progress. In a perfect world, the referral process would occur seamlessly as part of the patient flow, and the physician and care team would feel good knowing their patients were receiving the kind of focused time and attention the current medical model does not promote within the exam room. In a perfect world, the patient-centered medical home would have a valuable partner beyond its walls. We're not in that perfect world yet, but this toolkit is intended to get us closer.

The Goals of This Toolkit

Every primary care practice is different, which is part of why the work can be very stimulating and fulfilling. However, the very differences that make each practice unique also make it challenging to issue blanket guidelines for quality improvement (QI) projects that will work for every practice. This toolkit is intended to offer broad ideas based in actual practice experience with the understanding that every practice will need to customize concepts for their own specific needs. Ideally, clinicians and staff at every level of a practice should review the toolkit, as each member contributes to patient care.

When we created this toolkit, we intended to:

- Help primary care practices determine and evaluate what accessible and affordable resources exist in your community for patients struggling with obesity and/or prediabetes.
- Help primary care practices establish a productive relationship with community partners so that each party benefits, as well as the patients.
- Help primary care practices work with community partners to develop a bidirectional referral process that integrates directly into your existing patient flow. A bidirectional process considers both the information leaving the practice and the information flowing back in.

- Help primary care practices enhance engagement strategies with patients so that the referral process becomes a meaningful conversation with increased potential for patient activation.

A recently completed pilot project, funded by the Agency for Healthcare Research and Quality, followed the experience of seven primary care practices working closely with a well-known community resource, the YMCA, and the YMCA's Diabetes Prevention Program. This toolkit is the product of their experiences. The tool is intended to help the reader examine his or her practice, reach out to community resources, develop sustainable links, and exercise new strategies and tools to increase patent engagement. Although the YMCA, as a key partner in this project, played a critical role in developing the toolkit, the lessons and examples are intended to be translatable to any community resource and any practice willing to take the extra step to make it happen.

This toolkit will *not*:

- Suggest ways to connect patients to expensive hospital-based programs. While those programs can help improve the health of some patients, they are not the right fit for every patient.
- Suggest ways to integrate a cadre of additional health care professionals into your practice; e.g., a registered dietician, psychologist, or exercise physiologist. While such a scenario is ideal, many practices are not financially structured to support such additional staff.
- Suggest ways to fundamentally change the structure or design of your practice, or put resources into developing a new patient program. The goal is to develop links to existing programs with a referral/engagement process that assimilates within your existing workflow.

Definitions of Clinical Roles in This Toolkit
Clinician – physician (M.D., D.O.), nurse practitioner (N.P.), physician assistant (P.A.)
Practice manager – person who manages nonclinical aspects of the practice
Care team – everyone involved in patient care
(Clinical) care team – medical assistants, nurses (R.N., L.P.N.), others that assist in clinical care
(Administrative) care team – front desk staff, referral staff, billing staff

Chapter 2. Background: The Case for Community Linkages

Primary Care's Expanding Caseloads and Shrinking Workforce

Linking primary care practices with community resources makes sense in light of the increasing demands on primary care providers. In particular, increasing rates of overweight and obesity in the United States will increasingly tax primary care providers, making it unlikely they can handle their patients' needs alone. Consider the following statistics:

- According to the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, more than one-third (35.7%) of U.S. adults are obese .
- CDC estimates that 17% (or 12.5 million) of children and adolescents aged 2 through 19 years are obese.
- The U.S. Surgeon General reports that obesity accounts for nearly 300,000 deaths in the U.S. each year. Studies show that obesity is associated with more chronic health problems than smoking, heavy drinking, and poverty and is a major risk factor for developing prediabetes and type 2 diabetes.
- The CDC also estimates that 79 million people –1 of every 3 Americans—currently have prediabetes.
- Compared with normal-weight adults, overweight adults report the following more frequently: fair or poor health, limitations in daily activities, and more health care visits.[1]
- The average primary care physician oversees a panel of about 2,500 patients.[2,33] At the same time, the country faces a shortage of primary care physicians, especially in rural areas.[4]
- One analysis[5] suggests that in order to fully satisfy all U.S. Preventive Services Task Force recommendations, a physician must spend 7.4 hours per working day *just* on those activities—this does not include other activities, such as acute care, procedures, administrative tasks, quality improvement projects, and so forth.

The Promise of the Community Partner

Primary care practices are struggling to care for their patients with obesity and associated chronic conditions such as prediabetes. The Chronic Care Model, a framework developed in the late 1990s to help providers care for patients with chronic conditions, includes connecting patients to community resources as a major component.[6,7] Many resources exist to provide accessible, affordable services to those in need and often are funded with incoming caseloads. Furthermore, many community resources rely on a peer or trained layperson model of support that lends itself to the problem-solving and self-management tools that patients seem to crave, but few medical offices have time to adequately provide. While the concept is promising, the devil is in the details. Even among practices that have implemented innovative programs targeting tobacco use, risky drinking, unhealthy dietary patterns, and physical inactivity, referral to community resources is low.[7] This toolkit is intended to untangle those details so that a promising idea can translate into a reality.

Origin of This Toolkit: Collaboration Among AHRQ, SNOCAP-USA, and the YMCA

In 2010, AHRQ issued a national call for practice-based research networks to develop a practical, sustainable system to link primary care practices and community partners. In response, SNOCAP-USA partnered with the YMCA of the USA to build a referral and feedback system between primary care practices and the obesity and diabetes prevention programs offered by the YMCA, specifically, the YMCA's Diabetes Prevention Program (YDPP).

Under the recommendation of the YMCA of the USA, SNOCAP-USA joined forces with the YMCA of Greater Providence in Rhode Island. SNOCAP-USA worked with a trained YMCA health facilitator to help increase awareness among primary care practices about available community resources, to develop a bidirectional referral and linkage system, and to assess the project through process evaluation and patient outcomes. Specifically, the bidirectional system was developed to link patients at risk for diabetes to the YMCA's Diabetes Prevention Program.

The strategies and suggestions in this toolkit come directly from the experiences and observations of the practices that participated in the pilot project, along with the health facilitator at the YMCA who worked with them for 15 months. Information was gathered through an ongoing series of site visits, interviews, learning collaboratives, and constant communication. The participating practices were given the opportunity to review drafts of the toolkit and provide feedback for improvement. The toolkit also incorporates the accumulated knowledge of SNOCAP-USA after 12 years of assisting practices in quality improvement projects and evaluation methods.

Chapter 3. Linking With a Community Partner

Step 1: Establish Motivation and Interest of Practice

Literature on practice change and quality improvement[8-10] has shown that successful projects share the following characteristics:

1) The ability to establish practice champions (preferably, a physician champion for leadership and support and a project champion responsible for specific tasks and activities).
2) The ability to capture the overall interest and "buy-in" of the majority of the practice (i.e., the entire care team).
3) A focus on conditions that are of substantial interest to the practice (e.g., conditions that affect a majority of patients, cases that are problematic and frustrating, or topics that appeal to practice members on a personal level).

Establish a Project Champion

A project champion is "an individual who has the authority to use resources within or outside an organization for completion of a given project. A project champion is chosen by the management to ensure supervision of a specific project right from its initiation phase to its execution phase."[11]

As the individual reading this toolkit, you are more than likely the project champion. However, depending on the size of your practice, having more than one designated champion is optimal. If your practice is part of a system, it might be helpful to solicit a project champion from within administration that will support any extra time and effort you will put into this process.

As the project champion, you will likely take on the greatest responsibility in all steps of the project that occur outside the exam room and some of the steps inside the exam room as well. Your personal interest, passion, and commitment to the concept of connecting to community partners to improve patient care are critical to the success of the project. Your personal capacity and assessment of the practice's "adaptive reserve" (ability to absorb more projects and change) are also important.

Establish a Physician/Clinician Champion

The term *physician champion* is often used to describe a voluntary physician leadership role connected to a specific project or endeavor. While the physician champion of a quality improvement project *could* also be the financial and organizational lead of the practice, this is not necessary (and in some larger practices, not practical). The literature on physician champions equates the term with an opinion leader, a change agent, a physician who influences colleagues and friends.[12,13] Think of EHR implementation—likely, a physician champion took on the role of promoting the cause and serving as the sounding board, advisor, and cheerleader to those in the practice. Very often, the physician champion can help the project manager solicit support from administration if the practice is part of a system. While a physician champion may not be responsible for the day-to-day implementation of the project, he or she provides the support needed for the project champion to make it happen.

Establish a "Learning Transfer" System for Your Practice

Typically, knowledge is transferred or disseminated two ways in a practice. The first method involves a central point of contact, usually the project champion, who works to bring general information about the community partner to *all* key players and clinicians in the practice. This person also encourages practice-wide adoption, and works with clinicians as they adapt the system to best fit their practice.

The second method involves a project champion who works closely with only one other physician/clinician, and together they determine the exact details for how the system should work within a single care team, unit, or pod within the practice. Depending on the success of the project, unique practice dynamics, and attitudes of other clinicians, the ensuing knowledge of "what works" within the single care unit or pod is then shared with others in the practice.

Often practice size, number of clinicians, ratio of clinicians to medical assistants/care team members, and overall organizational style will determine the best method for learning transfer. This often is not a decision the project champion would singlehandedly make, but a decision determined by the mechanics and style of the practice. Taking time upfront to pinpoint the learning transfer style and communicating the learning transfer method with the community partner will save time and confusion down the road, as the community partner works with a practice to assist in disseminating the information.

Respond to the Project Champion's Personal Questionnaire

As the project champion reading this toolkit, think through the questions in Tool 1 below and jot write down the answers. (You can also share them with a potential physician champion.)

The exercise will help gauge your interest and energy level. If the effort seems overwhelming, this might not be the best time to embark on a new endeavor. Take the opportunity to ask yourself what kind of practice and patient activities would increase *your* professional satisfaction. This exercise will help you crystallize your own thoughts before you approach the rest of the practice. Don't worry if your primary population of interest is not patients with obesity; the majority of strategies in this toolkit should be applicable whether you are connecting with a YMCA or a support group for caretakers of patients with Alzheimer's disease. The key is picking a patient population that you are motivated to help through a QI project.

Tool 1. Personal Questionnaire

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

Potential Project Champion: Questions to Ask Yourself Before Approaching Your Practice	*Potential Project Champion: Your Responses*
What is the main concern I have about my patients?	
What interests me?	
What interests my practice?	
Is there a larger percent of my patient population that is facing a particular condition?	
What do I know about community resources that could be helpful?	
Does our practice need to do some kind of QI project for external reasons (e.g., NCQA medical home recognition) and how much flexibility do we have?	
On a scale of 1 to 10, how confident do I feel about my ability to take on a new project, (even one intended to eventually reduce practice workload)?	

Gather Support

Next, you'll want to cement the support of the physician champion. If you are the physician champion, and you have the benefit of a having project champion for assistance, make sure your support of the project is visible to the entire practice; it can make a big difference in increasing the motivation of staff to put in extra time or effort.

If you are the project champion, ensure you have physician support before approaching staff. Physicians and clinicians should participate in a formal introductory-type meeting (see Tool 2 below), as physician buy-in plays a critical role in staff buy-in.

Once the project champion and physician champion are identified, formally ascertain your practice's interest in embarking upon a QI project. Try setting aside 10 to 15 minutes in an all-hands staff meeting to share your thoughts and ideas. You can present the idea ahead of time, either through email, in person, or both. A sample communication is shown in Tool 2.

Sample Template for Communications with Practice:

"Dear Staff,
As you know, we strive to provide the highest level of care at our practice. Dr. _____ and I have been learning more about the benefits of formally partnering with community resources and concrete ways in which we can do this. I believe it's possible to enhance the care we provide *inside* the practice by connecting with community resources *outside* the practice. The resources I have mainly give advice for helping patients with obesity and diabetes; however, we can discuss the patient population that we think needs this extra help the most. We are going to devote _____ minutes to this topic at our next all-hands meeting. In order to maximize our time, please review the following questions ahead of time and come prepared to share your thoughts.

- What is the main concern we have about the majority of our patients?
- What conditions do they face?
- (Finish sentence) I wish I could better help the patients who struggle with _____

Regards,
Project Champion Signature
Physician Champion Signature

Facilitate Staff Discussion

At the staff meeting, share the idea of partnering with a community resource, tell them about this toolkit, and then elicit responses on the questions below. An efficient method of collecting thoughts is to give everyone a sticky notepad and ask them to scribble down responses to the different questions – one thought per sticky note. If you are ambitious, you and an assistant can quickly categorize those post-it notes on the walls. However, just allowing staff to read off their post-its gives everyone a chance to talk and formalize their thoughts. Make sure to collect the notes at the end of the meeting.

- Do we think the idea of formally partnering with community resource is worth trying? Do you think the idea of formally partnering with community resources is worth trying?
- What do you know about community resources that could help our patients?
- Is it important to you? Is it worth doing? Are you willing to find the time for this?
- What are the possible benefits to our practice (e.g., QI projects that must be done anyway, increased satisfaction in patient care, etc.)?
- What would success look like?

Although these questions and answers seem obvious, being able to honestly and explicitly state the reasons for pursuing a practice project is an important step toward generating sufficient practice buy-in. To be successful, the majority of clinicians and their care teams should want to participate. However, full participation and buy-in can be challenging. With one willing clinician (it might be the physician champion), however, the project can move forward provided the clinician has adequate infrastructure and support (for example, a committed care team and support from the practice manager). Some practices find it helpful to be frank about who will and won't actively participate, with the understanding that some clinicians and care teams may choose to wait and see the progress of their coworkers.

Summarize and Cement Commitment

Consider keeping notes during the staff discussion and later summarizing and sharing the notes as a reminder as to why the project is important. This is where the sticky notes come in, as the notes can be summarized through an email and later posted in a break room location that is readily observed, such as the refrigerator door. The sticky notes can also be displayed on a break room wall, perhaps organized into categories.

Documenting all-staff conversations can be difficult, but incredibly valuable. Tool 4 will help capitalize on the opportunity to preserve thoughts that can help generate future support and energy for the project.

Tool 3. Facilitate Staff Discussion

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

Questions to Ask Practice/Staff Re: QI Community Referral Project	*Practice/Staff Responses (Ask everyone to record responses on sticky notes and collect for later use)*
Quick overview of previous questions: • **What is the main concern we have about the majority of our patients?** • **What conditions do they face?** • **Finish sentence) I wish I could better help the patients who struggle with _____.**	
Do we think the idea of formally partnering with community resource is worth trying?	
What do we know about community resources that could help our patients?	
Why is it important to us… Is it worth doing? Are we willing to somehow find the time for this?	
What are the possible benefits to our practice? (e.g., QI projects that must be done anyway, increased satisfaction in patient care, etc.)	
What would success look like?	

Tool 4. Summarize and Cement Commitment

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

Summarize notes from the meeting using the sticky note method to help trigger thoughts and organize into categories.

- Send summary of notes in an email to all staff.
- Post summary on refrigerator door or above the microwave/coffee maker in the break room.
- Write a quick reminder on white board in the break room.
- Arrange the notes in categories on a break room wall.
- Use any other methods that will keep the project visible and current in the minds of busy staff members. In a busy practice, visual reminders are key.

