State Story

Rhode Island Uses Community Health Network to Increase Access to Chronic Disease Management

Rhode Island's Community Health Network partners multiple chronic disease management programs to provide a single access point for patient referrals. Patient navigators have facilitated more than 879 referrals to evidence-based programs around the state.

In 2012, the Rhode Island Department of Health (RIDOH) launched the Community Health Network (CHN), an innovative "one stop shop" for wellness programs. Through CHN, RIDOH provides a single access point where patients in need of chronic disease management can be referred to evidence-based programs around the state. Since its inception, RIDOH has continuously worked with large and small physician practices, health insurance companies, patient-centered medical home (PCMH) collaboratives and other health system partners to increase awareness and understanding of the CHN as an important resource to help patients become active and engaged in their care.

Community Health Network participants gain skills and knowledge to manage their chronic conditions and meet recommendations set forth by the Dietary Guidelines for Americans, the Physical Activity Guidelines for Americans, and other national recommendations.

Overview:

Like many states, over the last few decades Rhode Island has seen a dramatic increase in the percentage of adults with chronic conditions. Since 1993, the percentage of residents with diabetes has increased one-third to 7.4 percent, or 62,000 individuals with diagnosed diabetes and 31,000 with undiagnosed diabetes.[1] In addition, rates of asthma, arthritis, and hypertension among adults in Rhode Island (12%, 27%, and 33%, respectively) are all slightly higher than the national average[2], and 63 percent of adults are overweight or obese.[3]

Recognizing an increased need for chronic disease management, RIDOH made a strategic decision to establish CHN in 2012. The program aimed to address a common barrier to improving clinical outcomes among patients with chronic conditions: the reality that while providers know that chronic disease self-management can positively impact patients, they often do not know how to access these programs for their patients. CHN's goal is to support primary care practices and the health system by providing an easy link to such community-based programs, giving patients the necessary tools to take control of their health, and helping patients manage their chronic conditions by improving their diet and physical activity behaviors. RIDOH serves as a centralized point of referral through which healthcare providers can connect patients to more than 20 programs addressing such conditions as arthritis, asthma, cancer, COPD, chronic pain, diabetes, heart disease, smoking, and injury and fall prevention. CHN works with a diverse group of partners to provide these programs, including the YMCA of Greater Providence, physical therapist offices, independent living facilities, senior centers, and other community agencies and sites. Program examples include:

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- A Matter of Balance: Managing Concerns about Falls*
- Arthritis Foundation – Walk with Ease Program, Exercise Program
- Certified Cardiovascular Disease Outpatient Educator Program*
- Certified Diabetes Outpatient Educator*
- Draw a Breath Asthma Program
- Healthy Lifestyles for Youth*
- Living Well Rhode Island – Chronic Disease Self-Management, Chronic Pain Self-Management, and Diabetes Self-Management*
- QuitWorks-RI*
- YMCA of Greater Providence – EnhanceFitness, Health Smart Behaviors, Healthy Lifestyles Behavior Change Program, Diabetes Prevention Program, and Salsa, Sabor y Salud (in Spanish)

**Indicates programs operated by RIDOH.*

The Dietary Guidelines for Americans encourages Americans to eat a healthful diet to help achieve and maintain a healthy weight, promote health, and prevent disease.

The Physical Activity Guidelines for Americans discusses the health benefits and preventive effects of physical activity, which includes lowering the risk of developing heart disease and Type 2 diabetes.

Although the majority of the programs are designed for adults, the Draw a Breath Asthma Program and Healthy Lifestyles for Youth focus on children or young adults. Most of the programs are free or very low cost, and some offer incentives to patients completing the program. All CHN programs focus on empowering patients to increase control of their health. Patients learn how to work with their healthcare team to set goals to improve their health and lifestyle, eat healthier and increase physical activity, manage symptoms and medication, and handle difficult emotions.

Physicians can refer patients to any of the programs by sending a Community Health Network Program Referral to RIDOH via electronic health record, a secure fax line, phone, or email. A patient navigator employed or contracted by RIDOH then contacts patients to assess their needs, directs them to the appropriate program, and helps them to overcome any barriers to completing the referral. The patient navigator ensures that original providers are always informed of the referral outcome: If a navigator is unable to contact a patient after three attempts within two weeks, or if a patient is directed to a program but does not follow through, the navigator sends a referral feedback form back to the provider with the appropriate information. Similarly, when a patient enrolls in or completes a program, the navigator communicates this back to the provider.

