Information for the Integration of Care and Financing for Medicaid-Only and Medicare and Medicaid Eligible (MME)

HEALTH’s Chronic Conditions Integrated Work Force System

The Rhode Island Department of Health (HEALTH) has created a coordinated system to provide evidence based and best practice education to activate patients and improve patient skills necessary to self-manage their chronic condition(s). This system is comprised of a Chronic Conditions Workforce Collaborative (CCWC), which is a partnership between multiple evidence-based programs within the HEALTH, and other partners in Rhode Island who work on the management of chronic conditions. CCWC is building a skilled workforce of expertly trained staff both professional and community health workers who provide disease/self-management programs, chronic disease management programs, and patient navigation.

The CCWC supports Rhode Island’s health care movement towards integrated health care and patient centered medical homes. The 2011 Patient Centered Medical Home NCQA standards require patient self care support and access to community resources. The CCWC workforce provides a resource to providers, patients and payers which links to the practice team and leads to productive interactions between the patient and the practice team.

Components of the system include a centralized referral system with secure fax and email to HEALTH; follow up with the patient to assist with access to the CCWC resources, and communication back to the practice concerning the patient experience.

Evidence Based Programs include:
- Certified Diabetes Outpatient Educators (CDOE)
- Cardiovascular Disease Outpatient Educators (CVDOE)
- Living Well Rhode Island (chronic disease self-management and diabetes self-management)
- Peer Resource Specialists / Peer Navigators
- A Matter of Balance: Managing Concerns About Falls
- Chronic Pain Self Management (to be added in March 2013)
- Certified Asthma Educators (AE-C)
- Arthritis Foundation Walk with Ease
- Arthritis Foundation Exercise Program
- YMCA’s Diabetes Prevention Program
- The Home Asthma Response Program (HARP)
Details on Evidence Based Programs

Living Well Rhode Island (LWRI)

Overview
Living Well Rhode Island Chronic Disease Self Management Program (CDSMP) is an evidence-based program developed at Stanford University Education Research Institute in 1996. The goal of the LWRI program is to help participants gain confidence in their ability to manage their health and the impact the chronic condition has on their lives and emotions. Self-management strategies such as action planning and feedback, behavior modeling, problem solving techniques, and decision making are practiced in the small group workshops which run 2.5 hours per week over a 6 week period. The program is approved by the Administration on Aging, Centers of Disease Control and Prevention, and the National Council on Aging. LWRI offers workshops in English and Spanish in Chronic Disease Self-Management and Diabetes Self-Management throughout the state. There are 62 Leaders in Rhode Island who provide the above mentioned programs statewide.

HEALTH is working toward accreditation by the Centers for Medicare & Medicaid Services (CMS) for diabetes self-management training (DSMT). DSMT is a term used by CMS for a benefit available to Medicare Part B beneficiaries that covers participation in an accredited diabetes education program. Programs that are accredited and recognized are eligible for reimbursement under Medicare Part B and some Medicaid programs for DSMT services.

Supporting Evidence
Over 1,000 people with heart disease, lung disease, stroke, or arthritis participated in a randomized, controlled trial of CDSMP, and were followed for up to three years.

Subjects that participated in CDSMP, compared to those that did not, demonstrated significant improvements in exercise, cognitive symptom management, and communication with physicians, self-reported general health, health distress, and fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years.

References
Certified Diabetes Outpatient Educators (CDOE)
Overview
Currently there are 303 RI Registered Dietitians, Nurses, and Pharmacists who are trained in diabetes education, disease-management skills, and motivational interviewing techniques. CDOEs help patients to become active participants in controlling their diabetes to reduce complications and improve outcomes. CDOEs provide support for clinical management of patients. They can provide individual or group and in-practice group visit TEAMWorks education sessions. Programs are provided in English, Spanish and Portuguese statewide.

Supporting Evidence
Education helps people with diabetes initiate effective self-management and cope with diabetes when they are first diagnosed. Ongoing diabetes education also helps people with diabetes maintain effective self-management throughout a lifetime of diabetes as they face new challenges and as treatment advances become available.

