Healthcare Workforce Transformation:
Chronic Disease Sub-Group

November 22, 2016

EOHHS Healthcare Workforce Transformation Committee

RIDOH's Goal and Priorities

OVERARCHING GOAL

Positively Demonstrate for Rhode Islanders the Purpose and Importance of Public Health

LEADING PRIORITIES

- Address the Social and Environmental Determinants of Health in Rhode Island
- Eliminate the Disparities of Health in Rhode Island and Promote Health Equity
- Ensure Access to Quality Health Services for Rhode Islanders, Including Our Vulnerable Populations

Building a Healthcare Workforce for Chronic Disease Management Helps Address Each Leading Priority with a Special Focus on the Third Priority.

CROSS-CUTTING STRATEGIES

RIDOH Academic Center: Strengthen the Integration of Scholarly Activities with Public Health

RIDOH Health Equity Institute: Promote collective action to achieve the full potential of all RIers

Why Do We Need This Workforce?

Managing and preventing chronic disease

- High prevalence of diabetes, heart disease, high blood pressure
- 1 in 3 Rhode Islander adults have prediabetes
- ~12% of Rhode Islanders have asthma
- ~63% of adults are overweight
- ~17% of adults smoke
- Comorbidities common among chronic diseases and conditions, and often associated with behavioral health and social determinants of health
- High cost

RIDOH Workforce Development

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Initiatives supporting chronic disease self-management and care from a workforce development perspective include:

- **Patient-Centered Medical Home Models of Care**
  - RI Chronic Care Collaborative and Care, Community, and Equity
    - Collaborate with the Care Transformation Collaborative
  - Improving use of EHR to drive improvements in work flow, team-based care, coordination of care, screenings, referrals, etc., to improve population outcomes
  - Community-clinical linkages to connect patients to community resources for disease self-management

Expanding the Healthcare Team

- **Palliative Care**
  - Barrier: Improving access in RI
- **Certified Diabetes and Cardiovascular Disease Outpatient Educators**
  - Over 389 CDOEs coordinated by the Diabetes Education Partners in RI
  - Pharmacists, nurses, and registered dietitians
  - Barriers: Only 14 speak Spanish, only CDOE RDs get reimbursed by Medicaid
- **Pharmacists**
  - Efforts to increase # of practices who use pharmacists as part of care team for MTM
  - Barriers: Value recognition, reimbursement

RIDOH Workforce Development

- **Certified Community Health Workers (CHW)**
  - Certified through the RI Certification Board
  - Currently over 70 certified since May 2016

- **‘Endorsements’ for Certified CHWs to address chronic diseases**
  - Just starting the process with RI Certification Board
  - Examples of possible endorsements:
    - Cardiovascular Disease/Diabetes
    - Colorectal, Breast, Cervical Cancer screenings
    - Asthma
    - Healthy Housing

Offering Evidence-Based Programs

- **Diabetes Prevention Program**
  - Medicare reimbursement in January 2018
- **Stanford Disease Self-Management Programs:**
  - Chronic Disease Self-Management
  - Diabetes Self Management
- **Home Asthma Response Program (HARP)**

Improving Health with HARP

Home Asthma Response Program

- After an child visits the ED for asthma, three home visits assess home environment, remove/mitigate triggers, educate caregivers on medications and environmental control options.
- Certified Asthma Educators and CHWs ensure caregiver understands how to obtain and use medications and/or devices, thus enhancing compliance with physician Asthma Action Plan.
- For families who don’t have an Action Plan, the Asthma Educator does outreach to get one from the primary care provider and reviews it with the caregiver.

What is SIM Leveraging?

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Community Health Teams (CHTs) are:

- Multi-disciplinary teams that work directly within environments to address the factors that impact people's health.
- Support and work within primary care (e.g., Patient-Centered Medical Home).
- Increase access to comprehensive, community-based, coordinated care.
- Include, at a minimum, community health workers and a community-based, licensed health professional.
- Bridge the community and healthcare settings to help meet our strategic priorities.

What Has Been Suggested?

From the last meeting of the entire Committee, several suggestions were made:

- Social and environmental assessments should be comprehensive and aligned across healthcare professionals:
  - Cultural competencies, social determinants of health, substance abuse, behavioral health, and chronic disease

- Student clinical practicum should include cross-training in the issues listed above
- Lifestyle medicine to improve diet and physical activity levels
- Telemedicine support and coverage to enhance care
- Behavioral and chronic disease cross-training
- Code reimbursement by primary care and behavioral health
- Improve collaboration between paramedics in community and primary care providers

Nancy Sutton, MS, RD
Chief, Center for Chronic Care and Disease Management
P: 401-222-4040
E: Nancy.Sutton@health.ri.gov