Creating Community-Clinical Linkages
Learning Objectives

• Understand Community-Clinical Linkages and the Role of Healthcare Providers

• Learn the key components of the Population Health Strategy: Screen, Test, and Refer

• Learn the Steps to Implement STR for:
  • Tobacco Cessation
  • Diabetes Prevention
  • High Blood Pressure Control
Impact of Community-Clinical Linkages
This is what affects health
Public Health 3.0

1. Traditional Clinical Prevention
   - Increase the use of evidence-based services

2. Innovative Clinical Prevention
   - Provide services outside the clinical setting

3. Total Population or Community-wide Prevention
   - Implement interventions that reach whole populations
Community-Clinical Linkages

- Healthcare Providers
  - Rural Health Clinics (RHCs)
  - Public Health Units (PHUs)
  - Federally Qualified Health Centers (FQHCs)

- Community Organizations
  - Worksites
  - Faith-Based Organizations
  - Community Centers
  - YMCAs

- Community Resources
  - Diabetes Self-Management Education and Support (DSMES)
  - National Diabetes Prevention Program (NDPP)
  - Tobacco Cessation Services
Role of Healthcare Providers

- Change the underlying risk factors
- Educate and reinforce teachings
- Evaluate and identify gaps in resources
- Improve quality of care
- Decrease costs and secure savings long-term
- Improve population health
Expanding the Reach of Community Prevention Programs

Tier 1
• Promote Awareness

Tier 2
• Screen, Test, and Refer

Tier 3
• Offer Programs
Population Health Strategy: Screen, Test, and Refer (STR)
Value of the STR Strategy

• Most patients with chronic conditions are not identified in the early stages.
• Relationship between referrals from healthcare providers and enrollment in self-management programs.
• Reinforces the advice you give patients during their visits
• Saves you time during office visits, decreases costs and secures savings
• Improves quality of care
  • Health outcomes
  • Quality measures
  • Decreases your patient population risk
Effective Screening

• Determine the Target Population for the intervention
• Utilize your EHR to automate their identification
  • Create algorithms and data reports
  • Create an EHR Alert or Flag for use at point-of-care

• Team Huddles
• Panel Management
• Point-Of-Care Method- screening during a clinical visit
• Use available Self-Assessment Tests to screen for risk factors
High Quality Referrals

• High Quality Referrals are Bidirectional
• Creating a system with Community Organizations is a key element of successful Community-Clinical Linkages
Tobacco Cessation
Tobacco STR: 5 A’s Model

• 5 A’s Model to Treating Tobacco Use:
  • **Ask:** Identify tobacco use status
  • **Advise:** Recommend tobacco user to quit
  • **Assess:** Determine if the tobacco user is ready to quit
  • **Assist:** Connect to cessation services
  • **Arrange:** Schedule a follow up appointment

• Simple Three Step Process for the Clinical Setting:
  • **Ask:** Patient about tobacco use status
  • **Advise:** Patient to quit as soon as possible
  • **Refer:** Quitline or another approved cessation service

16,350 people called the LA Quitline in the past year!
Gauging Readiness to Quit

Who To Refer To The Quitline

- Ready to quit in 30 days or less
- Willing to receive Quitline calls, web chats, or texts
- Has regular access to a phone or computer

Who Not To Refer To The Quitline

- Not ready to quit in 30 days
- Not willing to receive Quitline calls, web chats, or texts
- Does not have access to a phone or computer
Fax-To-Quit Louisiana

Clinician screens for tobacco use

Patient wishes to quit

Form is faxed or emailed to the Quitline

Referral is processed

Intake call is placed

Biweekly outcome reports

Fax-To-Quit training can be found at: https://www.walpen.org/
Brief Tobacco Intervention Provider Training

• The Brief Tobacco Intervention (BTI) training aims to ensure tobacco users are screened for tobacco use, advised to quit, and referred to cessation services.