Step 2: Find, Connect with, and Evaluate a Community Partner

Think of your search to find an appropriate community partner as akin to a patient searching for a new primary care physician. While the phone book or Internet is a good start, there are typically some parameters (insurance coverage, geography, etc.) that can help guide the process. Similar parameters exist for a primary care physician searching for an appropriate community partner. As discussed in Step 1, the community partner needs to offer services that appear valuable to the practice and the patients they want to target. As appealing as a community program focusing on children's safety might be, it might not be the most useful partner for a practice with a large geriatric population. Acknowledge your practice's limited time and energy, and look for a partner in which you'll receive the highest return on investment for your efforts.

Find a Partner

To find a partner, combine "asking around" with searching the Internet. Bring up the topic when speaking with coworkers, staff, personnel from other practices, friends, and so forth. Also, keep your ears tuned for useful community resources mentioned by patients. Then, use the Internet to search recommended or mentioned community resources. Conduct strategic Internet searches on local resources, and then ask your networking group for their opinions and personal experiences. Develop a list outlining your research (see Tool 5 below).

Suggestions for an Internet search include:

- County health departments.
- State health departments.
- Programs offered by local hospitals (classes, wellness facilities, support groups, etc.).
- Local universities or colleges. (Type "community-based health" into the search finder to help locate the department that focuses on such services.)
- Health and wellness facilities, particularly nonprofit organizations such as the YMCA.
- Other nonprofit organizations such as TOPS (Taking Off Pounds Sensibly).
- Faith-based health programs.

Key words to use together or in combination during a search:

- *Obesity* (or the condition of interest)
- Your *city/town/county*
- *Community resources, organizations*
- *Non-profit* or *nonprofit*

Reach out to individuals who may know of community resources:

- Health reporters for local newspapers, television stations, radio stations, Web sites, and blogs.
- Libraries, chambers of commerce, and city social services.
- Suggested resources listed for the Internet search (e.g., local colleges) may not offer a service but may know of places that do.

While nonprofit organizations are not the only ones that can offer services to your patients, they have the best chance of offering services at a reduced or sliding-scale fee that economically disadvantaged patients can afford.

Tool 5 can be easily converted into a spreadsheet with the suggested categories and others as needed. The goal is to take time upfront to put all the necessary information in one place.

If a physician or staff member has a high school or college-aged student who needs credit for doing a service project, having them develop this list could benefit both the student and your practice. The spreadsheet could then be housed on the practice's shared server. If the student has enough time, consider having them develop a hard copy notebook that includes the information from Tool 5, plus the brochures or printouts from the practice's or community resource's Web site. For both the electronic and hard copy versions, be sure to date each entry.

Connect to the Partner

The next step will be critical to establishing or deepening a relationship with a community partners/resource: setting a time to meet with the correct representative of the organization with whom you are looking to partner. It is likely that the resource has not been contacted by a primary care practice, so be clear and direct in what you are seeking. The template in Tool 6 below can be modified for your practice and community.

Tool 5. Finding the Partner

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

Name of Local Community Resource	Website link	Primary Contact Info (LOCAL)	General description (targeted population, fees & costs, etc.)	"Word of mouth" information

Tool 6. Connecting to the Partner

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

(*script can be modified to be first phone call contact)*

Dear _____,

My name is Jane Johnson and I am the practice manager at Caring Family Associates in Anywhere, USA. I work closely with four family medicine physicians who see patients of all ages and conditions. One of our physicians, Dr. Jones, is particularly concerned about the increasing population of patients with obesity and prediabetes. These patients need substantial help making lifestyle changes in eating and physical activity, more help than we can provide in the average office visit.

Recently I noticed an article in the newspaper about the walking program held 4x/week at the city park and your name was the contact list. [Describe program as appropriate.]

Dr. Jones and I think many of her patients might benefit from this program. We would like to learn more about it before we start "referring" patients. I would like to set up a quick phone call in the near future, perhaps followed by a visit to our practice to meet Dr. Jones. What are some good times to reach you by phone? I am in the office Monday through Thursday.

Caring Family Medicine Associates has been part of this community for more than 10 years. It is great to see such healthy programs like your walking group as part of the community as well. I look forward to learning more about how we can perhaps partner together in the future to help our patients and community members become happier, healthier citizens.

I look forward to hearing back from you shortly.

Regards,

Project Champion

Evaluate the Partner

The number of attempts it takes to speak to a knowledgeable person can be an important consideration in a potential partner's capacity to work with your practice to develop a productive working relationship. The potential partner's capacity to connect you to the right person, answer questions, promptly return emails or phone calls, and send information should be considered. Like a medical practice, some community resources have the best intentions but become overwhelmed and struggle for time, money, or resources. Unless a partner is exceptional in its services and history, and your practice has enough capacity to carry the load, it would be wise to avoid any partnership with a community resource that seems perpetually short staffed and overloaded.

The AHRQ pilot project highlighted elements that practices might consider as they evaluate potential partners. When you make contact with the primary point of contact, consider asking the questions in the top part of Tool 7, below. The questions will help keep you on track, and the notes section that follows will help you make an objective evaluation about the organization's readiness and willingness to work with a medical practice. Tool 7 could be kept on the practice's shared drive.

When contacting the community resource, consider the experience from the patient's point of view. For example, is there one primary point of contact? Does he or she return calls and emails promptly? What is the sense of organization and caring from the person on the other end of the line? Your practice is probably cautious about the specialists you refer patients to; referring to a community partner is no different.

Once initial contact has been made with a potential partner, a time should be set up to meet. The first meeting should be casual and, if possible, on neutral ground (e.g., a local coffee shop). At this point, you can further discuss the questions from Tool 7, and also use this toolkit as a basis for conversation. Remember that these steps are as important as establishing a referral system for sending patients to a cardiologist or other specialist. You and your practice need to feel good about the partner, enough so that you're willing to invest the extra time and energy into the project. If your time and your potential community partner's time are limited, you may need to skip to the second meeting.

The second meeting should be at your practice. It is critical that the potential partner gets a sense of how your practice operates in terms of workflow, patient path, intra- and interoffice communication, use of an EHR for referral purposes, and so on. Devoting an hour to giving the community partner representative a tour of your practice and making introductions will lay the foundation for a successful relationship in the future. It is important to have the representative meet the practice referral coordinator if your practice has one. Primary care is built on relationships, and the relationship with your community partner is no different. Linking a name to a face can make the difference in whether a staff member remembers to take 30 seconds to tell a patient about this new community partner.

Finally, the second meeting with the potential partner should reveal how receptive the organization is to working with your practice and the steps it needs to take to make the collaboration successful. If the representative is not interested in learning about your practice and the logistics of the referral process, this might not be the best partner for your patients. The time spent upfront will be worth the time saved on the backend.

Tool 7. Evaluating the Partner

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

Community Resource Name:	Interview By:
Questions	**Responses**
What evidence-based programs do you offer for patients with _____ ?	
Please tell me more about the program.	
Who is the main contact person for the program, and how can I get a hold of them?	
Do you currently work with other medical groups or practices, or have you in the past?	
Do you have a way to securely send and receive electronic fax information?	
Are there eligibility criteria for your program and if so, how do you assess it?	
Do you have some kind of financial assistance for low-income patients?	
Can you send me program information that I can share with my practice?	
On a scale of 1 to 10....	Poor Average Excellent
How patient-centered does this organization seem? **Notes:**	1 2 3 4 5 6 7 8 9 10
	Not at all Moderate Very
How confident would I feel sending my patients to this organization – do I think they will receive high-quality and credible assistance? **Notes:**	1 2 3 4 5 6 7 8 9 10
	Not ready Moderate Very
How prepared does this organization seem to be for working closely with a medical practice like ours? **Notes:**	1 2 3 4 5 6 7 8 9 10

During the AHRQ pilot project, the community partner representative visited each practice and spent half a day watching, observing, and chatting with practice members when appropriate. The community partner also underwent some "Primary Care 101" training with study team members to learn the typical jargon and lingo of medical offices, as well as general information about patient flow, work patterns, roles, and responsibilities. It might be helpful to direct your community partner to the following resources:

- This toolkit, so he or she can better understand what you are trying to accomplish
- The YMCA toolkit for facilitators working with health care providers
- The **Community Based Organization and Health Care Professional Partnership Guide**, a toolkit from the National Initiative for Children's Healthcare Quality that guides advocates on how to link community based organizations with health care providers. Available at http://www.nichq.org/

Communicate With the Community Partner

After deciding to link with a community partner, the demanding and hectic schedule of the typical primary care practice can make regular contact challenging. Designating a project champion and sharing preferred contact information can help reduce the amount of missed phone calls, unread emails, incomplete messages, and general confusion. Designating a clinician champion will increase the chances that everyone in the practice will help the project champion, and allow the community partner representative a clinical point of contact when needed. As elementary as it sounds, providing the community partner with the following basic information can help reduce frustration and mixed messages on all sides.

Project Champion—Communicate the following to your community partner:

- Best time to be contacted (days of week, time of day)
- Best method of contact (office phone, cell phone, email, texts, in person)
- Current contact information (phone numbers, email addresses, etc.)
- Backup contact person
- Preferred methods of receiving information (email, fax, mail, in person, combination)

Clinician Champion—Communicate the following to your community partner via the project champion:

- Any administrative or non-patient-care time the clinician may have and therefore be more available for a phone call or meeting
- Current contact information (phone numbers, email addresses, etc.)
- Preferred methods of receiving information (email, fax, mail, in person, combination)

Tool 8 below will take less than 5 minutes to complete. The community partner can use the same form to provide you with their contact information.

Tool 8. Maintaining Contact with the Community Partner

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

Contact Information for Caring Family Medicine Associates	
Project Champion Name & Role in the Practice	*Physician/Clinician Champion* Name & Role in the Practice
The best day and time of day to contact me is:	When the clinician is most available for a quick phone call meeting:
Best Office Phone: Cell Phone/Text: Email: Fax: Other: Of the above, the preferred way to contact me is:	Best Office Phone: Cell Phone/Text: Email: Fax: Other: Of the above, the preferred way to contact the clinician is:
The best back-up person to contact is: Contact number/email:	Regular time for all-staff meetings: Day/Time:
I prefer the following method for receiving information/materials for myself or office/patient distribution: Email Fax Mail In person	Please copy me on emails to the following individuals in this office:

Most community partners that are willing to work with a primary care practice are willing to accommodate the practice however possible. As an example, the health facilitator in the AHRQ pilot project learned that emailing information to practices to distribute to patients didn't work because there was a time and expense associated with printing, which the practices could not afford to incur. Also, the large volume of emails that the practices received every day created a situation in which materials were getting lost—something mailed by the post office had a better chance of making it into the physician's inbox or being distributed at a staff meeting. Finally, the AHRQ pilot project was geographically suited so that the facilitator could make face-to-face visits with the practices and share materials.

What the health facilitator learned from this pilot is that while email is almost always easier for the sender (the community partner), it can be difficult for the recipient (the medical practice). However, there is no way for the partner to know this unless the practice specifically tells them, and there is no detail too small when it comes to establishing successful communication.

Step 3: Identify Patients

The identification of eligible patients is two-fold: first, does the patient fit the physiological profile of someone who may benefit from the community resource; and second, does the patient demonstrate a minimal level of "readiness to change?" In the AHRQ pilot project, practices had to identify patients who met the physiological requirements for the YMCA Diabetes Prevention Program (i.e., prediabetes by either a blood test or other risk value). Not surprisingly, identifying these patients by physiological measurements was fairly straightforward. However, both the study team and practices learned that physical eligibility alone was insufficient for prompting a patient to take the next step and acting on the referral. Assessing the patients' readiness to change will be addressed in "Chapter 4. Linking with the Patient," which includes patient engagement tools. In the AHRQ pilot project, practices had two distinct methods of targeting their patients (preemptive and point of care), and at times these methods were used interchangeably or simultaneously.

Preemptive Identification

Some practices in the AHRQ pilot project took a "wide net" approach by searching all possible patients who might be physiologically eligible for the YMCA's Diabetes Prevention Program (YDPP). Knowing the close association of elevated blood glucose with obesity, hypertension, and hyperlipidemia, practices used a combination of ICD-9 codes to query their EHRs to find eligible patients. In this particular pilot project, elevated blood glucose was a prerequisite to participate in the YDPP; however, many obesity management community programs exist that do not have such stipulations. (In such a case, querying by body mass index (BMI) or the ICD-9 code for unspecified obesity would likely work.) Once the patients were identified in the AHRQ pilot project, the practices used a variety of methods, specific to their work environment and EHR, to flag eligible patients. One practice was able to use a "pop-up" reminder within its EHR (e.g., "consider referral to the YDPP") for each identified patient. Other practices simply highlighted the information within the record. See Tool 9 for examples on how to query patients.

Once patients are queried, your practice can choose the best way to build a registry for tracking, either through your EHR or a stand-alone registry with a spreadsheet. Developing a registry is not the most critical step in developing a partnership with a community resource, so lacking the time or resources to do so should not impede work with a community partner. However, building a simple but formal registry for the patients you intend to refer will likely pay off with the enhanced ability to track patients and generate reports, as well as the incentives provided by many health care plans and the

Centers for Medicare and Medicaid Services (CMS). The steps to building a useable database are beyond the scope of this guidebook, but many excellent sources are available for free, including an article and brief toolkit from the American Academy of Family Physicians.[14]

Preemptive Identification Advantages. Casting a wide net allows a practice to review the entire spectrum of patients, including those who are overdue for a visit. The patient-centered medical home movement encourages practices to take a proactive population-based approach to patient care, and this strategy fits well within those domains and the requirements by some recognition organizations such as the National Committee on Quality Assurance (NCQA). The provision of self-care and community support is among NCQA's six standards for the 2011 recognition program for the patient-centered medical home. (More information is available at www.ncqa.org.)

Most practices have probably conducted a quality improvement project that requires the identification of a certain population of patients (e.g., patients due for a mammogram) and, thus, previous strategies can be adapted for identifying patients considered clinically overweight or obese.

This also allows clinicians to review patient lists ahead of time to identify which patients might be the best candidates for referral. This strategy affords the practice the opportunity to proactively reach out to identified patients with a phone call, email, letter, or other method of communication. One clinician in the AHRQ pilot project sent a letter to identified patients asking them to consider the YDPP and encouraged them to schedule an office visit to discuss the program in regards to their health.

Preemptive Identification Disadvantages. Not having an EHR and having to manually review patient charts could be considered a preemptive identification disadvantage. All the practices in the AHRQ pilot project that used preemptive identification had the benefit of an EHR. One practice implemented an EHR midway through the project, and it was only then that they could query for patients. Practices without EHRs could build a simple tracking database, but this would require the manual review of all patient charts to find the appropriate patients—time consuming, but not impossible.

Compiling patient names is just the first step. Additional time and resources will be needed to take the necessary steps to turn the patient list into actual referrals and then enrollment into the program. These steps need to be factored into the overall quality improvement project, which can make it seem more daunting.

There is a fundamental difference between identifying a patient by physiological criteria and making a referral, and identifying a patient by both physiological and "readiness to change" criteria and then making the referral. The AHRQ pilot project demonstrated that compiling a list and making referrals does not guarantee patients will act on that referral.

Preemptive Identification Case Study. One clinician and her care team in the AHRQ pilot project queried their EHR system to generate a list of patients who qualified for the YDPP (using ICD-9 codes for abnormal blood glucose). Next, they worked with their community partner (in this case, the YMCA) to create a simple letter that included information about the YDPP and the contact information. The letter also invited patients to schedule a visit with their clinician to talk about their health and why the YDPP might be a good choice to consider. This preemptive approach produced a list of several hundred patients, many of whom did schedule a follow-up visit after receiving the letter and were subsequently referred to the YDPP. See Tool 10 for a sample letter.