Steps Taken:

Although CHN was only established in 2012, considerable groundwork was laid in the years prior to its inception. Beginning in the late 1980s, RIDOH focused significant resources on developing a chronic disease self-management public health workforce. This included certifying nurses, dietians, and pharmacists in diabetes and cardiovascular disease management and training asthma educators. In addition, in 2002 RIDOH leveraged funding from the CDC and the Robert Wood Johnson Foundation to convene the Rhode Island Chronic Care Collaborative (RICCC). RICCC initially focused on diabetes-related quality improvement initiatives in primary care practices, federally qualified health centers, and hospital-based practices. Over the next few years, RIDOH integrated heart disease, asthma, and colorectal cancer management into the RICCC. In 2006, the concept of PCMHs began to gain momentum in Rhode Island thanks in great part to RICCC, the efforts of the multi-payer Rhode Island Chronic Care

Sustainability Initiative, and Blue Cross Blue Shield Rhode Island. The patient-centered approach emphasizes the role of a primary care physician or team in facilitating and coordinating continuous, integrated, and comprehensive care for a patient, including chronic disease management. Together, RICCC and PCMH provided an excellent foundation for CHN.

CHN also grew out of a chronic disease self-management collaborative that RIDOH formed in 2010 made up of state health department programs and external partners already working on the issue. The collaborative included RIDOH staff from diabetes, asthma, arthritis, cancer, injury prevention, disability, tobacco and obesity programs as well as representatives from the Rhode Island Parent Information Network, YMCA of Greater Providence, and Community Health Worker Association of Rhode Island. These programs were already working individually to connect Rhode Island residents with a variety of internal and external programs, including Living Well Rhode Island, a RIDOH program offering the Stanford Chronic Disease Self-Management Program, Diabetes Self-Management Program, and the Chronic Pain Self-Management Program (see text box on next page). RIDOH saw the opportunity to increase the collaborative's effectiveness by centralizing and coordinating referrals, and in 2012 formally established CHN.

Community Health Network
Keys to Success

- Lay out a clear vision of the network for physicians and other providers, including the benefits of a centralized referral system for their practice and patients.
- Start small to ensure that the network has enough programs to reach a broad geographic region.
- Build strong partnerships in the community, both on the chronic disease management program delivery side and on the physician side.
- Engage staff at the helm of the network who are flexible and have a basic understanding of how physicians practices work.
- Encourage strong, ongoing communication between patient navigators and providers.

Once established, RIDOH worked to ensure CHN's success by focusing on five essential elements:

1) **Partnering with the community organizations providing or hosting chronic disease management programs.** RIDOH has established strong partnerships with the YMCA of Greater Providence, the State Alliance of Rhode Island YMCAs, Arthritis Foundation New England Region, Community Health Worker Association of Rhode Island, Rhode Island Parent Information Network and the Federal Hill House Association. The participation of these organizations and their respective programs in the Network has been essential to expanding the breadth of programs offered.
2) **Ensuring adequate staff and appropriate protocols at RIDOH to handle the referrals and follow up with referring agencies.** RIDOH has leveraged funding from CDC and HHS cooperative agreements for arthritis and chronic disease prevention to employ two patient navigators—one full-time and one part-time.
3) **Providing a single access point online for information about different programs.** CHN has created a standard referral flow, a patient referral form, and physician communication form.

RIDH also built a webpage with up-to-date information about programs and locations that is searchable by chronic condition.

4) **Ensuring program availability across the state.** RIDOH staff has worked diligently both with internal RIDOH programs and external partners to ensure that there are sufficient programs available across the state, as experience has demonstrated that patients are generally not willing to travel more than 15 to 20 minutes to participate in a program.
5) **Talking to providers about CHN and its potential benefit to their practices and patients.** Staff from RIDOH have invested a significant amount of time educating providers about CHN. This has included many in-person "academic detailing" meetings with nurses, nurse managers, and physicians to explain the referral and feedback process. RIDOH had to learn how to "market" CHN to help physicians understand the value of a centralized referral system for their practice and patients to ensure high-quality evidence-based programs for chronic disease management and promote continuity of care. RIDOH's messaging emphasizes that CHN helps providers work *smarter,* not *harder*. Although RIDOH has built many relationships with some of the larger physician practices that operate as patient-centered medical homes, RIDOH has also been able to connect with three physician micro-practices (small practices with limited staff) that served as a piloting and feedback group to help implement CHN.

