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

Minneapolis
City of Lakes

Minneapolis SHIP Resource and Referral Network
Clinic Action Plan

Resource Referral and Follow-up System Key Components:

a. Incorporates health care clinician roles and responsibilities for referral in standard clinic processes
b. Identifies and addresses patients that can benefit from lifestyle changes that support healthy behavior
c. Establishes clinic processes for patient referral and follow-up
d. Develops a function for monitoring or tracking referrals and follow-up
e. Identifies patient resources and creates system to retain resources, using MinnesotaHelp.info® if possible
f. Creates at least one new community partnership and makes available at least one new patient resource
g. Designates responsible staff for maintaining resources, relationships, and systems

Agency: _____ **Date:** _____

Team Members: _____

Goal(s): What is the purpose?		
1.	Implement a resource referral system to increase provider referrals to clinic and community resources for obesity and tobacco cessation.	• Focuses on one type of activity? • Relatively long time frame?
2.	Develop relationships with local resources that can assist patients with prevention and management of obesity and tobacco.	
Aims: What are we trying to accomplish? *(E.g. Increase # of referrals for physical activity, healthy eating, and tobacco cessation for all patients by 50% by June 2011.)*		
1.		• Specify numeric target and timefra
2.		
Measures (process and outcome): How will we know that a change is an improvement? *(E.g. # of patients referred, % of patients with unhealthy behaviors referred to resources, % of patients with referral outcome result, # resources*		
1.		• Is it driven from the Aim? • Patient populati on (denomi nator) defined
2.		
3.		
4.		
Key Action Steps: What changes can we make that will result in an improvement? *(e.g. identify current referral process and number of referrals, identify resources and incorporate into referral system, integrate resources into clinic referral process)*		
1.		• Are change s small enough to be easily tested? • Can change s be tried on a small scale with
2.		
3.		
4.		
5.		

Action Plan Implementation

Tips:

- Create an implementation or project team
- Utilize baseline assessment findings to guide process and incorporate staff feedback
- Consider using MinnesotaHelp.info to manage resources and referral hand outs
- Engage clinic administration and staff in the project and encourage them to participate
- MDHFS can provide clinic training on SHIP, Motivational Interviewing, MinnesotaHelp.info, etc.

Establish clinic specific processes for referrals to community and clinic-based resources

1. Identify strategies for implementing key action plan steps and collecting measures (e.g. chart audits, system reports) and assign timeline and staff
2. Determine how to integrate referral system into clinic process (how to link patients with resources)
    a. Map out current and ideal clinic processes for referrals (refer to Resource Referral and Follow-up System Key Components on your SHIP Clinic Action Plan)
    b. Develop and compile tools to support process (e.g. assessment or readiness tools, referral tracking and follow-up tools, clinic decision support/EMR integration, MinnesotaHelp.info)
3. Conduct action steps for referrals using process improvement (e.g. PDSA, lean management)
    a. Pilot small changes with a few staff using outcome and process measures as a guide
    b. Present the new referral process to clinic staff and get input before finalizing
4. Conduct provider/staff training on final process, resources and systems (MinnesotaHelp.info, EMR)
5. Implement and evaluate referral resource process in clinic
    a. Collect outcome and process measures and report progress towards goal and aims to MDHFS
    b. Review ongoing clinic progress and updates with clinic staff and providers at meetings

Establish clinic specific community- and clinic-based referral resources and partnerships

1. Identify current clinic referral resources and gaps in resources through baseline assessment findings
2. Ascertain data specific to number of active referrals to the Call It Quits Fax Referral System
3. Establish 3-5 key clinic specific clinic and community based referral resources for each risk factor
4. Create partnerships with community organizations for existing and new resources (address gaps)
    a. Identify programs and services best-suited to offer at your clinic and facilitate implementation
    b. Facilitate partnership meetings or presentations with community leaders/agencies
5. Incorporate selected referral resources into clinic referral and resource system (EMR, MinnesotaHelp.Info)
    a. MDHFS to assist listing resources and create clinic directory in MinnesotaHelp.Info
6. Develop a plan for sustaining partnerships and making updates/changes to referral resource system

Pursue reimbursement for clinic-based programs and services from health plans or other funding

1. Identify current billing practices and reimbursement codes for lifestyle behavior change services
2. Pursue reimbursement options for clinic- and community-based lifestyle behavior change program