Tool 9. Identifying Appropriate Patients

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

METHOD	TIPS
• Use EHR to search by ICD-9 code or medication codes. • This can also be done by 'chart mining' if no EHR is available. Slow, but still effective.	• Non-specified obesity: 278.00 (BMI 30 and above – will not capture overweight) • Abnormal Blood Glucose: 790.2 (790.21, 790.22, 790.23) • Could add hypertension, hyperlipidemia
• Use practice management/billing system to search by appointment type or services billed.	• Any billable service possibly associated with obesity: diabetes, hypertension, hyperlipidemia, osteoarthritis, depression, etc.
• Ask contracting health care plans for their most recent lists that might include patients with obesity.	• Example: ask each health care plan for a list of all patients who started on diabetes medication over the last year
• Update in real time with each office visit.	• When patients come in with the diagnosis of obesity, add their name to the registry.
For an excellent article on simple methods of querying patients: White, B. Improving Patient Care: Building a Patient Registry From the Ground Up. *Fam Pract Manag.* 1999 Nov-Dec;6(10):43-44. http://www.aafp.org/fpm/1999/1100/p43.html	

Tool 10. Sample Letter to Identified Patients

Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity

(Use Practice Letterhead)

Dear Patient XX,

We are constantly trying to improve patient care here at Caring Family Medicine Associates. My care team recently helped me review all my patient records in order to pinpoint patients who might benefit from additional assistance in making lifestyle changes related to healthy eating, physical activity, and overall weight management. We think you might be one of those patients.

I love seeing my patients in the office; talking to patients is one of the reasons I chose primary care. Unfortunately, our visits never seem long enough to discuss all the appropriate strategies for a healthy lifestyle and how to best make those changes.

I am happy to say that I now have a new member of my care team outside my office. I have met several times with this community resource and I feel confident they can help my patients reach their personal health and wellness goals.

I have enclosed some material on this community resource. *[Opportunity here to add personal details about the resource or the representative]*

I encourage you to please call _____ and speak to _____. I also encourage you to call our office at _____ and schedule a quick visit with me so I can update your personal health records and make sure you are ready to join any kind of new program. We can also talk about any reservations or issues you might have. I am here to help you achieve your best personal health, and so is our new community partner.

I look forward to seeing you soon.

In Good Health,

Dr. XXXXX

Point-of-Care Identification

Some practices in the AHRQ pilot project adopted the approach of identifying a patient as a good candidate either directly before or during the patient encounter. In this scenario, the clinician or ancillary care staff (e.g., a certified diabetes educator) would note that the patient was eligible for the YDPP through both their physiological markers and their attitude towards making lifestyle changes. Patients would be approached individually and specifically selected for the referral "invitation," and the clinician would build upon past positive conversations and the existing relationship to make the case for lifestyle change. One physician described the trigger for the referral conversation as a "feeling" he had that this was the right time to bring up the topic.

Point-of-Care Identification Advantages. In practices where clinicians work in complete autonomy, it might be difficult or even impossible to initiate a practice-wide patient query. Point-of-care identification allows a single clinician to work independently (or with a key staff member) and still see success with his or her own patients.

This method also allows clinicians to embrace the "art" of medicine; instead of working from a list, they are using their intuition and patient relationships to make decisions about the timing of the referral process and subsequent conversations about lifestyle change. This step incorporates both critical pieces of the patient encounter: the patient's physiological status as well as their psychological, or mental, "readiness to change."

Point-of-Care Identification Disadvantages. Approaching patients based solely on the current office visit might mean missing a large percentage of patients who are not coming in for regular visits. This method is also largely dependent on clinicians or other key members of the care team remembering to identify the patient at the point of care. This increases the risk of forgetting to target appropriate patients, especially on busy days. Furthermore, this method doesn't lend itself to a more inclusive practice-wide activity that embraces the concepts of quality improvement, and could, thus, be "counted" toward specific programs such as NCQA's patient-centered medical home recognition. This method also puts a larger burden (remembering to identify and approach patients) on an already busy clinician.

Point-of-Care Identification Case Study. One physician in the AHRQ pilot project had personally gone through the process of losing weight and shared that this experience gave him an insider's perspective into which patients might be the most receptive to joining a community weight loss program (in this case, the YMCA Diabetes Prevention Program). He worked independently in his practice and found that the best strategy for him was to keep the YMCA Diabetes Prevention Program information visible at all times (e.g., promotional posters on the back of exam doors and a brochure tucked into the top of a manila folder he carried at all times). He said simple visual cues worked best for him and were all he needed to trigger the thought "Is this patient a good candidate for the community program? Do I think this patient is at the right state of receptivity to talk about lifestyle change?"

Although this physician did not refer many patients, the patients he did refer had the highest enrollment rates. This physician also relied upon motivational interviewing strategies with patients, some of which will be shared later in this toolkit.

Hybrid Approach

It is expected that most practices will choose a hybrid approach of the preemptive and point-of-care identification techniques. One approach does not preclude another, and practices are encouraged to

consider the advantages and disadvantages of both and reflect upon their own work environment. The following questions may provide some direction:

- **Practice buy-in:** How many clinicians would be willing to participate? Will this be a practice-wide effort or confined to just one clinician and care team?
- **EHR:** How accommodating would our current EHR be in our efforts to query patients and/or build a registry? How much help could we expect to get from the EHR vendor?
- **Patient outreach:** Do we have an established way of reaching patients outside the office (e.g., email, Web site, letters, etc.)? How much time, energy, and resources would it take to develop a method suitable for this endeavor?
- **Similar QI projects:** Has our practice conducted other quality improvement projects similar to this one, so we can repeat and reuse query requests, patient outreach methods, etc.? Or, would we be starting completely from scratch?
- **Clinician passion:** Is the physician champion heavily invested and committed to the success of the program, enough so to remember to self-identify appropriate patients and initiate a referral?

Hybrid Approach Case Study. One practice in the AHRQ pilot project had a highly functioning EHR that generated pages of lists of eligible patients for the community project. Several of the clinicians followed the lists and liberally used the referral forms. However, a feedback report provided by the community partner highlighted a conversion rate of only about 1:15—of every 15 patients referred, only one actually enrolled.

While acknowledging the power in numbers, the clinical care coordinator also realized that perhaps the clinicians needed to enhance the way they talked to patients about the referral process. She worked with the community provider to coordinate a brief training session on motivational interviewing as part of a regular monthly meeting. The practice still intends to cast a wide net by using EHR queries, but the motivational interview training has helped the clinicians target their time and energy into patients most receptive to change.

Step 4: Create and Use a Referral Form

A long, complicated referral form will either sit in a cabinet drawer and collect dust or reside, incomplete, within an EHR. Thus, it is helpful to take the time upfront to figure out the *exact* details that the community partner needs in order to initiate contact with the patient, and include nothing more. For the AHRQ pilot project, a set of clinicians provided feedback about what information they could reasonably document in a referral form during a typical patient encounter. The YMCA Diabetes Prevention Program representative was able to use their input to create a referral form that also gave her the information she needed; that is, was this patient eligible for the program, or did she need to conduct a more complete assessment? From this collaborative exercise, the following questions emerged:

- **What is the perfect marriage of information the community partner needs to initiate contact and information only a clinician can provide?** For example, there is no reason for the clinician to fill out the patient's address; the community partner representative can complete that part over the phone with referral patients. However, only the clinician can check whether or not a patient's blood work indicates a certain condition.
- **If the practice still uses paper, what is the preferred physical format of the referral form?** The AHRQ pilot project found most clinicians preferred a full sheet of paper, as it was easier to scan and/or slip into a medical chart. Even some "paperless" practices using an EHR for referrals still liked having the visual trigger of the paper format, and the ability to hand the form to the patient once the referral went through the EHR.

- **Who will fill out the referral form and at what point during the patient encounter?** (e.g., physician, medical assistant, referral coordinator, etc.?) In one practice, scanning the list of the day's patients gave the physician the opportunity to identify possible referral patients; then, the physician asked the medical assistant to partially fill out the referral form ahead of time.
- **How will the referral form be entered and passed through the system; and how will this referral be documented in the patient's chart?** (e.g., typed directly into the EHR, customize a drop-down referral screen, scan a paper form, etc.?) Some practices in the AHRQ pilot project were able to integrate the referral form into the EHR, allowing a simultaneous process of referral and documentation. Other practices electronically faxed the referral form, but still had to make separate notes in patient charts. Finally, others chose to save up the batches of forms to hand deliver to the community representative when she came to visit; those referrals also had to be noted separately in the patient chart, usually with inclusion of a scanned referral form.
- **What are some of the HIPAA-compliant considerations?** The practices participating in the AHRQ pilot project were fortunate in that the community partner, the YMCA, used a secure electronic fax system, and all individuals with access to the system underwent HIPAA training. Not every community partner will offer that degree of protection, so the referral form used should reflect this (i.e., only using the phone or regular fax to refer or not including any personal health information on the referral form). While there is no one-size-fits-all approach for computer security, an article by the American Academy of Family Physicians, "10 Steps to HIPPA Compliance," offers practical steps to consider: www.aafp.org/fpm/2005/0400/p43.html.[15]

Case Studies. Several practices in the AHRQ pilot project used a designated referral coordinator to manage the referral process. This individual was asked to integrate the community-resource program referral process into the system just as they would for a referral to a medical specialist or to ancillary care, such as physical therapy. The following elements seemed to markedly increase the success of the referral system and coordinator.

1. **The commitment level of the referral coordinator and his/her personal belief in the value of the community program.** In one practice, referrals were lagging until an unhappy employee left the practice. When the position was filled by someone excited and enthusiastic about the process, the referral numbers started to climb. This individual even took the initiative to send an email reminder to the clinicians every few weeks, reminding them to refer patients when appropriate.
2. **The technical ability to include the community program into a referral menu within the EHR**, allowing a seamless transfer of information while simultaneously documenting the referral, and possibly triggering an automatic electronic "tickler" to follow up.
3. **If the EHR does not facilitate community referrals, the ability and tenacity to establish a stand-alone simple tracking system.** Some practices in the AHRQ pilot project struggled with EHRs that did not allow customization of the drop-down referral box, making the process more difficult because the referral coordinator now had the extra step of external documentation. However, one referral coordinator developed a simple spreadsheet that tracked each patient, including the date of referral, the coordinator's follow-up efforts to contact the patient, and any information received back from the community program.
4. **The ability and tenacity of the referral coordinator to personally follow up with referred patients**. This impresses on the patient the importance of the referral to the clinician and the practice. While the ability to leave messages varied by practice in the AHRQ pilot project, the coordinator would use a script similar to this: "*Hello, this is _____ from Dr. _____'s office. I'm just calling to check up on your referral to the YMCA Diabetes Prevention Program. Dr. _____ really felt this program would be a good fit for you and wanted to make sure you were*

able to talk to them and get your questions answered. If you have any questions for Dr. _____ or for me, please call this number. I'm here from 9 am to 5 pm every day and coordinate all the referrals."

Note: Appendix A (Case Studies) in this toolkit describes some of the practices in the AHRQ pilot project in more detail. Of the practices, A, B, and D used a designated referral/chronic care coordinator. This individual was already doing another fulltime job, so she or he worked with the community partner to determine the best way to track referrals without adding extra work.

Step 5: Integrate the Process Within Patient Paths

Based on the experience of the AHRQ pilot project practices and the general evidence base currently available, establishing a successful referral system requires two complementary components: a committed physician/clinician champion who works to connect to the patient *inside* the exam room, and enough practice team members willing to reinforce that message at appropriate moments *outside* the exam room. The former component will be addressed in the second part of this toolkit; the latter component, however, can be addressed through a simple patient path exercise.

As part of the patient path exercise, conduct a physical walk-through the practice (perhaps using the community partner representative as a fresh set of eyes); use a large piece of paper taped to the wall during a staff or stakeholder meeting to diagram the patient path; or employ the tool that accompanies this toolkit. Whether physically or on paper, start by walking through your practice.

Initial Contact and Outreach

Before your patients even walk through the front door, how do they communicate with your practice, and can that source of communication promote weight management resources within the community?

> **Example:** A practice Web site could provide links to community resources such as to the YMCA or TOPS (Taking Off Pounds Sensibly); a clinician could provide an extra word of endorsement on the Web site; or a clinician, staff member, or patient could post their own weight loss success stories.

Waiting Room

What literature and reading materials are available in your waiting room? Will your patients feel like your practice promotes wellness and healthy lifestyle changes? Most community resources will be happy to provide brochures, but think beyond brochures and ask the community partner to provide a full-size poster for an easel, to take ownership of a bulletin board, or to provide a scrapbook of success stories (with participant permission).

> **Example:** Patient or staff testimonials can be very powerful. One of the most successful strategies in another healthy office research project used waiting room posters to highlight staff members who had lost weight. Many patients turned to these staff as role models.

Vital Signs and Weight Stations

Most practices have a scale in a specific area. Consider putting community resource signs or a BMI poster above the scale. This may help trigger a *positive* conversation about weight management during the weight measurement.

Example: Visual cues can be helpful to both patients and medical staff for different reasons. An appropriate sign could prompt the patient to start a conversation about their weight, and the medical assistant could either address the patient's concerns or make a note to the clinician to follow up. Likewise, the visual cue could help busy staff remember to focus on a specific component of the visit, such as making sure every patient understands the meaning of BMI.
Exam Room

Patients often spend more time in the exam room than in the waiting room, but with less access to reading material. Consider how a motivated community partner could use that opportunity to promote not only their program, but also healthy lifestyle choices in general with brochures, posters, and scrapbooks. A practice could also provide its own laminated list of community resources for obesity management—simply put the list on the exam room chair or table.

Example: Many practices now belong to health care systems with rules about posting anything beyond approved art or diplomas on exam room walls. One practice in the AHRQ pilot project received permission to put YMCA Diabetes Prevention Program posters on the backs of the exam room doors, which the clinicians said was effective in serving as a visual cue.

Other Opportunities for Visual Cues

Many practices have limited abilities to use exam room walls for promotional and visual cues. One clinician in the AHRQ pilot project got around this by simply placing the community brochure in a manila folder with other paperwork he intended to review for every patient. He explained that seeing the brochure several times a day helped him remember to talk to appropriate patients.

Example: Are there other areas, besides the exam room, where the patient might be sitting as a "captive audience?" Examples include the patient restroom, a screen saver on the computer in the exam room, or in the blood draw waiting area. Urge all interested clinicians to think about what kind of subtle visual cues might work best for them.

EHR

With the understanding that some practice staff already suffer from "reminder fatigue," consider feasible ways in which the EHR could be employed as a visual reminder (e.g., pop-up reminder box, question or statement added to the interview) or interactive tool (e.g., part of the patient's health risk assessment). The AHRQ pilot project revealed that several practices actually preferred poster or brochure cues, citing that the EHR was constantly changing. However, some practices did find ways to make the EHR part of the process.

Example: One practice in the AHRQ pilot project customized its EHR by adding a pop-up reminder for patients who met the criteria for the community resource. The reminder linked directly to the referral card, which was then electronically faxed to the resource. Two other practices added the community resource directly into their drop-down referral checkbox.