Living Well Rhode Island

Living Well Rhode Island (LWRI) is RIDOH's low-cost prevention program based on Stanford University's Chronic Disease Self-Management Education Programs, which were developed using recommendations outlined in the Dietary Guidelines for Americans, 2010 and the 2008 Physical Activity Guidelines for Americans. LWRI helps individuals with chronic diseases manage their conditions, improve their health status, and reduce their need for more costly medical care. The program consists of six weekly two-and-a-half hour workshops that clients attend in community settings. RIDOH partners with the Rhode Island Division of Elderly Affairs to offer the Stanford Chronic Disease Self-Management Program in addition to Stanford's Diabetes Self-Management Program and Chronic Pain Self-Management Program. The chronic disease program covers appropriate nutrition, exercise for maintaining and improving strength, flexibility, and endurance, and correct medication use, among other topics. Research shows that this program significantly improves physical activity levels and depression symptoms, and helps clients better communicate with physicians, decreasing emergency room visits and hospitalizations overall.[4]

Since LWRI's establishment in 2007, the program has significantly expanded its workshops by partnering with various community organizations, including the YMCA, AARP, Aging and Disability Resource Centers, senior centers and the Veterans Administration Medical Center. Out of the 2,230 people who have attended at least one LWRI session, 1,781 people have completed a LWRI workshop (attended four of six sessions) for an 80 percent completion rate.

Results:

Since its inception, CHN has grown to include more than 500 chronic disease, diabetes, and chronic pain self-management leaders, certified diabetes educators, cardiovascular disease educators, community health workers, patient navigators, and resource specialists across the state. The patient navigators at

RIDOH have facilitated more than 879 referrals to programs throughout Rhode Island. RIDOH is now working on increasing number-specific programs (e.g., a diabetes prevention program) in addition to the total number of programs and patient navigators in order to meet demand. RIDOH anticipates being able to achieve this by leveraging additional cooperative agreement funds from CDC related to diabetes and cardiovascular health.

Qualitative Analysis of Community Health Network

RIDOH partnered with a graduate student from Brown University to do a qualitative evaluation of CHN. The evaluation had two objectives: to assess CHN's process and identify the key elements for an effective referral and to understand healthcare providers' experiences with CHN by collecting information on satisfaction and challenges with this referral process and the barriers to conduct successful referrals. Initial results indicate that the CHN programs and providers believe that it improves the referral process and helps to coordinate care. Providers would like RIDOH to increase the number of programs and improve communication about program availability and patient referral status. CHN has already begun to address these issues by coordinating efforts to establish an online calendar of program offerings and by establishing programs in place-based locations for more routine schedules. RIDOH is also making improvements to the physician feedback loop with a standard referral status update by CHN patient navigators.

Lessons Learned:

- Building a state-level referral network requires patience and significant groundwork. Start small and ensure that there are enough programs in the network to reach a broad geographic region before scaling up.
- Strong partnerships in the community are key for success, both on the chronic disease management program delivery side and on the physician side.
- It's essential to have CHN staff that have a basic understanding of how physician practices work (e.g., office flow and how physicians integrate chronic disease self-management into existing protocols) and are flexible to adapt processes as needed.
- For many large physician practices, getting signed patient consent forms is challenging. Referrals to community-based programs outside of the RIDOH require signed patient consent for disclosure of confidential information. In cases where the referral is made without signed consent, RIDOH opts to send the form out to the patient with a postage paid return envelope.
- Strong ongoing communication with providers sets CHN up for future success. Patient navigators need to ensure to complete the communication loop with each referring provider. This includes notifying the provider if the navigator is unable to make contact with the patient and if s/he enrolled in or completed the program.
- It is important to state a clear vision of CHN for physicians and other providers, including how this type of centralized referral network for chronic disease management can benefit their practices and patients. Working beyond the walls of a practice, linking to programs in the community and focusing on physician-led referral rather than patient-activated enrollment is often a culture change for many providers.

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