Multiple studies have found that diabetes education is associated with improved diabetes knowledge and self-care behavior, improved clinical outcomes such as lower A1C, lower self-reported weight, improved quality of life, healthy coping, and lower costs. Both individual and group approaches have been found effective.

Diabetes education is associated with increased use of primary and preventive services and lower use of acute, inpatient hospital services. Patients who participate in diabetes education are more likely to follow best practice treatment recommendations, particularly among the Medicare population, and have lower Medicare and commercial claim costs.

References


**Cardiovascular Disease Outpatient Educators (CVDOE)**

**Overview**

RI Registered Dietitians, Nurses, and Pharmacists who are trained as CDOEs receive an in-depth training in cardiovascular disease education, disease-management skills and motivational interviewing techniques. Currently there are 73 CVDOEs in the state. CVDOEs help patients to become active participants in controlling their heart disease to reduce complications and improve outcomes. CVDOEs provide support for clinical management of patients. They can provide individual or group education sessions and an in-practice group visit TEAMWorks. Programs are available in English and Spanish statewide.

**Supporting Evidence**

In 2012, 7/4% of Rhode Island adults, (18 and older) reported that they had been diagnosed with one or more cardiovascular conditions. This translates into 60,391 Rhode Island adults with a diagnosed cardiovascular condition. As of 2010, in Rhode Island the years of potential life lost before age 75 years due to cardiovascular disease are 8,158 years. In the United States as of 2010, heart disease causes 3.0 million years of potential life lost before age 75 years. *(Source: Centers for Disease Control and Prevention).*

According to a Providence VA Medical Center pilot study (Martin et al), short-term multidisciplinary group behavioral and pharmacologic intervention program may be effective in improving cardiac risk factors in patients with diabetes. Forty-one veterans with diabetes attended weekly CDOE sessions for one month (3-4 sessions) “All parameters improved after the intervention with significant reductions in A1C and DBP.”
A September 2012 article (L. Cohen) concluded that patients receiving the intervention cardiac risk reduction for patients with diabetes for six months showed significant improvements in exercise, foot care, and goal attainment (hemoglobin A1C, LDL cholesterol and blood pressure).

References


Cohen, L. Pharmacists as Diabetes Educators and Diabetes Disease Managers. Medicine & Health/Rhode Island 2012; 95:275-276

A Matter of Balance: Managing Concerns About Falls
Overview
A Matter of Balance emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance. This program has been adapted from the original intervention to be more suitable for community-dwelling older adults by allowing small group sessions to be led by a trained facilitator.

Supporting Evidence
A randomized, single-blind controlled trial was conducted to test the efficacy of a community-based group intervention to reduce fear of falling and associated restrictions in activity levels among older adults. A sample of 434 persons age 60+ years, who reported fear of falling and associated activity restriction, was recruited from 40 senior housing sites in the Boston metropolitan area. Data were collected at baseline, and at six-week, six-month, and 12-month follow-ups. Compared with contact control subjects, intervention subjects reported increased levels of intended activity (p < .05) and greater mobility control (p < .05) immediately after the intervention. Effects at 12 months included improved social function (p < .05) and mobility range (p < .05).

A subsequent study examined whether A Matter of Balance could be translated into a community-based volunteer lay leader model and achieves outcomes comparable to those found in the RCT. A repeated measures single group design
was employed. Participants experienced significant increases in Falls Efficacy, Falls Management, and Falls Control at six weeks, six months, and 12 months, thus achieving comparable outcomes with those of participants in the RCT.

References


Certified Asthma Educators

Overview
Certified asthma Educators (AE-C) include nurses, nurse practitioners, physician assistants, pharmacists, and respiratory therapist who are well trained and specialize in asthma care. Certification is provided through the National Asthma Education Certification Board. Currently, there are 53 AE-Cs in the state who provide asthma education in individual and group sessions.

