RURAL HEALTH WORKSHOP

# Creating Community-Clinical Linkages

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# 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

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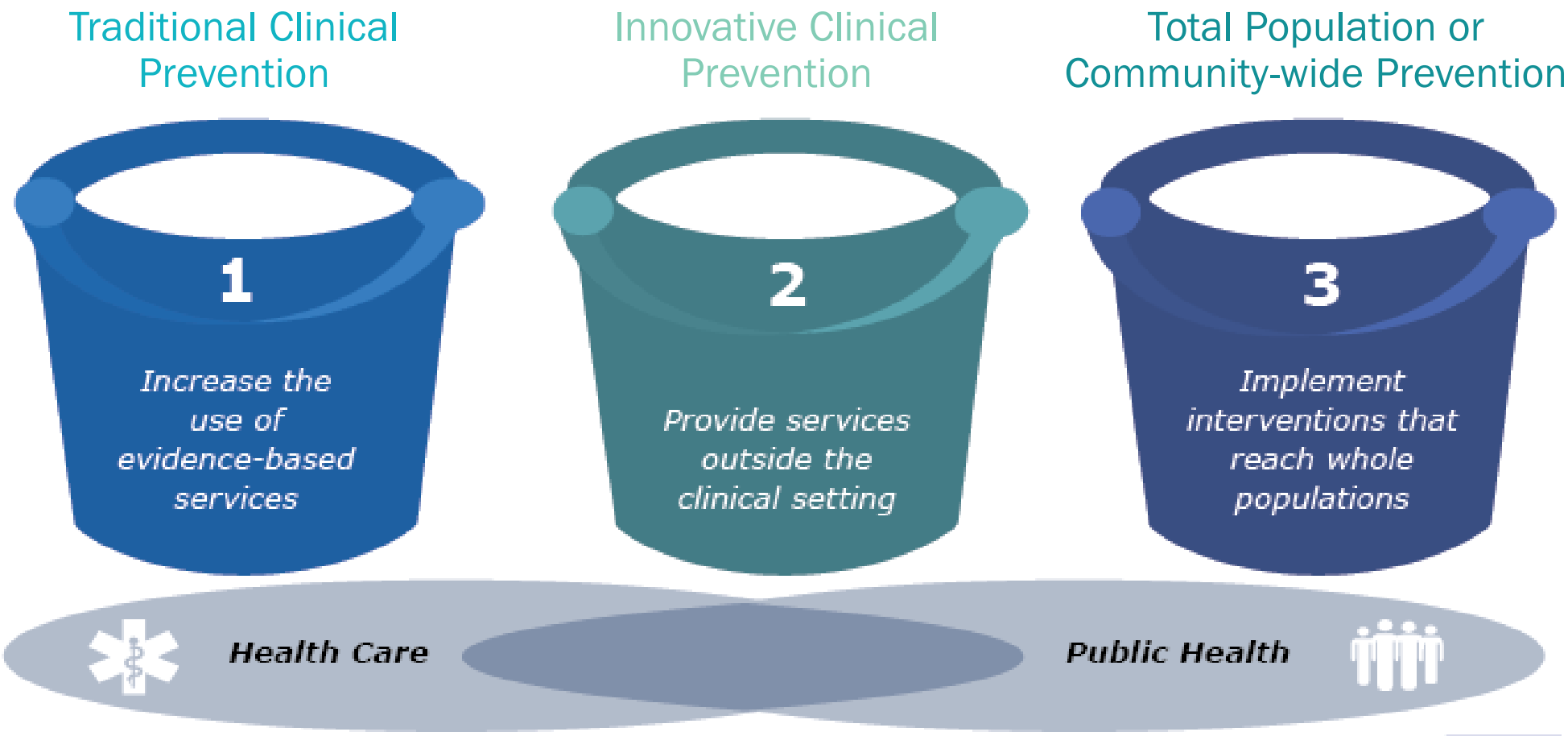
# Impact of Community-Clinical Linkages

This is what affects health

# Public Health 3.0



# 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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# 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 |

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# 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

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# 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

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# 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!*

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# 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

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# 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
    - http://wellaheadla.com/Well-Ahead-Community/Community-Resource-Guide

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# 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

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# 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

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# 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