Nonpatient Areas

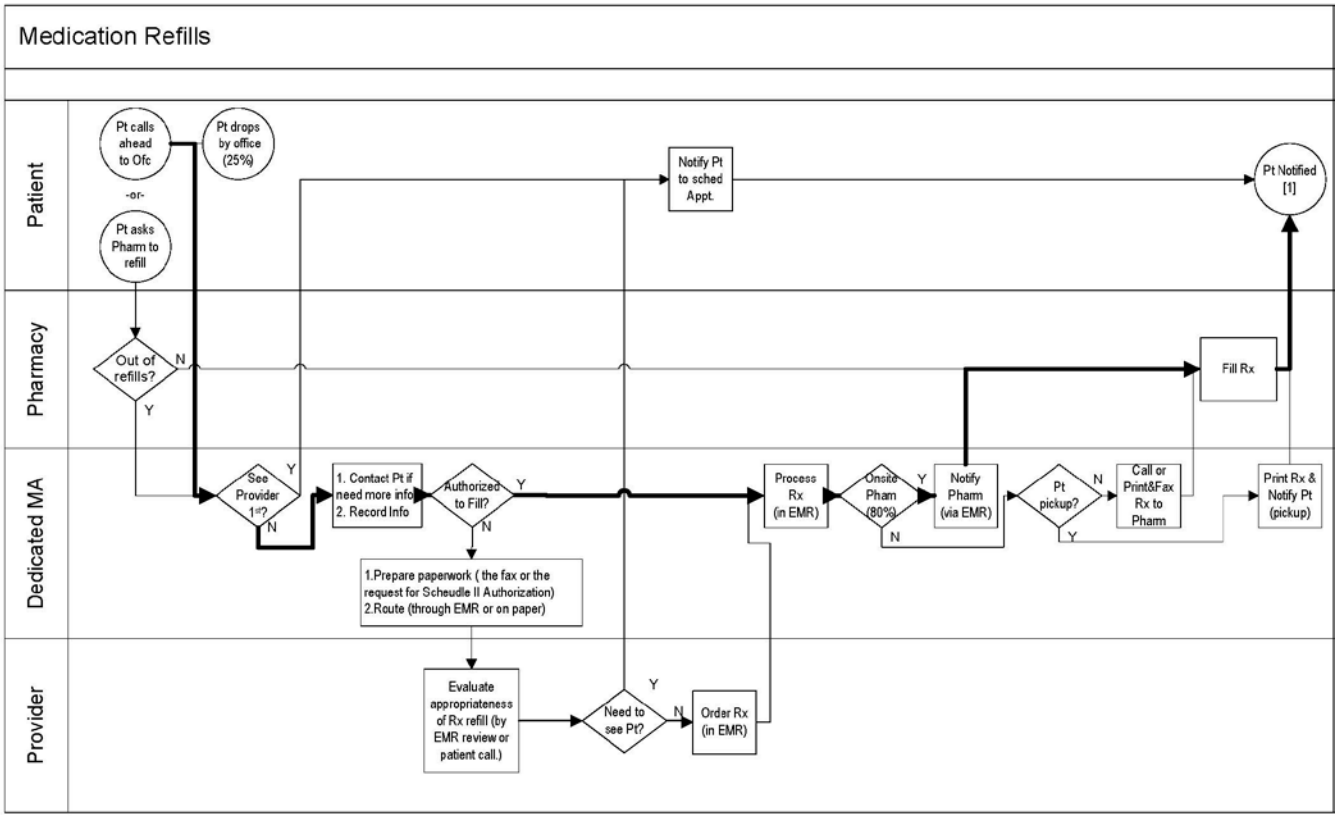
Although it sounds counter intuitive, do not limit the patient path to the areas where the patient physically moves. Where do staff and clinicians reside between patients, and how might that space be optimized for reminders? For example, if clinicians still receive some lab results via fax, a sign above the fax machine promoting a community program for prediabetes or diabetes might be a timely trigger.

Also, consider the staff break room, kitchen, and individual phone and computer stations as locations for community program materials.

> **Example:** The community representative in the AHRQ pilot project provided resistance bands to some practices along with a printout demonstrating several stretching exercises. Staff could do some of the exercises at their phone stations, which not only improved their wellbeing but kept the community partner at the forefront of their mind.

Process Mapping Resources. Some practices will find that a simple walkthrough is adequate for this process, and tips on maximizing the experience can be found in an article, " How to See Your Practice Through Your Patient's Eyes" (www.aafp.org/fpm/2008/0600/p18.html).[16] Other practices might find that taking a more formal approach by way of "process mapping" can be useful, particularly in larger practices or those with additional resources to help with continuous quality improvement efforts. Process mapping has its roots in industrial engineering as a way to help manufacturers reduce waste and optimize efforts. It has since become a tool for virtually all kinds of companies and businesses, including medical practices, as a way to objectively view workflow and realize opportunities for improvement. The Improving Efficiency in Primary Care toolkit (http://fammed.ucdenver.edu/efficiency/default.htm), provides a detailed example of a process map for prescription refills (see Figure 1 for example).

Figure 1. Example of Processing Mapping



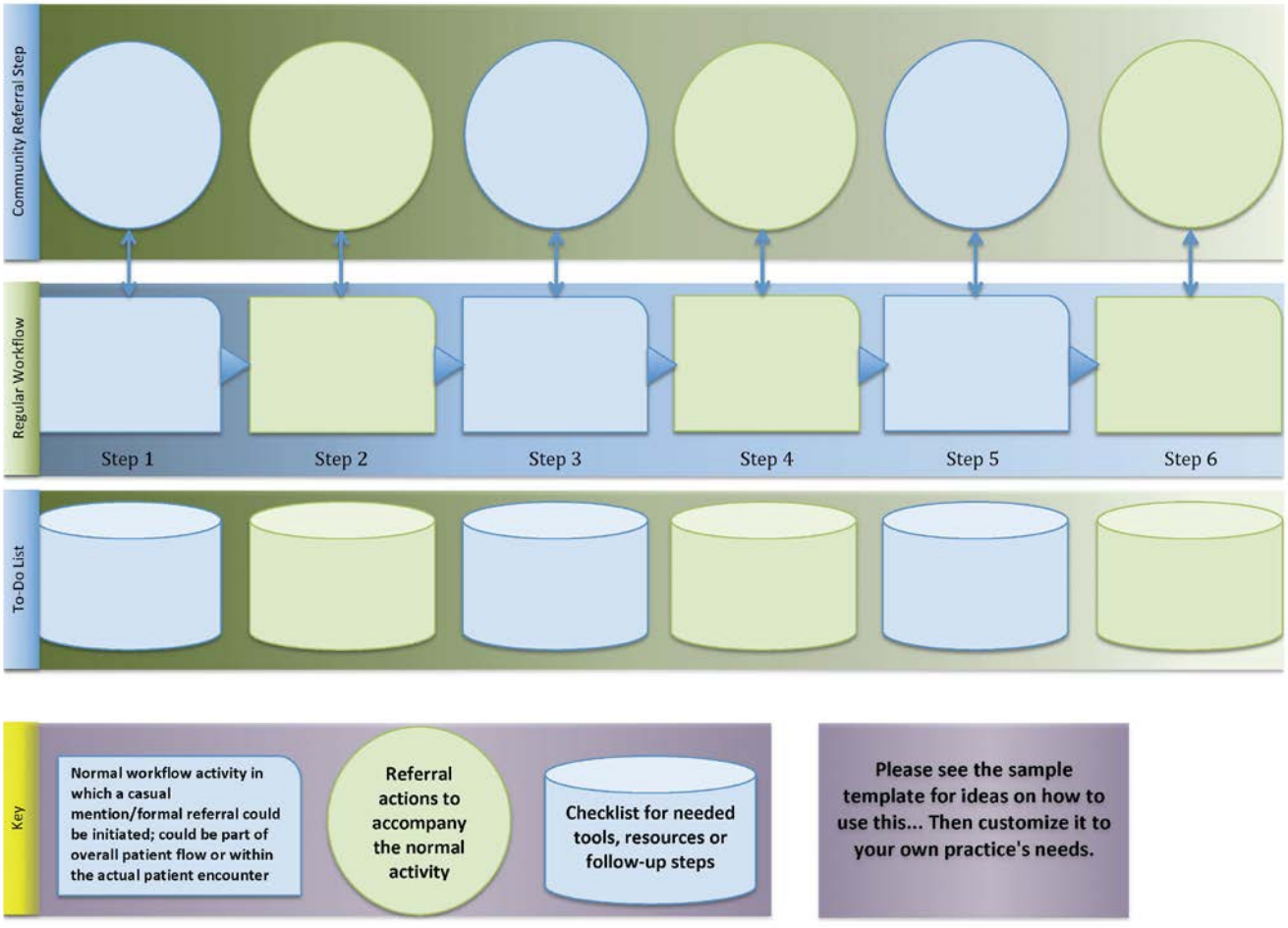
Tool 11 below is intended to combine the best of the practice walk-through and the process map. Consider filling it out as part of an all-staff meeting or a one-on-one discussion with other project stakeholders. The template can be printed out and distributed among the care team.

The **rectangles** represent each activity in which a casual mention or formal referral of the targeted community partner could be initiated (e.g., at the weigh-in portion of the patient encounter, during the family history portion of the exam, during medication reconciliation, during a phone call to report recent lab results). The level of detail can be personalized by your practice and the person responsible for completing the map. You may want to break out the activities on the map based on the different members of the care team, or you may choose to organize the map by activities within a patient encounter inside the exam room. The template is intended to be generic enough to allow customization.

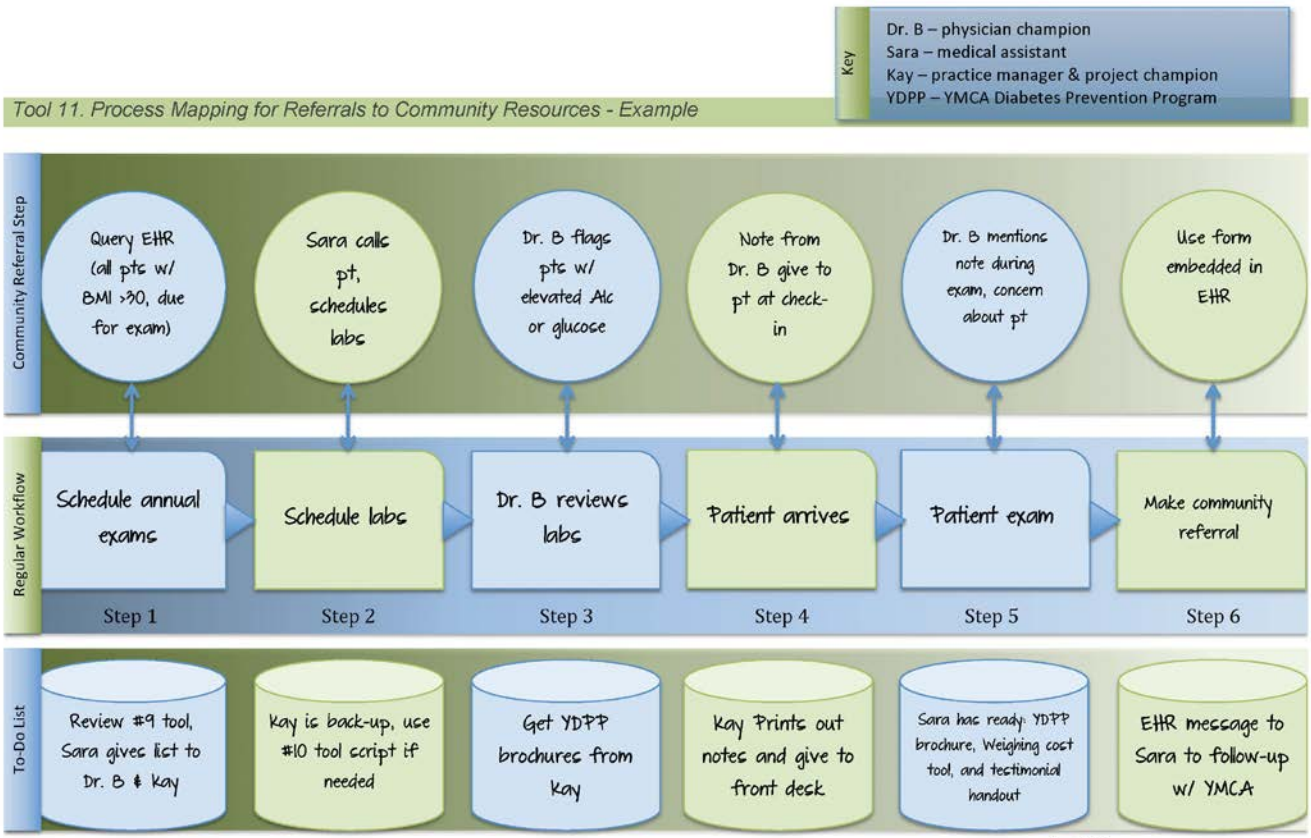
The **circles above the rectangles** represent the referral actions that accompany the original activity. For example, if a clinician reviews a patient chart during the morning huddle, the huddle would be indicated in the rectangle and the circle would represent the medical assistant flagging the chart to remind the clinician that the patient is a good candidate for a community referral. You might find that some of the tools or activities incorporated into the second part of this toolkit focusing on patient engagement also fit into the process map.

Finally, the **cylinders below the rectangles** are intended to serve as a checklist for needed tools, resources, or follow-up steps.

Tool 11. Process Mapping for Community Connections



Tool 11. Process Mapping for Referrals to Community Resources - Example



Note to Kay: Copy & scan this process map for NCQA III recognition (standard 6)!!!
Note to Dr. B: address back-up plan 3 wks if patients aren't responding

Step 6: Develop a Feedback System

A bidirectional referral process only works if the community partner knows what kind of information would be helpful to the practice, as well as how and to whom to send the information. Be very explicit in communicating to the community partner the importance of data and feedback. Chances are the partners will assume the patient is keeping the clinician up to date, and will want to avoid sending duplicate information. Provided your practice wants to receive regular and timely feedback, you might ask the community partner to provide your practice with regular reports that answer the following questions:

- Were you able to make contact with the patient? If contact was made, did the patient enroll in the program, or did the patient decline entry?
- If the patient *did* enroll, did your program collect baseline and ongoing data that you can share as the program progresses (e.g., weight or attendance in class)?
- If the patient declined enrollment, can you share their reason?
- Can you send the information back to our practice using our preferred format (e.g., electronic fax)? (Note: the practice will need to specify the preferred format; do not assume the partner will know this. Also, specify the best person to receive the reports to ensure they get to the right clinicians.)

It should be noted that once a patient joins a program, the community partner might be limited on how much information they can share without the patient's permission. Some programs ask the patient to sign a form that allows the instructor to send attendance or biometric data to their clinician. In the AHRQ pilot project, at least one patient did not want their physician to know they were in the YMCA Diabetes Prevention Program because they wanted to surprise the physician after they lost weight.

Once you have determined what type of information the community partner is able to provide, decide on the best ways to receive that information. Issues to consider:

- Should the feedback reports come back via fax, email, postal mail, etc?
- Who should receive the reports, and who should be responsible for sharing the information with the rest of the practice, especially the clinicians?
- If the feedback report goes directly into a patient chart, how will the clinician be alerted that the information is there?
- If the information is delivered in a way that requires entry into an EHR (data entry or scan), who will be responsible for doing so?