Supporting Evidence
Asthma education for patient self-management by a Certified Asthma Educator aligns with the evidence-based asthma standards of care developed by the 2007 NHLBI National Asthma Education and Prevention Program (NAEPP), Guidelines for the Diagnosis and Management of Asthma. “Self-management education improves patient outcomes (e.g., reduced urgent care visits, hospitalizations, and limitations on activities as well as improved health status, quality of life, and perceived control of asthma) and can be cost-effective. Self-management education is an integral component of effective asthma care and should be treated as such by health care providers as well as health care policies and reimbursements.” (Guevara) Asthma education sessions should address the following:

- Asthma Action Plan,
- proper medication use,
- self-assessment of asthma control and monitoring symptoms,
- establishment of self-management goals,
- use of peak flow meter, and
- reducing exposure to triggers.

References
Rhode Island Smokers’ Quitline

Overview
Quitlines are telephone-based tobacco cessation services that help tobacco users quit through a variety of services, including counseling, information and self-help materials. A trained quit coach assesses callers and develops a customized plan which fits their needs. Free cessation information, multi-session telephone counseling, and self-help materials are also provided.

Supporting Evidence
Quitlines represent a best practice in tobacco cessation with demonstrated broad reach. The most recently updated Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update, concludes that counseling, in person or by phone, is more effective at helping people quit than no counseling. Counseling that provides general problem solving or skills training is 50% more effective than no counseling, with an estimated quit rate of 16.2%. Counseling that provides social support as part of the treatment protocol is 30% more effective than no counseling, with an estimated quit rate of 14.4%. When medication is added to counseling, the combination is 70% more effective than counseling alone, with an estimated quit rate of 22.1%.

References


**Other evidence based programs associated with the Chronic Conditions Workforce**

**Peer Resource Specialists**

**Overview**
Peer Resource Specialists/Peer Navigators is a workforce developed and trained by the RI Department of Health, Office of Special Needs in collaboration with Medicaid and the RI Parent Information Network. Since 2004, nearly 400 practitioners throughout RI have connected their patients with Peer Resource Specialist and experienced coordinated care. Peer Resource Specialists are trained to help people navigate healthcare systems, coordinate care, and access basic needs that often interfere with health and wellness (such as housing, transportation, employment supports, etc.). Peer Resource services are offered at participating doctor’s offices, in the home, hospitals, and community agencies.

Peer Resource Specialists are either family members raising children with special health care needs or individuals with a chronic care condition or a disability who have experience navigating a variety of systems and services personally, who are trained to provide peer-to-peer support, systems navigation, information, referrals, self advocacy skills and assistance with care coordination for patients, and parents of children with special health care needs. Peer Resource Specialist work from an empowerment model by providing the individuals they support with the skills they need to be their own or their child’s best advocate and giving them the skills they need to navigate systems. Peer Resource Specialists are located in primary care, specialty care, hospital and community settings.

**Supporting Evidence**
Peer Resource Specialist are part of the care team offering a unique role on the team which has been shown to promote patient centered medical home, improve health outcomes, reduce emergency room use, increase use of community based resources, tap into their own natural resources, reduce inpatient admissions and reduction of overall health care costs. Peer Resource Specialist identify barriers faced by individuals and families and are able to bring these to the attention of decision makers in an effort to improve systems and services for consumers.
Walk With Ease
Overview
Developed in 1999 and updated in 2009, the Arthritis Foundation Walk with Ease Program strives to teach participants how to safely make physical activity part of their everyday life through a workbook, and the choice of participating in a six-week group program led by a trained leader or by doing the program on a self-directed basis, using the workbook as a guide. While designed to help people living with arthritis better manage their pain, people without arthritis who want to increase or improve their physical activity habits can also derive benefits from the program.

Groups meet for six weeks, three times per week at sessions that last approximately one hour. The program can be modified to meet the needs of its participants. Each session typically begins with a brief discussion around walking or arthritis management topics and is followed by a stretching and walking component. For participants, the only requirement for enrollment is to be able to stay on their feet for 10 minutes without increased pain. Self-directed walkers use the workbook and set their own pace. They are encouraged to build up to walking at least 30 minutes on 3 or more days a week for 6 weeks.