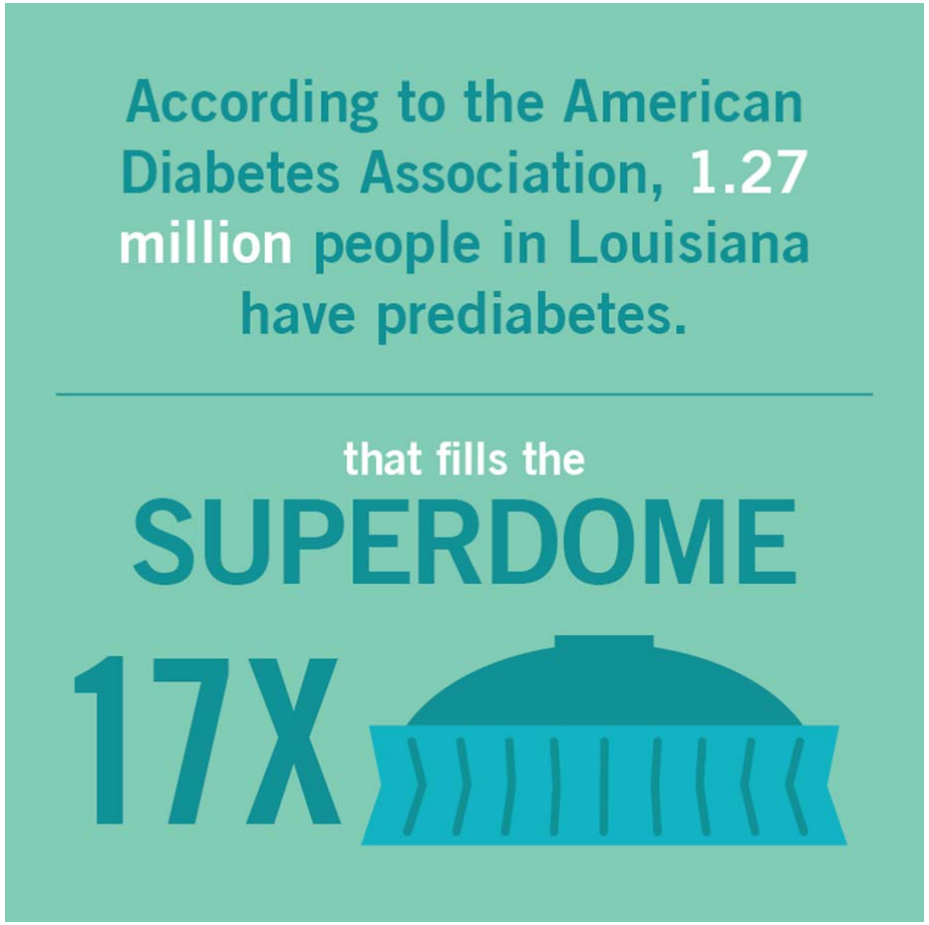
- Blood Pressure Self-Monitoring programs
- SMBP Community Toolkit
  - Promoted to community-based entities who can support SMBP work including senior centers, councils on aging, faith-based