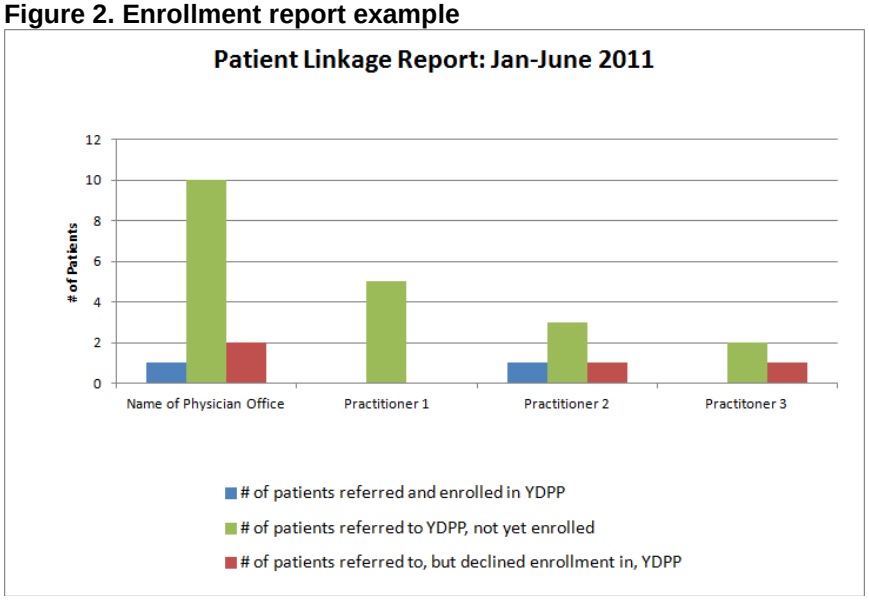
Case Studies

For the AHRQ pilot project, the YMCA health facilitator employed two types of reports to keep the practices notified of patient referral activity: enrollment reports and specific patient followup reports.

Enrollment reports. Originally it was thought that practices would only be interested in how many patients they had referred to the YMCA Diabetes Prevention Program, and how many of these patients converted to enrollments. The facilitator used a type of customer relationship management (CRM) software to create quarterly feedback reports and emailed the reports (no patient names, number of patients only) to the practices. In some cases, the reports didn't reach the right individual, which is why this toolkit encourages explicit designation of a point of contact. However, when the charts reached the right individual, they were displayed on a break room wall, which helped increase overall awareness of the project and fostered healthy competition.

Even if your community partner is unable to create colorful reports as in Figure 2, consider ways the information can be easily shared with the entire practice. Although email is fast, consider the impact of printing and posting the data in a place that is well populated.

Figure 2. Enrollment report example



Specific Patient Follow-up Reports. In the AHRQ pilot project, it was a surprise to the community health facilitator how much the clinicians wanted follow-up information on the patients, especially when the patients did *not* respond to the referral or declined participation. As one clinician explained, "If I referred my patient, and they come back to see me in 2 weeks for another problem, I would like to know if they actually acted on that referral. If they joined the class, I want to congratulate and encourage them. If they didn't, maybe I can find out why and suggest something else. Being able to follow up increases any possible impact I can have." Based on that feedback, the health facilitator created follow-up patient reports to fax to the practice every month. Again, it was critical to determine a primary point of contact that made sure the correct physician received the correct patient data. Do not assume the community partner knows the type of information that is helpful. Be specific and then follow up to make sure there is a functioning communications trail.

Chapter 4. Linking With the Patient

Patient Engagement

The first part of this toolkit focused on the mechanics of the referral process, the nuts and bolts of setting up a structure within a primary care practice. The success of the referral process is dependent upon the practice and the community partner. The success of the next step, linking with the patient, depends on the receptivity and response of the targeted patients.

Midway through the AHRQ pilot project it became clear that practices were establishing functional, bidirectional referral systems, and clinicians were remembering to refer eligible patients to the targeted community program. However, the majority of referrals were *not* converting to enrollments. Eight months after consistent program referral by the four practices in the AHRQ pilot project, results showed that only about 1 in 10 patients who were referred actually enrolled. Physicians and other team members were disappointed that their work to establish a referral system wasn't paying off with improvements in patient health. The community representative was frustrated by the sheer volume of follow-up calls to referred patients who had not enrolled in the program, and sometimes were surprised, angry, or befuddled when the partner called. At this point, the project shifted to a much stronger focus on the patient engagement aspect of the referral process.

Through an ongoing series of interviews, one-on-one meetings, and a cross-practice learning collaborative, the practices and community partner developed strategies to improve patient enrollment. Several clinicians with the highest "conversion" rates shared their methods for selecting patients for the program. "We all know our patients, and you just know when they're ready. They might still need a push, but you know when they're ready. You have to trust your instincts," one physician explained. Another physician commented that community program referral is different than referring a patient to a specialist. While the mechanics might be the same on the practice side, it presents a new scenario for the patient who is not just putting another medical appointment on the calendar. By committing to enroll in a community program, like the YDPP, they are committing to a lifestyle change. This is why clinician and patient interaction during the referral process cannot be overemphasized.

During a cross-practice learning collaborative, participants mutually agreed that referring a patient based on physiologic criteria alone was not a successful method. There was a collective sense that clinicians needed to consider another equally important criteria —the patient's readiness to change. This second consideration spurred the development of the patient engagement tools described below.

Patient Engagement Tools

Nine tools for increasing patient engagement appear on the following pages.

Number	Tool	Description	Audience
Tool 12	Motivational Interviewing Approach	Reviews fundamentals of motivational interview and gives examples of how to use OARS	Clinician
Tool 13	Videos on Motivational Interviewing Strategies	Synopsis and links to several high-quality demonstration videos	Clinician
Tool 14	Decisional Balance Worksheet	Instructions on how to use worksheet with patient; includes example and handout	Clinician; Patient Handout
Tool 15	Patient Videos on Healthy Lifestyles	Synopsis and links to several patient videos; clinician could mark personal favorites	Patient Handout
Tool 16	Patient Testimonials from Community Program	Testimonials from individuals who attended the YMCA Diabetes Prevention Program; template could be modified for other community programs	Patient Handout
Tool 17	"Weighing the Cost"	Instructions on how to explain graph to patient; graph to give patients	Clinician; Patient Handout Use
Tool 18	"The Time Game"	Clinician instructions on how to use worksheet with patient; includes example and patient worksheet	Clinician; Patient Handout
Tool 19	"Turn off the Oven"– Prediabetes Awareness	Information about diabetes development	Patient Handout
Tool 20	"Shedding Light"– Prediabetes Awareness	Information about diabetes development	Patient Handout

Tool 12. Using the Motivational Interviewing Approach

The phrase "motivational interviewing" (MI) is a phrase that has recently gained familiarity in the vernacular of health care professionals, particularly in regards to patient activation and patient empowerment. MI represents a coherent and evidence-based approach to behavior change counseling that is rooted in several existing models of psychotherapy and health behavior change theory. Although MI developed several decades ago from the world of substance abuse and addiction counseling, the basic concepts and philosophy are finding a place with healthcare professionals dealing with chronic conditions such as diabetes. Anecdotal success stories by clinicians are now being joined by peer-reviewed evidence demonstrating the feasibility and utility of MI strategies as part of the overall primary care encounter.

Motivational Interviewing is a particular type of counseling style, generally seen as more patient-centered than the conventional didactic style of health education. The goal of MI is to elicit a positive behavior change in patients by helping them explore and resolve their own ambivalence. One of the main purposes of the technique is to have a conversation that stimulates a patient's desire to change and gives him or her the confidence to change. MI is very different from most conventional medicine encounters, and especially acute care, where the focus is on a clinician-driven treatment plan that aims to "fix" a broken patient. Rather, the objective of MI is not to solve the patient's problem or even to develop a plan; the goal is to help the patient resolve his or her ambivalence, develop some momentum, and begin to believe that behavior change is possible.

Regular practitioners and trainers of MI spend years perfecting their skills, and it would be foolish to think that a simple handout can effectively teach the many nuances of this therapeutic technique. However, the reason why MI shows such promise for today's time-crunched clinicians is that basic elements *can* be learned and successfully applied in brief patient encounters. Furthermore, much of the MI literature emphasizes how the "spirit" of MI is the driving force behind any success, rather than particular techniques or training. Think about MI as another kind of approach to health behavior change consultations with patients, whereas the clinician's primary goal is to provide high-quality listening rather than ready-made answers or advice. Most importantly, the clinician offers genuine empathy for the patient's difficulty in making changes and does not take the previous lack of change as a personal affront of the clinician's "problem to fix."

The "OARS" acronym offers a foundation for patient discussions. "OARS" stands for Open-ended Questions, Affirmation, Reflective Listening, and Summaries. A common fear from busy clinicians is that asking open-ended questions will literally open the door to long, rambling conversations with multiple opportunities for new problems and complaints. However, the literature notes that clinicians experienced in the MI counseling style report that patients only need 3 to 4 minutes of active, high-quality listening in order to discuss their ambivalence regarding a targeted behavior change. Such discussions often lead to the next step, finding the motivation.

For more information on MI, visit the extremely comprehensive website http://www.motivationalinterview.org/. Additional references for this handout are below.

Welch G, Rose G, Ernst D. Motivational Interviewing and Diabetes: What is it, how is it used, and does it work? *Diabetes Spectrum* (2006). Vol 19;1:5-11.
Miller WR, Yahne CE, Moyers TB, et al. A randomized trial of methods to help clinicians learn motivational interviewing. *J Consult Clin Psychol* (2004). Vol 72:1050-1063.
Hettema J, Steele J, Miller WR. *Motivational Interviewing*. Ann Rev Clin Psychol (2005). Vol 1:91-111.

Open-ended questions. Avoid asking questions that can be answered with a "yes" or "no." Broad questions allow patients maximum freedom to respond.

☐ "What's been going on with you since we last met?"
☐ "If you had one habit to change in order to improve your health, what would that be?"
☐ "What goal would you like to set?"
☐ "What might be one thing you could consider doing/changing?"
☐ "You seem ____ (*feeling*). Tell me about that."

Affirmations. Never underestimate the power of expressing empathy during tough spots or in celebrating patients' accomplishments. When you review patients' goals, take joy in their success and show your joy.

☐ "You seem happy with your _____ *(weight, blood pressure, energy).* That's great."
☐ "It sounds like you are really trying to_____ *(eat less junk food)*. I'm proud of you."
☐ "You're doing such a nice job at _____ *(getting up early to walk).* I'm putting a gold star in your chart"

Reflective listening. Patients often have the answers; the clinician's role is to help guide them. Reflective listening involves letting patients express their thoughts and then, instead of telling them what to do, capturing the essence of what they have said without judgment. It is also appropriate to acknowledge the patient's mood about what he or she is telling you.

Patient: "I wish I didn't eat so much fast food."	Doctor: You eat fast food fairly often."
Patient: "Pretty much every day. I know I shouldn't, but it's just easier."	Doctor: "It's easier because you don't have to plan and cook meals."
Patient: "And I can just run over to the drive-through."	Doctor: "So you don't want to give up the convenience of fast food, but you would like to eat healthier."
Patient: "Right. ... I guess there are some healthy items on the menu."	

Summaries. This involves recapping what the patient has said, calling attention to the salient elements of the discussion, and allowing the patient to correct any misunderstandings and add anything that was missed. Summaries are particularly helpful in bringing the visit to a close.

☐ "I am wondering what you're feeling at this point"

☐ "I am wondering what you think your next step should be."

☐ "It sounds like you are saying…" ☐ "… did I get that right?" *(summarize in about 10 words)*

The open-ended questions in Tool 12 are adapted from: William R. Miller and Stephen Rollnick. Motivational Interviewing: Preparing People for Change. 2nd ed. The Guilford Press, New York, 2002.

Tool 13. Videos on Motivational Interviewing Strategies

The following two videos are 10 minutes or less in length.

MI Demonstration: Evoking Commitment to Change – Weight Loss

http://www.youtube.com/watch?v=dm-rJJPCuTE

This video shows a physician effectively dealing with the difficult issue of weight loss. By focusing on one specific barrier reported (in this case, drinking too much fruit juice), the physician is able to help to his patient refocus his efforts and get back on track with his weight loss plans. Watch how the physician efficiently but empathetically uses reflective listening and a scale from 1-10 to gauge the patient's confidence in his ability to be successful in the new goal.

Run time: 5:35

MI Demonstration: Evoking Commitment to Change - Smoking Cessation

http://www.youtube.com/watch?v=URiKA7CKtfc

This video shows a physician tackling the delicate issue of smoking secession for a new mom who is struggling to quit. Again, the physician combines empathy and efficiency in her ability to use reflective listening to help the patient come to her own conclusion about her need quit smoking. She also uses a scale from 1-10 to realistically address the patient's confidence in herself to quit smoking. This video also emphasizes the importance of working with the patient to find a treatment that strengthens her sense of self-efficacy. The video was funded by Flight Attendant Medical Research Institute Grant #63504.

Run time: 6:33

The following video is more than 10 minutes in length.

Coaching Patients for Successful Self-Management

http://www.chcf.org/publications/2008/08/video-on-coaching-patients-for-successful-selfmanagement

This video explains techniques that the physician or office staff can use to help motivate patients to better manage certain aspects of their disease. It demonstrates counseling a diabetic patient to improve their A1c levels by using an Action Plan. A PDF of the Action Plan is available for printing on the same site as the video. It also demonstrates how to increase compliance with medications by checking for understanding. This video emphasizes developing a common goal with the patient for success. *NOTE: You are required to enter your name and email address to access this video for copyright reasons.*

Run time: 14:25

Tool 14. Decisional Balance Worksheet

Tool. 14a. Decisional Balance Worksheet – Physician Instructions

What It Is: The **Decisional Balance Worksheet (DBW)** is a tool that can be used quickly and easily with patients who are in the process of deciding whether to initiate a change in behavior. The act of completing the worksheet requires patients to attend to the many factors that may be influencing their current behavior. It also requires active and intentional thinking about the reasons supporting a change.

When to Use: An ideal time to use the **DBW** is after your patient has identified an area of possible lifestyle change, but before he or she has committed to the process. Sometimes it is beneficial to introduce the tool with the phrase "I have found this helpful when I'm trying to change," or "some patients have found this tool helpful."

Step 1: Once your patient can articulate the potential change, have him or her fill in the first blank, phrasing it as an action. For example, he or she might write, "eating more vegetables," "walking 15 minutes each day," or "joining a weight loss group recommended by my doctor."

Step 2*:* This part may be a little different than other decision type tools you have seen. Note that boxes are numbered to go from 1 to 4 in a counter-clockwise fashion. The conversation begins around the advantages of NOT changing. While this may seem counter-intuitive, many behavioral change psychologists recommend this approach as the best non-confrontational, patient-directed way to begin the conversation and short-circuit resistance.

- Box 1: Ask your patient to consider all the advantages of not changing/status quo
- Box 2: Ask your patient to consider all the disadvantages of not changing/status quo
- Box 3: Ask your patient to consider all the disadvantages of committing to change
- Box 4: Ask your patient to consider all the advantages of committing to a change.

For a 10-minute video on how to use this tool, and why this particular pattern of questions works so well, please check out Dr. Bill Matulich's video demonstration:
http://www.youtube.com/watch?v=JLLoEBj3GDw

Step 3: Once your patient has completed the **DBW**, ask them to indicate their current position in the change process on the accompanying **Readiness Ruler**:

- "Looking at this ruler, how ready do you feel to start eating more vegetables/walking 15 minutes a day/joining a weight loss group?"
- Next, ask your patient why they did not indicate a lower number, a question intended to elicit their perceived strengths to achieve the change.
- Then, ask why they did not indicate a higher number, a question intended to elicit their perceived barriers.

