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

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Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity is a toolkit based on research conducted by the State Networks of Colorado Ambulatory Practices and Partners for the Agency for Health Care Research and Quality. This toolkit is intended to serve as a resource for health care practitioners working with primary care clinics and community agencies. The goal of the toolkit is to help health care practitioners examine their practice, establish relationships with community resources and partners, develop sustainable links, and exercise new strategies and tools to increase patient engagement. This toolkit can be used by health educators, clinic administrators, physicians, students, and other clinic staff as a step-by-step resource for developing or enhancing their community referral process and to develop strategies for improving patient engagement and enrollment practices for obesity management community programs.

Keywords: care team/clinical care team; clinician; community linkage/community referral; community partner; motivational interviewing; patient engagement; point of care identification; practice manager; preemptive identification; primary care; readiness to change; referral system

The publication provides a brief introduction and highlighted the goals of the toolkit, which included offering suggestions of some process models for health care practitioners to follow: assist with determining and evaluating accessible and affordable resources within the community to refer patients struggling with obesity or prediabetes, assist with establishing productive relationships with community partners, assist with the development of a bidirectional referral process that integrates directly into existing patient flow, and assist practitioners with enhanced patient engagement strategies so the referral process becomes meaningful with increased potential for patient activation.

The first chapter also introduces data from completed pilot work that was funded by Agency for Health Care Research and Quality. The pilot work took place in seven primary care practices who worked closely with the YMCA diabetes prevention project. The data
presented highlights lessons learned and examples that can be translated into practice in health care settings nationally. Many of the goals described in the toolkit fall in line with efforts underway by many clinical practices throughout the country working toward Patient Centered Medical Home Certification, Meaningful Use, and an accountable care model for patient care.

Chapter 2, titled “Background: The Case for Community Linkages,” provides health care practitioners with information on why it is essential to create community linkages for the treatment and prevention of obesity. The authors indicate that linking primary care practice with community resources is essential to health care practice especially with growing demands on clinics and primary care. Currently, in the United States, one third of all adults are obese, 17% of children and adolescence aged 2 to 19 years are obese, and 1 in 3 Americans have prediabetes (Centers for Disease Control and Prevention, 2014). These staggering numbers make it difficult for primary care practices to care for patients with obesity and associated chronic conditions. Linking with community partners oftentimes provides clinics and their patients with accessible, affordable services for the treatment and management of obesity. However, the evidence suggested that although community programs exist, the referral and enrollment remained low (Barlow, 2007). Chapter 2 sets the stage for strategies and suggestions that will be presented in toolkit. The authors indicate that all the resources presented in the toolkit were derived from a series of site visits, interviews, learning collaborative, and knowledge from quality improvement projects and evaluation methods. The chapter provides a comprehensive overview of the evidence and statistics for obesity and chronic conditions and can aid health care practitioners in developing a platform for a community resource referral system in their practice.

Chapter 3, “Linking with a Community Partner,” serves as a process model for developing a community referral system in a clinical setting. The chapter provides practitioners with a set of comprehensive steps for developing a systematic process to refer patients to community partners.

**Step 1. Establishing, Motivation, and Interest of Practice:**
The section highlights essential personnel, discusses a learning transfer system, and provides resources for assessing personal interest and capacity, gathering support for implementation, facilitating staff discussion around partnering with community agencies, and cementing commitment for establishing protocols for community referrals.

**Step 2. Find, Connect, and Evaluate a Partner:** The section provides details on how best to locate potential partners through web searches, key stakeholders, local universities, and city and state health departments. Resources for developing tracking tools are provided, and recommendations are made for creating institutional resources to track and manage records of potential partners.

**Step 3. Identify Patients:** The section provides guidelines clinics can use for patient identification. Two methods are discussed: (1) preemptive identification—a method that identifies patients, through a “wide net” approach focused on a spectrum of patients and (2) point of care—focused on identification of patients at point of service.

**Step 4. Create and Use Referral Forms:** The section highlights important items to consider when developing a referral form (i.e., clinical protocols and community partner protocols).

**Step 5. Integrate Process Within Patient Paths:** The section highlights establishing a system where you have a “committed physician/clinician champion that works to connect with patients inside the exam room and a practice where health care practitioners are willing to reinforce the message at appropriate moments outside the exam room” (p. 28).

**Step 6. Develop a Feedback System:** The section highlights the importance of developing a bidirectional referral process that is explicit in informing partners of clinic need, ensures documentation of data, and has feedback methods in place.

Chapter 3 provides great insight on the assessment and implementation process model for creating community linkages. The step-by-step resources provided in this section will assist health care practitioners with both infrastructure development and patient integration models for community referrals.

Chapter 4, “Linking with Patients,” moves away from the process and procedures for establishing community linkages and focuses on engaging with the patient. The chapter discusses results from the Agency for Health Care Research and Quality pilot sites, which indicated that although “practices were establishing functional, bidirectional referral systems with community agencies for obesity management services that the majority of referrals were not converting into patient enrollments” (p. 35). Data collected from the pilot sites suggested that community referrals are different from referring patients to specialist, although procedures for referral may be the same on the clinic side, for the patient committing to enroll in a community program such as a diabetes prevention program required patients to commit to lifestyle
changes. Establishing patient engagement models in clinical practices serves as a means to increase patient enrollment practices in clinical settings (Barlow, 2007).

The toolkit highlights some resources to aid health care practitioners with patient engagement and behavioral change. It features several models to aid in patient engagement and behavioral change. The strategies highlighted in the toolkit include motivational interviewing, decisional balance, and patient educational resources. The toolkit provides health care practitioners with the educational materials and resources necessary to carry out the patient engagement strategies in clinical practice by increasing patient engagement and enrollment to community programs.

Chapter 5 of the toolkit provides a summary for health care practitioners of the resources that are highlighted throughout the publication. Overall, the authors intend for the toolkit to serve as a resource for health care practitioners to “examine their practice, reach out to community agencies to develop sustainable linkages, and exercise new strategies and tools to increase patient engagement” (p. 56). The resources provided are intended to be transferable to any community agency or practice who would like to link patients with outside resources. Health care practitioners using this toolkit can walk away with key elements for building a clinical infrastructure that benefits both the practice and the patient.

**SUMMARY**

Guidelines developed for obesity management in primary care call for linking patients to community resources. The *Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity* toolkit offers a wealth of resources for health care practitioners working to develop a community referral system for their practice. The toolkit provides strategies, educational materials, and outcome data from pilot projects to aid with creating an infrastructure for linking patients to community resources. The toolkit also provides resources for health care practitioners to use for engaging patients looking to make healthy lifestyle changes. Public health professionals, practitioners, administrations, clinicians, students, and anyone interested in learning to develop relationships with community partners can gain a wealth of procedural knowledge from this toolkit.

**REFERENCES**