• The BTI Training Offers:
  • Communication techniques
  • Evidence-based cessation treatments
  • Patient referral
  • Continuing education credits

The BTI training can be found at: https://www.walpen.org/
Integrating Fax-To-Quit Into Workflow

- Designate Staff Members
- Ask About Tobacco Use
- Advise To Quit
- Fill Out Referral Form
- Fax or Email Referral Form to The Quitline
- Provide Patients Not Ready to Quit with Quitline Information
Helpful Resources: Tobacco Cessation

• Healthcare Provider Trainings:
  • Fax-To-Quit Louisiana
    • https://www.walpen.org/tobacco-intervention-training
  • Brief Tobacco Intervention Online Provider Training
    • https://www.walpen.org/tobacco-intervention-training

• Cessation Resources Available to Louisiana Residents:
  • Quit With Us Louisiana Homepage (Quitline information found here)
    • http://quitwithusla.org
  • Smoking Cessation Trust Homepage
    • https://smokingcessationtrust.org
  • Well-Ahead Community Resource Guide
Blood Pressure Control
BP Control STR: MAP Framework

• Measure
  • Measure blood pressure accurately, every time
  • Assess patients to determine those who are at risk for heart disease

• Act
  • Act rapidly to address high blood pressure and follow treatment protocols to bring blood pressure
  • Counsel or refer at-risk patients to community-based resources that build heart healthy lifestyle habits (i.e. active living, healthy eating, medication adherence)

• Partner
  • Identify, communicate and form a working relationship with patients, families, and communities to promote self-management and monitor progress
  • Use the Well-Ahead Community Resource Guide to identify available resources
Integrating MAP for BP Control Into Workflow

- Patient Population Identification
- Blood Pressure Measurement
- Determine Treatment Options
- Teach Patients How to Perform SMBP and Track Results
- Provide Patients with Community Resources to Support Lifestyle Changes
- Schedule Patient Follow Up
Evidence-Based Quality Improvement

• Well-Ahead Louisiana partners with the American Heart Association to support RHCs achieve TARGET:BP Recognition
• BP Improvement Program
• Patient-Measured BP Program
BP Control Community Resources

• Blood Pressure Self-Monitoring programs

• SMBP Community Toolkit
  • Promoted to community-based entities who can support SMBP work including senior centers, councils on aging, faith-based
Prediabetes STR: MAP Framework

• Measure
  • Assess patients to determine those with prediabetes

• Act
  • Counsel and/or refer patients with prediabetes to a National Diabetes Prevention Program (National DPP)

• Partner
  • Identify, communicate and form a working relationship with local/available programs

According to the American Diabetes Association, 1.27 million people in Louisiana have prediabetes.
Screening Populations At Risk

• With 3 or more of the shown risk factors, patients are more likely to have prediabetes and are at high risk for type 2 diabetes.

• Best practice is to screen all non-diabetic patients 18 years and older.
Testing

Identified at Risk Patient

- Fasting Plasma Glucose
  - 100-125 mg/dL: Prediabetes
  - >125 mg/dL: Diabetes

- A1C
  - 5.7-6.4%: Prediabetes
  - >6.4%: Diabetes

- 2-hour 75g Oral Glucose Challenge
  - 140-199 mg/dL: Prediabetes
  - >199 mg/dL: Diabetes
# Actionable Steps for Patient-Care Plan

<table>
<thead>
<tr>
<th>Normal Test Results</th>
<th>Prediabetes</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Encourage patient to maintain a healthy lifestyle</td>
<td>• Refer to Diabetes Prevention Program (DPP)</td>
<td>• Confirm diagnosis; retest if necessary</td>
</tr>
<tr>
<td>• Retest within 3 years of last negative/normal test</td>
<td>• Consider retesting annually to check for diabetes onset</td>
<td>• Counsel patient re: diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Initiate therapy</td>
</tr>
</tbody>
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**Note:** This table outlines steps for patients with normal test results, prediabetes, and diabetes. Each section provides specific guidance on maintaining health and monitoring for diabetes onset or progression.
Partner with a National Diabetes Prevention Program (National DPP)

- Establish a bidirectional referral process
- Provide warm handoff
- Address barriers with patient enrollment and retention
- Availability in your community?
  - Online options
  - **Consider starting a National DPP with a community partner!**
  - Registry of Recognized Organizations Website: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx
Core Elements of the National DPP

A Trained Lifestyle Coach

CDC-Approved Curriculum

Group Support Over the Course of a Year
Helpful Resources: Diabetes Prevention

• AMA Diabetes Prevention Toolkit: https://amapreventdiabetes.org/tools-resources

• Prevent Diabetes STAT Toolkit: https://preventdiabetesstat.org/toolkit.html

• National DPP coverage Toolkit: https://coveragetoolkit.org/


• CDC/ADA Prediabetes Risk Test https://www.cdc.gov/prediabetes/takethetest/
How Well-Ahead Can Help You Implement STR

• EHR Optimization
• Workflow Integration
• Community Resource Development
• Partnership Engagement for service Linkages
• Other Resources
Thank You!