Let your patient's responses guide you as you to try to encourage their perceived strengths, but also work together to develop ways to overcome potential barriers.

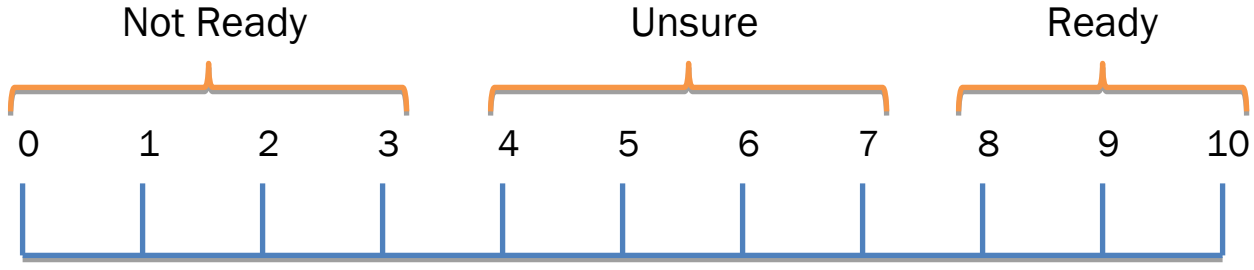
Note: This **DBW** is intended to spur conversations that may move your patients closer to activation of behavior change. However, if your patient shows no willingness to consider change, try not to grow too frustrated or disappointed. One of the key principles of Motivational Interviewing is *Roll with Resistance*, as resistance is an expected part of any conversation about change. Patients who resist are actually providing valuable information about factors that foster or reduce their motivation to change. As a clinician, your ability to "roll" with resistance will allow your patient a greater chance to become actively involved in the process of problem solving. The problem may not get solved during that visit, but the process is underway.

Decisional Balance Worksheet
Joining a Weight Loss Group

	Not Changing Behavior	Changing Behavior
Pros	**Box 1:** What is something good that could come from NOT taking from this action?	**Box 4:** What is something good that could come from taking this action?
	• No extra effort needed • I like to watch TV in my spare time • Need time to myself • I don't have to share my weight loss struggle with others (not really a "group" person)	• More energy for my kids • Lose a few pounds • Better able to catch my breath • Get healthier overall • Look better, feel more confident
Cons	**Box 2:** What is something bad that could come from NOT taking this action?	**Box 3:** What is something bad that could come from NOT taking this action?
	• I would not get healthier • Continue to gain weight • Not able to keep up with my kids, • Kids embarrassed by me • I could end up like my mom (disabled)	• My schedule is already packed • I would miss some TV shows • I would have to share my struggle to lose weight with others • Weight loss groups are too expensive

Example

Readiness Ruler



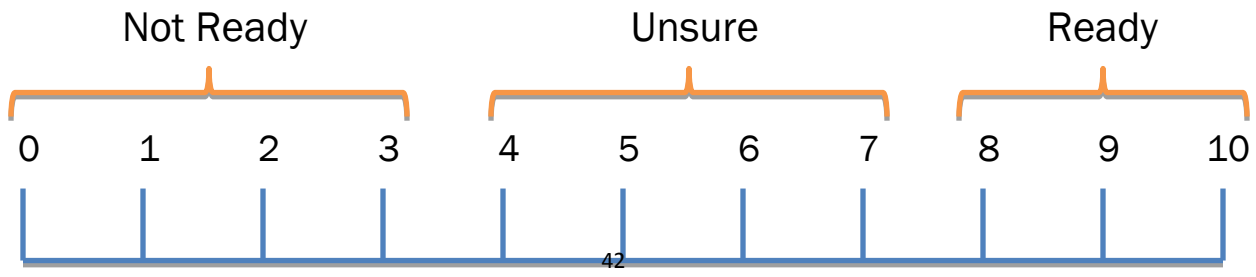
Tool 14b. Decisional Balance Worksheet (Patient)

1. In the blank space at the top, write the specific lifestyle change you'd like to make.
2. Fill out the form according to the questions for each box. Go in counter-clockwise fashion from Box 1 to Box 4. See the next page for an example of a completed 2 X 2 form.
3. Now gauge your willingness to take action, using the Readiness Ruler scale from 1 to 10.
4. If you score below a 5 on the Readiness Ruler, reconsider your targeted change.
5. Share this Decisional Balance Worksheet with your physician or clinician.

Decisional Balance Worksheet

	Not Changing Behavior	Changing Behavior
Pros	**Box 1:** What is something good that could come from *not* taking this action?	**Box 4:** What is something good that could come from taking this action?
Cons	**Box 2:** What is something bad that could come from *not* taking this action?	**Box 3:** What is something bad that could come from taking this action?

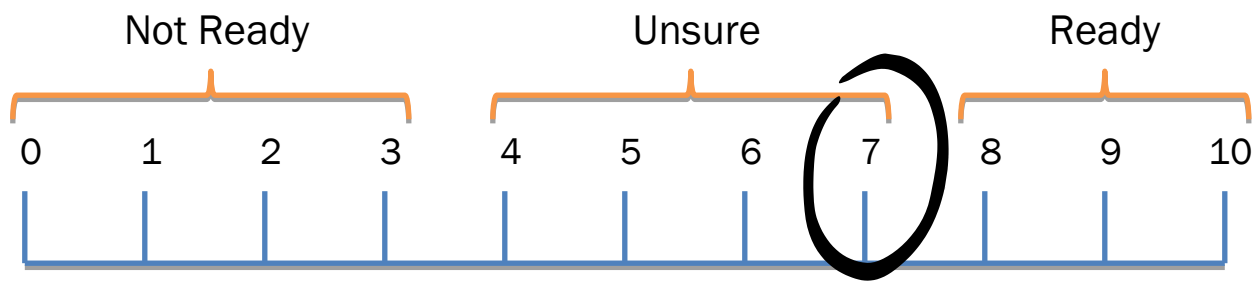
Readiness Ruler



Decisional Balance Worksheet: Completed Example
Joining a Weight Loss Group

Not Changing Behavior	Changing Behavior
Box 1: What is something good that could come from *not* taking from this action?	**Box 4**: What is something good that could come from taking this action?
• No extra effort needed • I like to watch TV in my spare time • Need time to myself • I don't have to share my weight loss struggle with others (not really a "group" person)	• More energy for my kids • Lose a few pounds • Better able to catch my breath • Get healthier overall • Look better, feel more confident
Box 2: What is something bad that could come from *not* taking this action?	**Box 3:** What is something bad that could come from taking this action?
• I would not get healthier • Continue to gain weight • Not able to keep up with my kids, • Kids embarrassed by me • I could end up like my mom (disabled)	• My schedule is already packed • I would miss some TV shows • I would have to share my struggle to lose weight with others • Weight loss groups are too expensive

Readiness Ruler



Tool 15. Patient Videos on Healthy Lifestyles

23 and ½ hours

http://www.youtube.com/watch_popup?v=aUaInS6HIGo&vq=medium

This video answers the question of "What is the single best thing you can do for your health" with the answer, of course, being physical activity of some kind. The physician tells the story with an extremely novel and engaging storyboard strategy that is hard to stop watching.

Run Time: 9:19

ABC's of Diabetes

http://www.youtube.com/watch_popup?v=MUb0nywugug&vq=medium

The same creator of the 23 and ½ hour video uses the same innovate strategy to explain the importance of maintaining "ABC x 2", which stands for ABC1: A1c, Blood pressure, and Cholesterol and ABC2: Activity, Belly, and Change.

Run Time: 1:46

The Weight of the Nation

http://theweightofthenation.hbo.com/films

This is a series of films that explores the obesity epidemic in America. Each of the four films address a different aspect of the obesity epidemic:

1. Consequences – reviews the scope and serious health complications of obesity, and how it is affecting the future of the United States.
2. Choices – describes how it is possible to successfully lose weight with appropriate diet and physical activity. *This particular video showcases several inspiring success stories, including individuals who went through a Diabetes Prevention Program (DPP).*
3. Children is Crisis – examines the growing epidemic of obesity in children.
4. Challenges – explores the origin of the obesity epidemic and presents the many opportunities, present and future, to reverse the trend.

Run Time: Approximately 1 hour per film

Tool 16. Patient Testimonials From Community Program

YOU CAN TAKE CONTROL...

Stories from patients who stared diabetes in the face

I don't remember a life without diabetes and an awareness of my potential for diagnosis. I watched as my grandparents, mother, aunts, uncles and cousins struggled with the disease--and while experience was a great lesson, the YMCA's Diabetes Prevention Program was the first education course to truly impact me.

My life has been so positively impacted that several friends want to know what I'm doing that is working so well for me. The straightforward, simple preventative approach of counting calories, decreasing fat and increasing activity is easy to follow. It is put into easy-to-understand concepts that help me to focus on achieving a goal of lifestyle balance.

I used to lay awake at night and try to figure out how to lose weight and lower my risk of getting diabetes. Thanks to the YMCA's Diabetes Prevention Program, I now know what to do, am doing it, and am experiencing success.

"Thank you" is not enough to say, but it will have to do. Thank you.

Donna N. – Ft. Wayne, IN

This program has made a huge difference in my life. My blood pressure and cholesterol are back down where they are supposed to be. I have more energy. I want to do everything I can to stay on track and to keep myself motivated.

I feel good about the fact that I am taking charge of my health and am doing what I can to be healthy. This is really important to me at a time when health care is so expensive.

This program did wonders for me and I know it can help other people as well.

Marilyn N. – Seattle, WA

I was one cheeseburger away from carrying 265 pounds on 5'10" frame. When I saw the flyer for the YMCA's Diabetes Prevention Program, it was pretty much calling my name. In the Y's program, you give and get encouragement and motivation from others as you learn practical ways to take control of your health. Not only do I work out every day at the Y, it's become my social scene.

I'm grateful that I saw the flyer and made that first call. I felt supported right away. I can't speak highly enough about all of the staff. I owe them a great deal. They've not only helped me improve my life, they've helped me prolong it.

These days, it just feels good to be alive.

Wade H. – Seattle, WA

I feel healthier—terrific even—and friends tell me I look great. I've changed the way I cook for myself and my daughter, and now [she] is checking the packaging on foods, taking smaller portions for dessert and making wiser food decisions.

I'm now doing something that is positive for both of us, and I want to tell everyone about it.

Nancy R. – New York, NY

These stories and more can be found on the YMCA's Diabetes Prevention Program website at www.ymca.net/diabetes-prevention/testimonials.html

I learned I was borderline diabetic, and I knew I needed to do something about it. I was looking for a program with real interaction among other people facing the same struggle. Recently, I lost more than 50 pounds, and I accomplished this with the help of the Decatur Family Y and the YMCA's Diabetes Prevention Program.

When I started the program, I was at 342 pounds. Currently, I weigh 290 pounds, a 13 percent decrease in my weight. At age 51, this program and the weight I've lost have made me a more confident person.

Eating smaller portions was difficult at first, because I'm a food guy. I really enjoy eating food, but this program taught me about nutrition and helped me establish a habit of eating healthier foods that I enjoy. I am more confident with meal planning and consumption, and I'm not mindlessly eating anymore.

This whole experience is having a positive effect on my family. I am able to engage more with my 16-year-old son and be a role model for him. For the first time, he's eating and enjoying nutritious foods. He learned that healthy eating is important for everyone.

The YMCA's Diabetes Prevention Program changed my life. I am balancing my life better and am altogether healthier, happier and more confident.

John S. – Stone Mountain, GA

I have lost 65 pounds over the last two years on my own, but then I just stopped losing anything: I worked out but still nothing was working. My blood pressure was still high, I was overweight and my age all put me at risk of developing type 2 diabetes.

I learned about the YMCA's Diabetes Prevention Program through a staff email at work. I fit the requirements so I thought it couldn't hurt to try.

I learned that I was eating over 100 grams of fat and over 2,500 calories a day. I have had some ups and downs, but have learned a lot about myself and my eating habits. I can eat healthy and still be happy. I know how to read labels on food to find out what is good for me and what is not. My achievements in the program are how I feel about myself, how great I have done and will continue to do.

Paula W. – Boise, ID

When I started this class I had been trying to lose weight and get into better shape, but did not seem to have success. I had started riding my bicycle to work again, but was not seeing the results I had expected. I was riding 3 days a week, 7 miles each way and did not lose any weight. I knew much of what I should be doing, but was not following much of anything. Stress at work was really crazy, along with stress raising and providing for a spouse and 5 kids.

I started to program at 305 pounds and doing some activity, but not as much as I needed. I was not controlling the amount of food I ate, and I did eat a lot of fast food meals.

The program has helped me to reinforce much of what I already knew. It also gave me the ability to progress towards a more healthy and happy lifestyle.

I have a lot more energy now and able to be more active with my kids. I enjoy riding my bike, swimming, walking and other activities. It has been a great help to me and I look forward to the rest of the classes and then maintaining this healthy lifestyle in the years to come.

Todd H. - Phoenix, AZ

Truth be told, I was a bit apprehensive about participating in the small-group discussion setting of the YMCA's Diabetes Prevention Program. However, after just a few sessions, I was sold on the idea and felt a responsibility to myself and to my group to make progress. The goals were well-defined and attainable.

I was surprised at how much new information I gained and how I looked forward to hearing the opinions and the actions suggested by the group.
I could write a chapter about how much I learned; the lessons made quite an impression on me. The three simple mantras of the class--calories, fat, and activity-- became so ingrained that I could actually handle the lifestyle changes.

I appreciate the fact that there are maintenance sessions and that my doctor was informed of the Y's efforts in this area. He is looking forward to seeing some progress in my weight and blood sugar levels the next time I visit his office, and I look forward to sharing my results.

