ences in recruitment. Control practices were able to personally use the tools after completing patient enrollment, which may have motivated control practices to complete enrollment quickly. The telephony system we used for research purposes presented a barrier, decreasing our ability to detect behavior changes at the individual level. For both groups the average number of weeks participants reported data was very low because many patients reported only 1 week of data.

CONCLUSIONS

Interventions designed to fit unique interests and needs of each practice, including easy-to-use informational resources and incentives, can change behavior and promote a healthy primary care office. Personal success with behavioral change activities and practice-level enthusiasm for change did not translate to enhanced patient recruitment, however. Fitting health promotion into personal routines for clinicians and staff seemed easier than integrating LEAP tools into the routine of busy primary care practice. Although early findings suggest a very modest impact of the LEAP tools for both control and intervention patients, enhancing coaching skills and using simpler self-monitoring systems might improve the program’s impact.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/3/Suppl_2/S52.

Key words: Primary care; behavior change; practice culture; exercise and diet; physical activity; diet; practice-based research network; health behavior

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The participatory approach to tailoring the intervention and the ongoing implementation support provided by the facilitator led to a synergistic exchange of creative ideas among practices, resulting in substantial changes to the Pad. With the practice facilitator acting as a conveyor of key information about each practice's tailoring decisions, accumulated wisdom was shared at practice team meetings to adapt the tools in successively more innovative ways. The facilitator's stories of past developments from previously launched practices spurred brainstorming and discussion at each successive practice, resulting in additional modifications in accordance with the needs of that practice. Table 1 depicts the sequence of events that led to one major change in the Pad.

Through ongoing, iterative conveyance of practices' innovative ideas via the facilitator, the Pad's design and method of use were further modified. For example, practice 6 engaged medical assistants to check off health behavior topics the patient wished to discuss. The Pad was then clipped to the chart for the clinician. Used in this manner, the Pad was transformed into a screening tool and clinician reminder. Other innovations included
printing the Pad in a distinctive color to enhance its use as a clinician reminder and adding visual icons for use with low-literacy patients in place of written advice.\(^2\) What started as a prescription pad for health behavior change was transformed through the cumulative wisdom of 7 practices into a new, multipurpose tool.

**CONCLUSIONS**

Although we intended to tailor the tools to practices’ needs, the methods used in this study facilitated changes in the tools’ intended use and design beyond our expectations. For such innovations to occur, the research team must assume roles as both learners and conduits of cumulative participant wisdom, rather than as experts.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/3/Suppl_2/S54.

**Key words:** Health promotion; practice-based research network; health promotion/disease prevention; Internet; health behavior; patient education

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**Minnesota Clinicians Motivating Health Improvement (MINIT) Study: Motivating Healthy Habits**

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**Conflicts of interest:** Dr. Botelho is owner of www.MotivateHealthyHabits.com, the MHH online learning program, and MHH publication, LLC.

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**PURPOSE**

The MINIT (Minnesota Clinicians Motivating Health Improvement) Study was designed to target 4 risk behaviors that are strongly linked to a variety of negative health outcomes in the United States: (1) cigarette smoking, (2) sedentary lifestyle, (3) poor diet, and (4) risky drinking.

The specific purpose of this investigation was to field-test an interactive educational program that implemented a motivational approach to behavior change in order to enhance the use and success of established behavior-specific modification programs.

**METHODS**

We recruited for the study 114 patients from 10 participating community-based primary care clinics within the Minnesota Academy of Family Physicians Research Network (MAFPRN). Subjects were initially identified by the physician or site coordinator as having 1 of the 4 targeted risk behaviors, and were not actively participating in behavior change or a behavioral intervention program. After introducing the study to patients and obtaining appropriate consent, we asked participants a set of questions to assess their readiness to change. They were also assessed on a scale of 10 motivational