Barbershop Project

# Diabetes Prevention

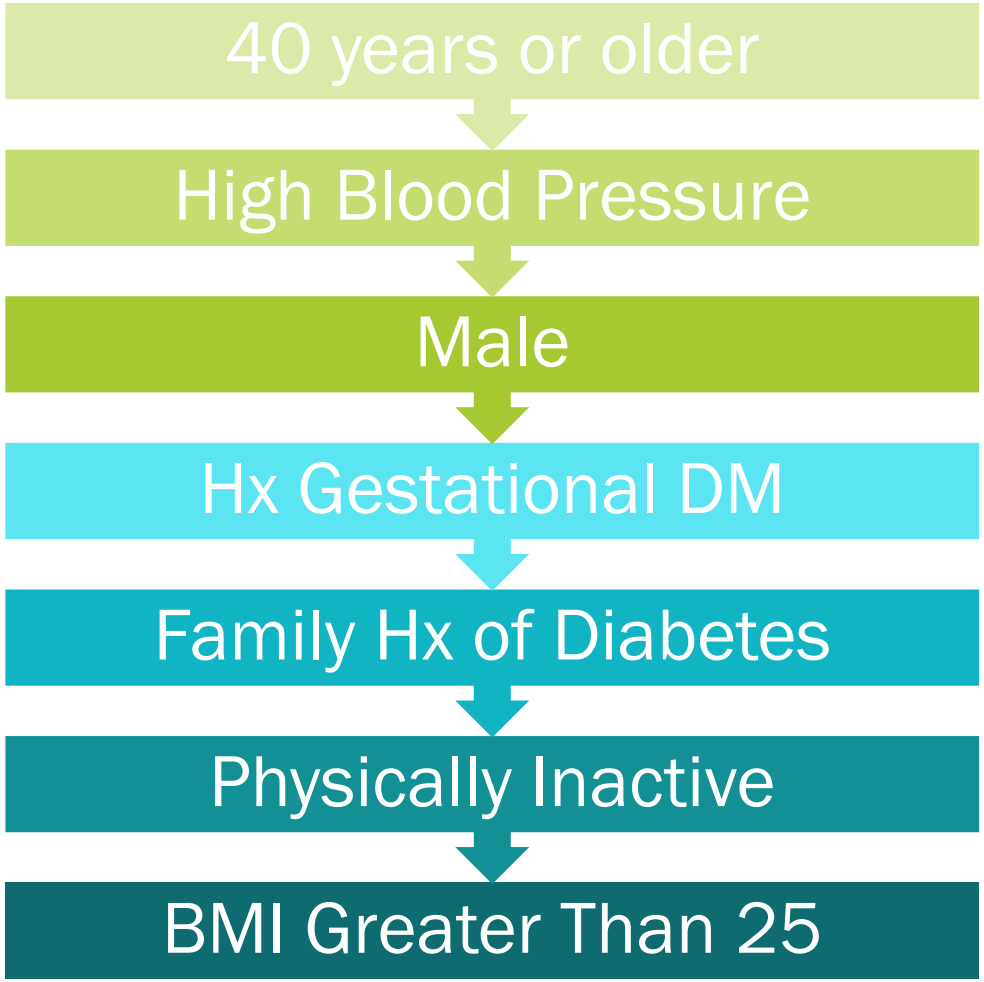
# Prediabetes STR: MAP Framework

- 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



# 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.

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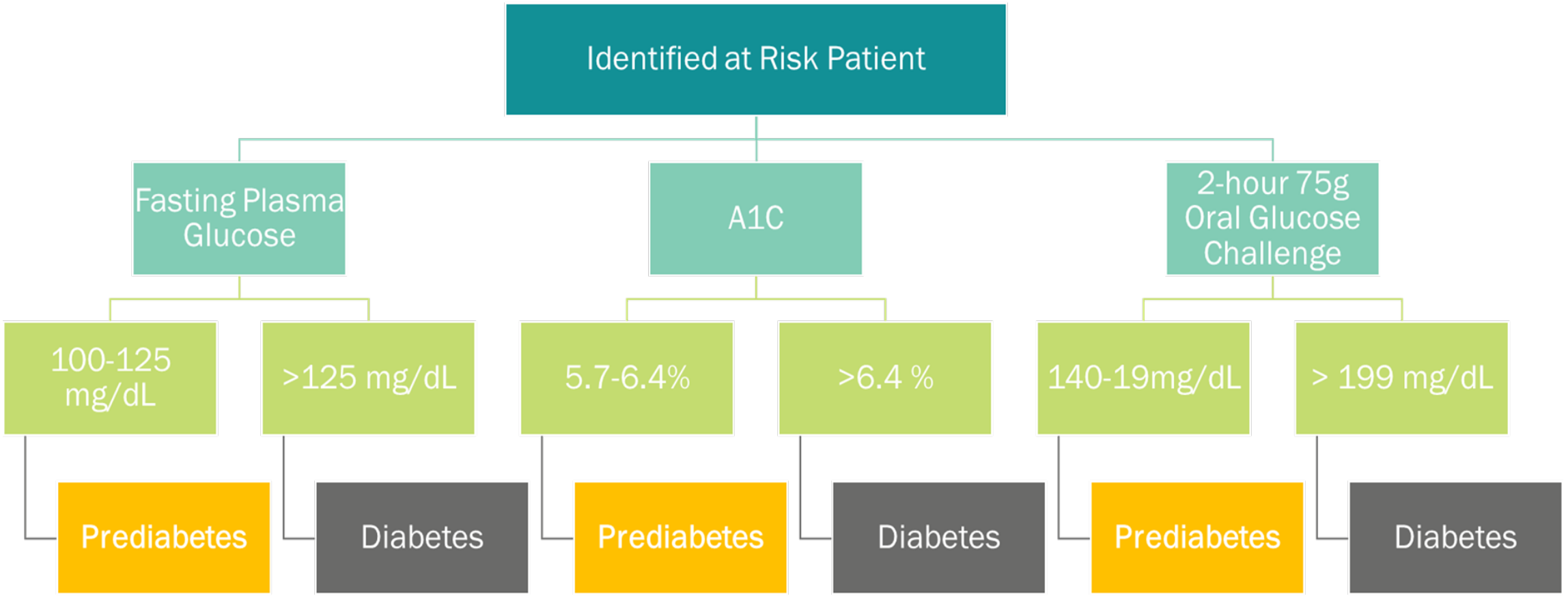
# Testing


Identified at Risk Patient
Fasting Plasma Glucose
A1C
2-hour 75g Oral Glucose Challenge
100-125 mg/dL
>125 mg/dL
5.7-6.4%
>6.4 %
140-19mg/dL
> 199 mg/dL
Prediabetes
Diabetes
Prediabetes
Diabetes
Prediabetes
Diabetes

# Actionable Steps for Patient-Care Plan

| Normal Test Results | Prediabetes | Diabetes |
|---|---|---|
| • Encourage patient to maintain a healthy lifestyle<br>• Retest within 3 years of last negative/normal test | • Refer to Diabetes Prevention Program (DPP)<br>• Consider retesting annually to check for diabetes onset | • Confirm diagnosis; retest if necessary<br>• Counsel patient re: diagnosis<br>• Initiate therapy |

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# 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!**
  - Well-Ahead Louisiana's Community Resource Guide: http://wellaheadla.com/Well-Ahead-Community/Community-ResourceGuide
  - Registry of Recognized Organizations Website: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx

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# Core Elements of the National DPP



# 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 National Diabetes Prevention Program https://www.cdc.gov/diabetes/prevention/index.html
- CDC/ADA Prediabetes Risk Test https://www.cdc.gov/prediabetes/takethetest/

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# How Well-Ahead Can Help You Implement STR

- EHR Optimization
- Workflow Integration
- Community Resource Development
- Partnership Engagement for service Linkages
- Other Resources

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# Thank You!

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