Valerie R. – Ft. Wayne, IN

Tool 17. "Weighing the Cost"
(Cost of Lifestyle Change vs. Cost of Diabetes)

Clinician Instructions

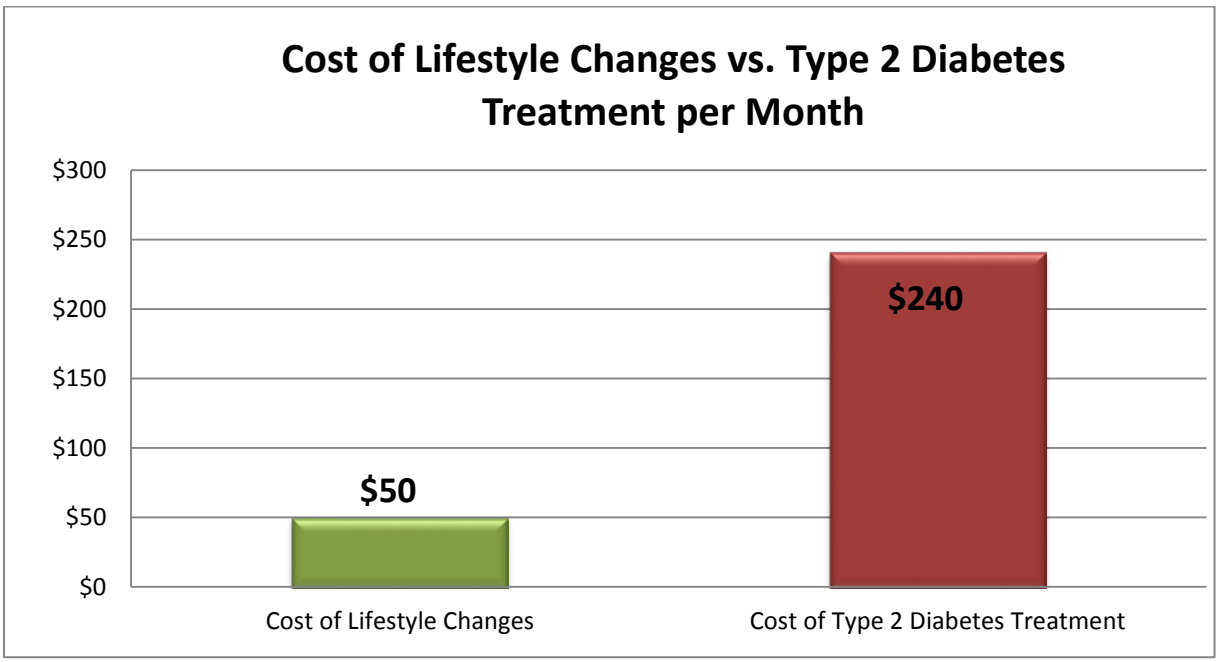
The High Cost of Diabetes is a graphic that may be useful when discussing lifestyle change with patients. We often hear that patients don't have the financial means to eat better food or exercise more. A common refrain is that they don't have money to pay for exercise equipment, new shoes, gym memberships, or fitness classes. They argue that their supermarket bill will be much higher if they start "eating healthy." It's tempting to get into debates with these patients; e.g., pointing out that high-quality, unprocessed foods like beans and whole fruits are actually cheaper than calorie-dense convenient foods or fast foods. Sometimes that approach works, but this tool is designed to shift perspectives. Because regardless of whether a patient's claim of cost barrier is legitimate or not, their perception is what matters most when they are making their decision.

That's where the **Weighing the Cost** graphic may be useful. This graphic is a combination of dollar figures for the actual costs a person with diabetes would incur plus the quality of life/mortality data related to diabetes. All costs were calculated in 2011, using data collected by a research intern who scoured websites, called pharmacies and insurance companies, spoke to several physicians (e.g., primary care physicians, endocrinologists, etc.) and looked at health economist articles. The goal was to determine the actual out-of-pocket costs to the patient, not the overall healthcare system. Costs were calculated with the assumption the patient would have employer-provided insurance or Medicare; obviously, costs will be much higher for the self-insured or uninsured patient. In order to emphasize the point, the graph was intentionally created to be as conservative as possible for the cost of diabetes and more liberal on the cost of lifestyle change.

The graph was originally developed to compare the personal costs to patients to join a YMCA Diabetes Prevention Program but the figure of $50/month is comparable to joining a wellness center or commercial weight loss group, even when accounting for things like gas money. Patients could also use the figure to think about the money they might put towards new walking shoes or healthy convenience foods like bagged salads.

1. If you encounter a patient for whom finances are providing a convenient argument for the status quo, you might begin by asking the patient how much, each month, a potential lifestyle change would cost.
2. If the patient's estimates are far off what you know for your area, you may have an opportunity to help them rethink their perception of costs.
3. Then you can have the patient imagine what it might cost if she or he develops health complications from an inactive or overweight lifestyle. You can use diabetes as an example, and bring out this graphic to help your discussion.

Weighing the Cost



Cost of Lifestyle Change	Cost of Type 2 Diabetes
$50 per month could buy…	**$240 per month** NOTE: Costs calculated for patient *with* insurance or Medicare; expect higher costs for self-insured
Wellness facility or gym membership • **Average cost $40/month**	$140 out-of-pocket monthly medication expenses* • Medication to treat diabetes • Daily test strips to use with glucometers • Medication to treat high blood pressure • Medication to treat high cholesterol • Medication to treat depression/anxiety
Weight loss program (ex: Weight Watchers) • **Average cost $10/week** **Extra cost of healthy convenience foods vs unhealthy convenience choices:** • **Example: pre-cut vegetables or fruit**	$20 - $30 (average co-pay) for additional screenings: • Optometrists (eye doctor) • Podiatrist (foot doctor) • Dentist • Neurologist (specialist for nerve damage)
Prediabetes treatment (ex: YMCA Diabetes Prevention Program) • **Average $120 for 4 months, Y membership included**	$25 - $40 additional costs for specialized footwear • Average pair diabetes shoes $130 • Average pair diabetes socks $10 • Topical foot treatment $10
Physical Activity gear • **New walking/exercise shoes** • **New workout clothes** • **Exercise equipment**	$20 additional monthly cost for erectile dysfunction • At least 50% diabetic cases affected by ED • Medication (about $3/pill) • Vacuum pump (about $100 at 20% co-pay)

* Rodbard H.W, Green A.J, Fox M.C, Grandy S. Impact of type 2 diabetes mellitus on prescription medication burden and out-of-pocket healthcare expenses. *Diabetes Research & Clinical Practice;* 8 7 (2 0 1 0) 3 6 0 – 3 6 5.

Tool 18. "The Time Game"

Clinician Instructions

Patients often use "not enough time" as a reason they cannot incorporate more physical activity into their lives, or start preparing more nutritious foods, or participate in some kind of group or class intended to promote healthy lifestyles. This tool won't work with every patient, but it will give some the opportunity to objectively review their time "budget" and see where and how they are spending it. Ask the patient to consider their schedule in the same way they would be asked to review their finances. Everyone has the same 168 hours allotted each week… the goal of this activity is to determine how, where and why they are spending those hours.

In the spirit of motivational interviewing, this activity should not be presented in a way that puts your patient on the defense. Rather, he or she should be invited to complete the "Time Sheet" as a way to help them better understand if any opportunities exist in their very busy lives to devote to healthy changes. The beauty of this tool is that the patients self-discover where their time is going and can draw their own conclusions. Some may realize they are spending an inordinate amount of time in caregiving activities for others. Others may see that they are spending much more time surfing the Internet or watching TV than previously thought. They may decide that their time is well spent on the activities they are doing and see no reason to change. However, the tool serves as a catalyst to help resolve any ambivalence they may have about the changes they want to make and the inability to make those changes based on preconceived notions about their schedules.

Suggested Script

"Everyone is extremely busy… it's hard to find time to squeeze even one more thing into the day. Some patients have found this simple tool helpful. It works like a financial budget where you track everything coming in and going out. But it's easier than a financial budget, because what's coming in never changes. We all have 168 hours a week. The key is figuring out if you are spending those hours in the way that's best for you and your health.

"This tool will take about 5 minutes, at the most, to complete. Start with your normal activities, like working, commuting, sleeping, showering, shopping, meals, childcare, and so forth. Make sure you also include your downtime, such as watching TV, reading magazines, talking on the phone. You can see how the sample tool was completed. At the bottom, there's a blank space to write in whatever activity or change you might want to try.

"So just try this out. See where your time is going, and if you are leaving enough time for yourself for things you want to do to improve your health. Let me know what you find out and how the game worked for you."

Tool 18a. The "Time Game" – Example

Daily or Weekly Activities

8 hour(s) of sleep per day X 7 days = 56 hours per week

10 hour(s) of work per day X 5 days = 50 hours per week

1 hour(s) of commuting per day X 5 days = 5 hours per week

2 hour(s) of Showering/ Getting ready per day X 7 days = 14 hours per week

2 hour(s) of Cooking/ Meal planning per day X 7 days = 14 hours per week

2 hour(s) of Chores/errands per day X 5 days = 10 hours per week

2 hour(s) of Watching TV per day X 7 days = 14 hours per week

Total Hours of Activity Per Week = 163

Total Hours in a Week = 168

Hours Available for = Walking = 5

Tool 18b. "The Time Game" – Patient Worksheet

Daily or Weekly Activities

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

_____ hour(s) of _____ per day X _____ days = _____hours per week

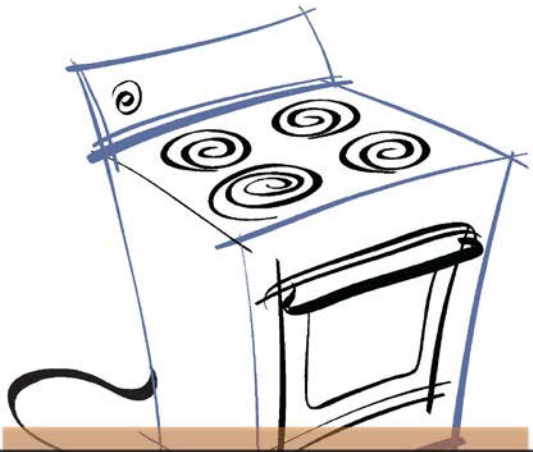
_____ hour(s) of _____ per day X _____ days = _____hours per week

Total Hours of Activity Per Week = _____

Total Hours in a Week = 168

Hours Available for _____ = _____

Tool 19. "Turn off the Oven"--Prediabetes Awareness



PREDIABETES: A BIGGER DEAL THAN IT SEEMS

What is the difference between prediabetes and diabetes? Turns out… not very much. A clinical lab marker will finally prompt the diagnosis of diabetes, but this doesn't happen overnight. Healthcare professionals used to think diabetes was like a pregnancy – you're either pregnant, or you're not. Now we know a person can be in a prediabetes stage for many years, never quite reaching that clinical cut-off for a formal diagnosis.

However, every day of prediabetes can still damage the body.

TURN OFF THE OVEN

HEATING THE OVEN

As strange as it sounds, developing diabetes is similar to the first step in preparing your favorite recipe… preheating the oven to the specific temperature. Recipes will caution not to put in the food until the temperature hits that magic targeted number. But during all the time it takes to preheat, the oven is still very hot, and still very capable of burning unprotected fingers. Damage will occur at 375 degrees, just as it does at 400 degrees – even if it's not quite the "cut-off" point for your recipe. Heating an oven is a gradual process, not the on-off process of a light bulb.

Diabetes is the same way – **it's a gradual process with accumulating effects over the years**, not an on-off switch that just happens one day. This gradual process is actually a good thing, because it allows time for reversal. Once you turn the oven off, it takes a while a cool down… but eventually it will. The same can be true for prediabetes.

It takes some time to start reversing the trend, but it CAN be done. YOU have control to make this change.

TURN OFF THE OVEN, THE SOONER THE BETTER

Studies have shown it can take anywhere from 2 to 10 years for prediabetes to evolve into a clinical diagnosis of diabetes. Unfortunately, **damage is happening every step of the way**. Elevated blood sugar affects the entire body, but the three main areas include the heart, kidneys, and nervous system (especially nerves in the feet and eyes). A prediabetic has a **1.5 greater chance of heart disease and heart attack** than people with normal blood sugar. The kidneys work very hard to keep the body functioning, but prediabetic kidneys get closer to wearing out each year - which is why so dialysis for diabetes is so common. Nerve damage to feet and eyes is also invisible in the early years, but it's estimated that **half of all diabetes cases cause some kind of significant, life-altering nerve damage** (such as blindness). These damages don't happen in one second like the light switch; they happen slowly over time, like the oven preheating. While it's scary to think so many things can be happening without any warnings, this extended period of time is also a gift. **It's a rare opportunity to look a disease in the face and stare it down.**

Ask your primary care physician about your risk of prediabetes and start making a plan.

THE "OTHER" SILENT EPIDEMIC

About 79 million Americans have prediabetes… and many have no idea. Most people have no symptoms except maybe a warning by their doctor. Or they think their symptoms are the byproduct of leading a busy, stressful life and just getting older. A primary symptom is feeling tired most of the time for no apparent reason. No matter what your schedule is, this isn't normal. Chronically high blood sugar affects the body in a way that means you're often not getting the energy you need from food, no matter how much you eat. You've probably heard of high blood pressure called "the silent epidemic." Prediabetes is the same way. But unlike blood pressure, you don't need medication to treat the condition. You don't even need to get to the "ideal" weight. **Losing just 5 to 7% of body weight, which for most people is about 10 to 20 pounds, can make a significant difference and many times even reverse the disease.**

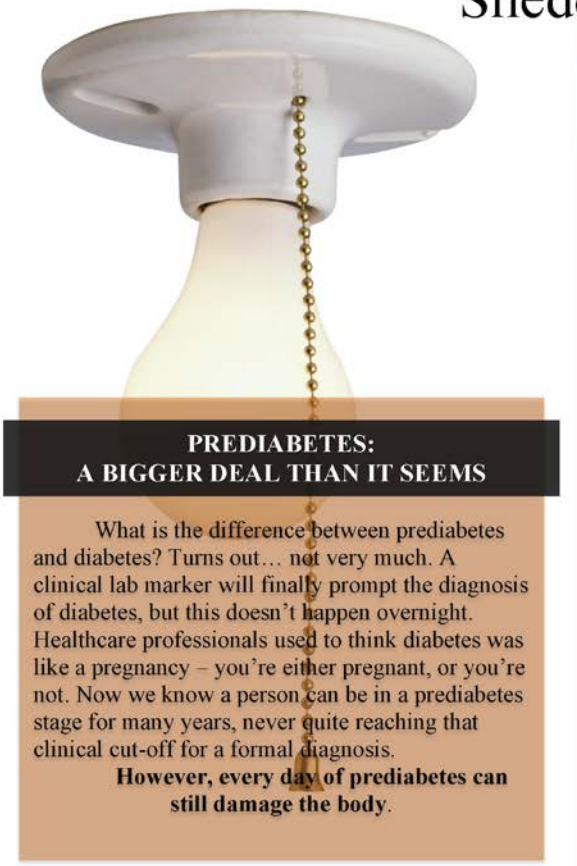
HELPFUL LINKS

American Diabetic Association – www.diabetes.org

National Institute of Diabetes and Digestive and Kidney Diseases - www.niddk.nih.gov

YMCA Diabetes Prevention Program – www.ymca.net/diabetes-prevention

Tool 20.--"Shedding Light"--Prediabetes Awareness



PREDIABETES: A BIGGER DEAL THAN IT SEEMS

What is the difference between prediabetes and diabetes? Turns out… not very much. A clinical lab marker will finally prompt the diagnosis of diabetes, but this doesn't happen overnight. Healthcare professionals used to think diabetes was like a pregnancy – you're either pregnant, or you're not. Now we know a person can be in a prediabetes stage for many years, never quite reaching that clinical cut-off for a formal diagnosis.

However, every day of prediabetes can still damage the body.

Shedding Light on Prediabetes

DIMMING THE LIGHT

To better understand prediabetes and how it differs from other health conditions, think about a light switch and the way it works. One moment the light switch is off and the room is dark, but the moment someone flips on the light, the room is flooded with light. While some illnesses react as quickly as the light switch, diabetes is not one of them. The actual diagnosis may come in just one exam, but the process leading up to that moment can take years and years.

The progression to diabetes is like a dimmer on your light switch. The dimmer will eventually light up the room, but the speed depends on the person adjusting the controls. As a patient, you have the opportunity to adjust the controls for your own body. Many lifestyle decisions can speed up the "lighting" process, moving that dimmer switch toward full power. On the same token, other lifestyle decisions can start nudging the switch the other way, dimming the chances of diabetes or even reversing them all together.

Diabetes is a gradual process with accumulating effects over the years, not an on-off switch that just happens one day. It takes some time to start reversing the trend, but it CAN be done. **YOU have control to make this change.**

Studies have shown it can take anywhere from 2 to 10 years for prediabetes to evolve into a clinical diagnosis of diabetes. Unfortunately, **damage is happening every step of the way**.

START DIMMING THE LIGHTS, THE SOONER THE BETTER

Elevated blood sugar affects the entire body, but the three main areas include the heart, kidneys, and nervous system (especially nerves in the feet and eyes). A prediabetic has a **1.5 greater chance of heart disease and heart attack** than people with normal blood sugar. The kidneys work very hard to keep the body functioning, but prediabetic kidneys get closer to wearing out each year - which is why dialysis for diabetes is so common. Nerve damage to the feet and eyes is also invisible in the early years, but it's estimated that **half of all diabetes cases cause some kind of significant, life-altering nerve damage** (such as blindness). These damages don't happen in one second like the light switch; they happen slowly over time, like the light dimmer. While it's scary to think so many things can be happening without any warnings, this extended period of time is also a gift. **It's a rare opportunity to look a disease in the face and stare it down.**

Ask your primary care physician about your risk of prediabetes and start making a plan.

THE "OTHER" SILENT EPIDEMIC

About 79 million Americans have prediabetes… and many have no idea. Most people have no symptoms except maybe a warning by their doctor. Or they think their symptoms are the byproduct of leading a busy, stressful life and just getting older. A primary symptom is feeling tired most of the time for no apparent reason. No matter what your schedule is, this isn't normal. Chronically high blood sugar affects the body in a way that means you're often not getting the energy you need from food, no matter how much you eat. You've probably heard of high blood pressure being called "the silent epidemic." Prediabetes is the same way. But unlike blood pressure, you don't need medication to treat the condition. You don't even need to get to the "ideal" weight. **Losing just 5 to 7% of body weight, which for most people is about 10 to 20 pounds, can make a significant difference and many times even reverse the disease.**

HELPFUL LINKS

American Diabetic Association – www.diabetes.org

National Institute of Diabetes and Digestive and Kidney Diseases - www.niddk.nih.gov

YMCA Diabetes Prevention Program – www.ymca.net/diabetes-prevention

Chapter 5. Summary

Primary care physicians and staff face both opportunities and challenges in the treatment and prevention of obesity. The primary care office is typically the first point of contact for patients, serving as the frontline for preventive medicine. However, practices consistently report that they do not have the luxury of spending time counseling patients on weight loss and lifestyle change. There is hope, however, in the form of community resources dedicated to obesity and weight loss efforts. Such resources already exist, so physicians may work to raise awareness with patients, engage them in a manner that promotes action, and make a formal referral as part of routine clinical care. The key is to create a sustainable clinic-community linkage where the community partner becomes a trusted member of the care team.

Although it sounds simple, implementing any kind of change into a busy primary care practices takes intentional time and effort. This tool is intended to help the reader examine his or her practice, reach out to community resources, develop sustainable links, and exercise new strategies and tools to increase patent engagement. Although the YMCA, as a key partner in this project, played a critical role in developing the toolkit, the lessons and examples are intended to be translatable to any community resource and any practice willing to take the extra step to make it happen.

Appendix A. Case Studies

Practice A

Practice A is a federally qualified health center, caring for low-income patients. When they began working with their community partner, the local YMCA's Diabetes Prevention Program, they were operating in a crowded, run-down clinic. Staff morale was low and both the staff and providers seemed uninspired.

Their community partner overloaded them with information in an attempt to help them adopt a healthy workplace, while simultaneously teaching them about which patients could be referred to the community program. The community partner also was recruiting for two separate YMCA programs, which turned out to be confusing as to which patients were appropriate for which program. The result was low conversion rates of referral enrollment.

Midway through the partnership, the practice moved to a new location and brought in new clinicians who provided a fresh outlook. The executive director made clear his support, and then delegated the work to a nurse manager who took on the project. New energy, combined with bigger space, resulted in improved staff morale.

At the same time, the community partner began to focus on helping the practice recruit patients to a single YMCA program with straightforward patient eligibility. They stripped away the efforts to create a healthy office within the practice and kept working toward the goal of more patient referrals. The community partner began spending a lot of time onsite, but quickly learned that being there every week was not a good use of time and her presence resulted in a low number of referrals. She now visits the practice once a month and meets with a group of patients who have been referred. She does a group registration during this time, and then meets individually with providers and the staff. The result is better staff understanding of the goals and process, higher referral rates from clinicians, and an easier registration process for patients.

Lessons learned:

- Do not provide the practice with too much information.
- Focus on a single program to refer patients to.
- Get buy-in from the medical assistants.
- Demonstrate the community resource's value.
- Obtain support from high-level leaders, but find a member of the practice who can be active and focus on the partnership.

Practice B

Practice B is a group practice that is part of the primary care independent practice association. Practice B has a high National Committee for Quality Assurance medical home rating. The practice was the first in its state to be certified. The practice champion is a nurse care manager who is open to learning and improving her skills. She has a relationship with the patients and knows them well. She meets and communicates with the community partner often. When the community partner provides tools, the nurse is open to using them. She also prioritizes her staff's skill improvement. She asked the community partner to work with a medical assistant at the practice to build the medical assistant's motivational interviewing skills. The nurse case manager refers fewer people than some practices, but the people are ready to enroll in the program.

Lessons learned:

- One motivated, informed practice champion can make all the difference.
- Identifying patients who are really ready for the community program means a high rate of follow-through on the referrals, even if the overall number of referrals is low.

Practice C

Practice C is a group practice owned by a community hospital; the practice serves several rural communities. The physician champion is good at motivational interviewing. He cares about his patients, and he has made his own lifestyle changes, so he is personally attached to the concept. Of the patients he and his medical assistant refer, a large percent enroll. However, the remaining staff and clinicians in the practice are not engaged in the program and do not have a good sense of why the community partner is involved.

Lessons learned:

- Even in the absence of practice-wide buy-in, one motivated and committed provider can successfully engage with a community partner.

Practice D

Practice D, a private practice with three physicians and two nurse practitioners, operates efficiently and effectively. The high volume practice works through lunch, so they can see 100 patients a day. They are engaged in a number of chronic care quality improvement projects and diabetes studies. For interacting with their community partner, they rely heavily on the champion for the practice, so when that person went on leave, the connection with the community partner suffered significantly. The physicians understand the community partnership and refer regularly; however, the rate of patient enrollment is not high. Even so, the clinicians don't seem interested in improving their process and are not willing to try new methods of trying to get referrals.

Lessons learned:

- Busy, well-functioning practices may prioritize existing relationships and projects above new ones.
- Relying heavily on a single point of contact can jeopardize the partnership if that person leaves.

Appendix B. Shared Appointments

Although it took time to develop, one of the most successful strategies in the AHRQ pilot project was having shared appointments, which were led by the health facilitator from the YMCA. It soon became clear that clinicians not only lacked the time to answer patient questions about the targeted community program, but also lacked the time to discuss prediabetes and obesity in depth. Working as a team, the practices and health facilitator developed the following system:

- The practice scheduler asked the patient to return to the practice for a follow-up appointment, *at no charge*, with the community health facilitator. (NOTE: It was helpful to provide the scheduler a script with key details; otherwise, patients often thought they were coming back to see their physician. It was also important to stress the "no charge" component.)
- Between four and six patients were scheduled to return at the same time on the same day.
- The health facilitator used an empty meeting room in the practice to conduct a shared appointment with the patients. The agenda included a discussion on prediabetes followed by details on the YMCA Diabetes Prevention Program, including information on cost, financial assistance, class structure, and other topics. Patients who were interested in enrolling could do so immediately. (It should be noted that this strategy only worked with practices that had access to a meeting room during the day.)
- The health facilitator reported that patients usually came with the "right mindset" to learn about prediabetes. "They seemed to think that if their doctor wanted them to come to this additional appointment with me, it must be important. We had no other competing demands except to talk about prediabetes and maybe obesity," she said.
- Most of the shared appointments lasted between 30 and 45 minutes. Except for scheduling and ushering the patients to the meeting place, the practice incurred no additional work.

Appendix C. What Is a Diabetes Prevention Program?

The YMCA Diabetes Prevention Program (YDPP) served as the community partner for this AHRQ-sponsored project. The YDPP is part of a National Diabetes Prevention Program led by the Centers for Disease Control and Prevention (CDC). The CDC program is intended to help communities offer evidence-based lifestyle-change programs for preventing type 2 diabetes.

Programming for YDPP s based on research conducted by the Diabetes Prevention Program Research Group led by the National Institutes of Health (NIH) and supported by the CDC. NIH trials have demonstrated that making modest behavior changes, such as improving food choices and increasing physical activity to at least 150 minutes per week, helped participants lose 5 percent to 7 percent of their body weight. These lifestyle changes reduced the risk of developing type 2 diabetes by 58 percent in people at high risk for diabetes.[17-20]

Participants in the YDPP work with a trained lifestyle coach in a group setting as part of a lifestyle change program that includes 16 core sessions (usually 1 per week) and 6 post-core sessions (1 per month). The sessions focus on healthy eating and increased physical activity with the goal of losing 5 percent to 7 percent body weight. Participants are given practical tools to help with everyday health changes, and sessions are often taught in a way that maximizes peer-to-peer learning. The DEPLOY study, described in detail below, served as the springboard for the current model offered in YMCAs across the country.

Overall, the National Diabetes Prevention Program (www.cdc.gov/diabetes/prevention/) encourages collaboration among Federal agencies, community-based organizations, employers, insurers, health care professionals, academia, and other stakeholders to promote and sustain the program. The inaugural partners of the National Diabetes Prevention Program were the YMCA of the USA and the UnitedHealth Group. These partner organizations were instrumental in starting the national program and continue to expand the reach of evidence-based lifestyle programs.

DEPLOY and the YMCA's Diabetes Prevention Program

In 2008, the "American Journal of Preventive Medicine" published a study on the DEPLOY (Diabetes Education and Prevention With a Lifestyle Intervention Offered at the YMCA) project. The aim of the DEPLOY project was to test the feasibility of offering a community-based diabetes prevention program in partnership with the YMCA.

A randomized trial compared a group based intervention with a brief (2 to 5 minutes), one-time counseling session. Significant differences between the two groups were reported, in favor of the YMCA program. DEPLOY was a promising first step, particularly for cost savings. While the original diabetes prevention program research study cost more than $5,000 per participant (due to personalized counseling and incentives), the group-based DEPLOY model averaged less than $500 per participant with similar clinical results.[17]

The results from DEPLOY evolved into the current YMCA Diabetes Prevention Program, now accredited by the CDC, and partially funded by the CDC and UnitedHealthCare. Following the National Diabetes Prevention Program guidelines, the YMCA program is specifically designed for people with prediabetes according to the guidelines set by the American Diabetes Association. Individuals in the 4-month program meet in a group once a week for an hour at a time. A trained lifestyle coach facilitates participant learning around lifestyle changes through healthy eating, physical activity, and moderate

weight loss. After the initial 16 sessions, participants meet monthly for an additional 4 months for added support during the maintenance phase. Program goals include reducing body weight by 7 percent and participation in 150 minutes of physical activity per week.

YMCA Diabetes Prevention Program courses are taught by trained laypersons rather than health care professionals, such as registered dieticians or exercise physiologists. However, the training is extremely thorough and focuses on helping individuals make decisions to change rather than offering information in a typical didactic style. YMCA Diabetes Prevention Program lifestyle coaches complete a 13-hour motivational interviewing course, "Listen First," and a 16-hour certification course based on the building blocks of the program. They are encouraged to take an additional 13-hour course, "Advanced Relationship Building," which focuses on goal setting and assessment of readiness to change.

The cost of the program (ydiabetes.org) varies by each independent YMCA. However, costs for the 16 weeks of core classes and 4 months of monthly maintenance sessions typically range from $99 to $149. Members receive a reduced rate, and nonmembers receive a YMCA membership for 16 weeks so they can use the exercise facilities while participating in the program. The YMCA also offers financial assistance for qualified individuals; part of the YMCA's overall mission is to never to turn anyone away due to inability to pay.

References

1. McDowell MA, Hughes JP, Borrud LG. Health characteristics of U.S. adults by body mass index category: results from NHANES 1999-2002. *Public Health Rep.* Jan-Feb 2006;121(1):67-73.
2. Murray M, Tantau C. Same-day appointments: exploding the access paradigm. *Fam Pract Manag.* Sep 2000;7(8):45-50.
3. Murray M, Berwick DM. Advanced access: reducing waiting and delays in primary care. *JAMA.* Feb 26 2003;289(8):1035-1040.
4. Centers. NAoCH. *Primary Care Access: An Essential Building Block of Health Reform.* Bethesda, MD2009.
5. Yarnall KS, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: Is there enough time for prevention? *American Journal of Public Health.* 2003 Apr 2003;93(4):635-641.
6. Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice.* 1998 1998;1(1):2-4.
7. Hung DY, Rundall TG, Tallia AF, Cohen DJ, Halpin HA, Crabtree BF. Rethinking prevention in primary care: applying the chronic care model to address health risk behaviors. *Milbank Q.* 2007;85(1):69-91.
8. Kirchner JE, Parker LE, Bonner LM, Fickel JJ, Yano EM, Ritchie MJ. Roles of managers, frontline staff and local champions, in implementing quality improvement: stakeholders' perspectives. *Journal of Evaluation in Clinical Practice.* Feb 2012;18(1):63-69.
9. Peterson KA, Radosevich DM, O'Connor PJ, et al. Improving Diabetes Care in Practice: findings from the TRANSLATE trial. *Diabetes Care.* Dec 2008;31(12):2238-2243.
10. Mold JW, Peterson KA. Primary care practice-based research networks: Working at the interface between research and quality improvement. *Annals of Family Medicine.* 2005 May-Jun 2005;3(Suppl 1):S12-20.
11. Khan V. Responsibities of a Project Champion. *Bright Hub* 2009; http://www.brighthub.com/office/project-management/articles/49034.aspx. Accessed June 27, 2012.
12. Shortell SM, Marsteller JA, Lin M, et al. The role of perceived team effectiveness in improving chronic illness care. *Med Care.* Nov 2004;42(11):1040-1048.
13. Gallagher K, Nutting PA, Nease DE, Jr., et al. It takes two: using coleaders to champion improvements in small primary care practices. *J Am Board Fam Med.* Sep-Oct 2010;23(5):632-639.
14. Bagley BA, Mitchell J. Registries made simple. *Fam Pract Manag.* May-Jun 2011;18(3):11-14.
15. Kibbe DC. 10 steps to HIPAA security compliance. *Fam Pract Manag.* Apr 2005;12(4):43-49.
16. Stewart EE, McMillen M. How to see your practice through your patients' eyes. *Fam Pract Manag.* Jun 2008;15(6):18-20.
17. Diabetes Prevention Program (DPP) Research Group. The Diabetes Prevention Program (DPP): description of lifestyle intervention. *Diabetes Care.* Dec 2002;25(12):2165-2171.
18. Herman WH, Hoerger TJ, Brandle M, et al. The cost-effectiveness of lifestyle modification or metformin in preventing type 2 diabetes in adults with impaired glucose tolerance. *Annals of Internal Medicine.* 2005 Mar 1. 2005;142(5):323-332.
19. Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *New England Journal of Medicine.* 2002 Feb 7. 2002;346(6):393-403.
20. Rubin RR, Knowler WC, Ma Y, et al. Depression symptoms and antidepressant medicine use in Diabetes Prevention Program participants. *Diabetes Care.* 2005 Apr. 2005;28(4):830-837.