Supporting Evidence
Walk with Ease’s information and strategies are based on research and tested programs in exercise science, behavior change, and arthritis management. Evaluated by the Thurston Arthritis Research Center and the Institute on Aging at the University of North Carolina, the program has shown to increase balance, strength and walking pace, as well as reduce pain for participants. The revised Walk with Ease program decreases disability and improves arthritis symptoms, self-efficacy, and perceived control, balance, strength, and walking pace in individuals with arthritis, regardless of whether they are taking a group class or doing the program as self-directed walkers. At one year, some benefits are maintained, particularly among the self-directed. This is a safe, easy, and inexpensive program to promote community-based physical activity.

References


**Diabetes Prevention Program**

**Overview**

The YMCA’s Diabetes Prevention Program (YDPP) is an innovative evidence-based 16 week program to reduce the risk of diabetes in individuals with pre-diabetes. Each one hour session per week is facilitated by a trained Lifestyle interventionist who helps participants change their lifestyle by learning about healthy eating, physical activity and other behavior changes over the course of 16 one-hour sessions. Topics covered include healthy eating, getting started with physical activity, overcoming stress, staying motivated, and more. After the initial 16 core sessions, participants meet monthly for added support to help them maintain their progress.

**Supporting Evidence**

The Diabetes Prevention Program was designed by Indiana University School of Medicine. The YDPP is based on the national Diabetes Prevention Program funded by the National Institutes of Health and others—which showed that by eating healthier, increasing physical activity and losing a small amount of weight, a person with pre-diabetes who is overweight can prevent or delay the onset of type 2 diabetes by 58%.

**References:**


**The Home Asthma Response Program (HARP)**

**Overview**

HARP is designed to reduce unnecessary asthma emergency department (ED) visits and hospitalizations among pediatric asthma patients through home visits to improve disease self-management and reduce asthma home triggers. It builds on previous evidence-based models and was developed to accommodate
practices to provide comprehensive asthma care as part of a patient-centered medical home. The basic elements involve identification of children with one or more ED visits for asthma, referral for a home visit for asthma education and healthy home assessment, with two follow-up visits for remediation of environmental allergens and triggers, and feedback to the health care provider and health plan case manager on the results of the home assessment and asthma status.

Supporting Evidence
Controlling and managing asthma is extremely costly. In 2007, the U.S. paid $14.7 billion in direct health care costs and another $5 billion in indirect costs (lost productivity) for a total of $19.7 billion. In 2009, asthma represented a significant drain on the time and resources of the health care sector, and is estimated to cost more than $30 billion every year in the U.S.

The published literature provides strong evidence that asthma education and home-base environmental trigger interventions are cost effective aspects of clinical asthma management, especially when targeting high risk patients who tend to use health care services frequently. In December 2009, the US Centers for Disease Control and Prevention (CDC) released findings of a thorough review of the literature on the Economic Evaluation of Home-Based Environmental Interventions to Reduce Asthma Morbidity. Findings included:
- Studies with satisfactory program cost information report the range of program costs from $231 to $1,720 per participant.
- Cost benefit studies show that positive returns on investment with a benefit-cost ratio of 5.3-14.0.
- Cost effectiveness studies show that costs per symptom-free day (recommended economic indicator for asthma) range from $12-$57 per symptom free day, and could be lower if all direct and indirect costs (productivity) were included.
- Studies summarized above provided home-based visits which included education on asthma self-management as well as environmental home-based trigger reduction services such as environmental assessments, remediations, and supplies. Studies focused on children with moderate to severe asthma. The types of home visitors included: nurse, respiratory therapist, asthma educator, sanitarian/housing officer, and/or community health worker.

Additional citations can be found below supporting the cost:benefit of asthma education by a Certified Asthma Educator or well-trained provider who specializes in asthma to improve asthma self-management and the use of Community Health Worker to improve the environmental health of the home to reduce exposure to asthma triggers.

References
Economic Evaluation of Home-Based Environmental Interventions Webinar. 
CDC, 2010. 

http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf


