Community Health Network

2020-2025 Strategic Plan

RHODE ISLAND DEPARTMENT OF HEALTH

RHODE ISLAND PARENT INFORMATION NETWORK
RIPIN

Own Your Health

Acknowledgements

Since its inception in 2012, the Community Health Network (CHN) has experienced increased utilization by providers and patients; however, there is tremendous growth potential for referrals, program utilization, and, ultimately, positive health outcomes attributable to program participation. The purpose of this strategic planning process and plan document is to establish an informed and detailed roadmap for future growth and long-term sustainability.

Development of this Strategic Plan was completed from November 2018 through June 2019. The process included meetings of the Rhode Island Department of Health (RIDOH) CHN team, a large group planning charrette involving key CHN stakeholders, and follow-up meetings focusing on specific strategic priorities. The following individuals played a significant role in shaping the planning process and the content of this Plan:

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Dear Colleagues,

According to the Centers for Disease Control and Prevention (CDC), six in 10 Americans live with at least one chronic condition, and chronic conditions are the leading causes of death and disability in the United States.

Like our national counterparts, too many Rhode Islanders are affected. In fact, for Rhode Islanders, diseases such as diabetes and chronic obstructive pulmonary disorder (COPD) often co-occur with three or more other chronic conditions. The reality is that those with chronic conditions are sicker than the general population. Many Rhode Islanders struggle to control diseases like high blood pressure and diabetes, which combined, affect more than 240,000 people—nearly 25% of the State's population.

The Community Health Network (CHN) was established in 2012 to provide support to people who are battling chronic conditions. Most chronic conditions can be controlled, but it is difficult for those suffering with these diseases to do it without support. Changing lifestyles is often the critical component to chronic disease management, but it's not something that most patients initiate after leaving their primary care physicians' offices. They need help.

Through its 13 programs, CHN is positioned as a resource for primary and specialty care physicians and is an important part of the continuum of care. We've made great strides in the past seven years, and we are confident that CHN is having a positive impact on the health of those combatting these conditions, and ultimately improves their quality of life.

As with any effort, it's important to assess the current state of CHN. This Strategic Plan is the result of countless hours of research, reflection, and honest dialogue. It's a look toward the future and how CHN can reach even more Rhode Islanders. I applaud this effort and look forward to the continued evolution of this critical service.

I want to thank the Rhode Island Parent Information Network (RIPIN) for the pivotal role they play in the administration of CHN. RIPIN is a terrific partner and has been critical to the success of CHN. Together, we will continue to ensure that those with chronic conditions have access to quality health promotion programs within their communities.

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health

Dear Colleagues,

Since its inception in 2012, the partnership between RIDOH's Community Health Network (CHN) and the Rhode Island Parent Information Network (RIPIN) has been one that aligns directly with why these organizations exist: to make it possible for those of us in this special state to live healthier lives.

It's easy to talk about healthier lifestyles, but providing the tools and support that will enable those with chronic conditions to control their own destiny is why CHN and RIPIN came together. You could be living with asthma, diabetes, or chronic pain; or fighting an addiction to cigarettes. Perhaps you're just worn out as a caregiver and need guidance on how to persevere. That's why we established CHN.

RIPIN provides the infrastructure needed to make the CHN mechanisms work for the benefit of patients and doctors. If operating correctly, CHN becomes an extension of the primary care physician's integrated team…a critical part of the ongoing care needed to control chronic conditions.

Though we have experienced success with this endeavor, it's important—and "healthy"—to step back, assess how CHN is doing, and discuss how we can have a greater impact on the lives of patients and the providers who care for them. This is why the development of this Strategic Plan is so critical, and why so many people have spent so much time to produce this important, in-depth analysis and honest assessment. This is a living, breathing, and actionable piece of work, which establishes where the CHN is today, with a critical look forward on what CHN needs to do to remain viable and effective in winning the fight against chronic diseases.

This Strategic Plan begins a new chapter in a strong partnership that helps Rhode Islanders enjoy the benefits of healthier lives.

Samuel Salganik
Executive Director
Rhode Island Parent Information Network

Executive Summary

For the past seven years, the Community Health Network (CHN) has served as a centralized referral system for evidence- and community-based chronic disease prevention and management programs, and for evidence-based healthy lifestyle programs (EBLP). As of September 2019, there are 13 programs and services available through the CHN. The CHN operates as part of RIDOH's Diabetes, Heart Disease, and Stroke Program (DHDS) and is staffed/operated through a partnership with RIPIN.

The CHN has continued to grow since its inception, as the number of programs offered, providers referring patients, and program participants are at an all-time high. There is a realization, however, that the CHN needs to develop a Strategic Plan for the next five years (2019-2024) that focuses on vital issues that will contribute to the long-term sustainability of the CHN. In turn, this will have a direct impact on the Chronic Disease Self-Management Education (CDSME) programs that are such a vital part of CHN. The CDSME programs are funded through the Administration for Community Living (ACL) and Centers for Disease Control and Prevention (CDC) and include: Chronic Disease Self-Management Program, Chronic Pain Self-Management Program, Diabetes Self-Management Program, and Walk with Ease. These programs provide the foundation for CHN and are part of RIDOH's effort to help control chronic diseases.

This plan focuses on five overarching goals:

- **Goal 1: Reimbursement for sustainability**
  Identify potential funding strategies and mechanisms to support the long-term sustainability of the CHN and the individual programs providing services.
- **Goal 2: Program stability and supply**
  Reduce geographic and seasonal variability in program availability that is tied to funding cycles.
- **Goal 3: Community-clinical linkages**
  Enhance the level and quality of case-specific, bi-directional communication between provider and program: referral process, use of electronic health records, improved tracking and sharing of outcome data, and increased feedback to providers.
- **Goal 4: CHN-wide communications**
  Enhance CHN communications by sharing information about policies and procedures, best practices, and additional resources with program facilitators, leaders, coordinators, patient navigators, and RIDOH staff.
- **Goal 5: Marketing CHN**
  Increase provider and public awareness of the CHN, with the goal of increasing enrollment in all EBLPs particularly in target populations at high risk for health disparities and inequality.

The Plan provides a snapshot of the current state of the CHN, and then drills down into the specific strategies and action steps aligning with each of the goals.

The overall intention of this Plan is to:

- Enhance the current operational infrastructure.
- Raise awareness and use of the CHN among providers and patients.
- Obtain meaningful and actionable data collection.
- Establish efficient communications channels among all audiences.
- Determine a reimbursement model that satisfies the needs of providers, programs, payers, and the CHN.
- Increase enrollment in EBLPs across the state.

Charter

Linkage between the clinical milieu and community-based support programs is one of the CDC's four key domains of chronic disease prevention and a focal point for funding provided to state health departments. The domains are

1. Epidemiology and surveillance—to monitor trends and track progress;
2. Environmental approaches—to promote health and support healthy behaviors;
3. Healthcare system interventions—to improve the effective delivery and use of clinical and other high-value preventive services; and
4. Community programs linked to clinical services—to improve and sustain management of chronic conditions.

(Approaches to Promoting Referrals to Diabetes Self-Management Education and CDC-Recognized Diabetes Prevention Program Sites, Centers for Disease Control, September 2016, www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-promoting_referrals.pdf)

Created in 2012 with CDC and ACL funding, the CHN is an innovative, centralized referral system for evidence- and community-based chronic disease prevention and management programs, and for EBLP. The CHN is funded by RIDOH's Diabetes, Heart Disease, and Stroke Program (DHDS) and is implemented through a partnership with RIPIN.

The purpose of the CHN is to support the medical system and complement medical practices by providing links to patient resources in the community. Patients include any Rhode Islander who is experiencing, or at risk for, chronic diseases or conditions. In addition, programs support the caregivers of individuals experiencing, or at risk for, chronic diseases or conditions. Among Rhode Island adults 18 and older, 56% have a chronic disease and 26% have two or more chronic diseases to manage. (Rhode Island State Health Improvement Plan, Version 3 – July 28, 2017; www.health.ri.gov/publications/reports/2017StateInnovationModelHealthAssessment.pdf) The goal of the CHN is to connect these patients to programs proven to help them take control of their health. Particular emphasis is placed on patients in designated Health Equity Zones (www.health.ri.gov/programs/detail.php?pgm_id=1108) where healthcare disparities are particularly prevalent and Care + Community + Equity (formerly Rhode Island Chronic Care Collaborative) practices, which are Rhode Island's federally qualified health centers and free clinics (see Addendum/Definitions).

CHN stakeholder groups include healthcare providers, community-based organizations and program facilitators, State agencies, and program participants. These audiences are the focal points of many of the action steps discerned in this planning process.

Mission, Vision, Values

We remain steadfast in our mission, which is the object of our long-term, continuous effort. Our vision is an ambitious, yet attainable, goal. Our values represent the genuinely held principles and practices that we determine as essential to our success.

Mission: To empower individuals with chronic conditions—through communication and connection—to manage their health and change their outcomes for the better.

Vision: We envision a Rhode Island where new chronic conditions are on a decline and existing chronic conditions are managed effectively by patients and providers through a variety of home, clinical, and community-based methods.

Values and Competencies:

- Effective collaboration: We connect and manage a network of community and clinical partners, ensuring ease of use, optimal information sharing, and positive outcomes for patients and stakeholders.
- Focus on quality and outcomes: We evaluate, select, and engage effective, evidence-based programs and approaches; and we monitor CHN patient outcomes.
- Commitment to access and equity: We facilitate simple, one-stop shopping for convenient, free, or low-cost programs for all Rhode Islanders in need of services, particularly those populations and communities that are vulnerable to health disparities.
- Empowerment: We support patients, and their caregivers, with useful and necessary tools and the information they need to take control of their health.

Programs and services

The CHN facilitates referrals to evidence- and community-based chronic disease prevention and management programs, and to EBLP. Current programs and services available for CHN referral include:

Asthma Services
(www.health.ri.gov/find/communityhealthnetworkprograms/results.php?parm=Asthma)
Open to youth up to age 17, RIDOH's Asthma Control Program focuses on asthma at home, school, and healthcare centers. The program aims to lower asthma-related hospitalizations, emergency room visits, and missed days of work and school. Funding: CDC

Chronic Disease Self-Management Program
(www.health.ri.gov/find/services/detail.php?id=5)
Open to adults 18 and older who have, or who care for someone with, a chronic condition such as asthma, arthritis, cancer, COPD, diabetes, or heart disease. Group sessions are led by peer leaders and meet for 2½ hours per week for six weeks. We help individuals manage symptoms and medications, communicate with families and doctors, relieve stress, eat well and exercise, and set goals to improve overall health and lifestyle. Funding: CDC, Administration for Community Living (ACL), Tufts Healthcare Foundation, Health Resources and Services Administration (HRSA)

Chronic Pain Self-Management Program
(www.health.ri.gov/find/services/detail.php?id=48)
Open to adults 18 and older, this program provides participants with the tools to manage medications, fatigue, frustration, and proper nutrition; improve communication skills; evaluate treatments; and design action plans. The program is facilitated by two certified peer leaders in group sessions and takes place for 2½ hours per week for six weeks. Funding: CDC, ACL, Tufts Healthcare Foundation, HRSA

Diabetes Self-Management Education and Support (DSMES)
(www.health.ri.gov/find/services/detail.php?id=7)
Open to adults 18 and older with diabetes and who have been referred by a healthcare provider. Certified diabetes outpatient educators, trained registered nurses, registered dietitians, and pharmacists lead individual or group consultations in doctors' offices, pharmacies, or dedicated sites. Individuals are taught how to eat healthier and manage glucose, blood pressure, and cholesterol levels. Funding: reimbursement from insurance companies

Diabetes Prevention Program
(www.health.ri.gov/find/services/detail.php?id=8)
Open to adults 18 and older with pre-diabetes or to people at risk for developing type 2 diabetes and who also have a qualifying BMI (www.cdc.gov/diabetes/prevention/lifestyle-program/program-eligibility.html). Group sessions that teach healthy eating and how to increase physical activity are held once a week for 16 weeks. Individuals are helped to lower their risk of getting type 2 diabetes by eating healthier, increasing physical activity, and losing weight. Maintenance sessions are offered after the completion of this 16-week program. Funding: CDC

Diabetes Self-Management Program
(http://health.ri.gov/find/services/detail.php?id=9)
Open to adults 18 and older who have, or who care for someone with, diabetes. Group sessions are led by certified peer leaders who teach techniques to deal with physical and emotional symptoms of diabetes, promote exercise, teach healthy eating and proper use of medications, and encourage effective communication.

Sessions meet for 2½ hours per week for six weeks. We help individuals better manage diabetes and deal with emotional and physical symptoms of diabetes. Funding: Centers for Medicare and Medicaid Services, ACL

Matter of Balance: Managing Concerns about Falls Workshops
(www.health.ri.gov/find/services/detail.php?id=16)
Open to adults 18 and older with a focus on those age 60 and older who are ambulatory and able to problem solve. Eight two-hour, small group sessions are led by a trained facilitator. Participants are helped to reduce fear of falling and to be more active. Funding: United Way, Tufts Healthcare Foundation, ACL

Pedaling for Parkinson's (PFP)
(https://www.ymcagreaterprovidence.org/programs/healthy-living)
Open to adults 18 and older with a diagnosis of Parkinson's disease who are able to safely sit on a stationary bicycle. This program is taught by a certified group exercise instructor who has also been trained in the PFP curriculum. Classes consist of a short warm up, pedaling at a target of 80-90 revolutions per minute, followed by a short cool down. Participants are permitted to bring a caregiver to assist in getting on and off the bicycle, if needed. Program offered by YMCA.

Powerful Tools for Caregivers
(www.health.ri.gov/find/services/detail.php?id=49)
Open to adults 18 and older who are caregivers for older adults. This program is facilitated by two certified peer leaders in group sessions of 2½ hours per week for six weeks. Class participants receive a copy of The Caregiver Help Book, developed specifically for the class. Caregivers are helped to communicate more effectively in challenging situations, recognize the messages in their emotions, deal with difficult feelings, and make tough caregiving decisions. Participants develop a wealth of self-care tools to reduce personal stress, change negative self-talk, and communicate their needs to family members and healthcare or service providers. Funding: Tufts Healthcare Foundation, United Way

Tobacco Cessation Services
(www.health.ri.gov/find/services/detail.php?id=20)
Open to youth (13 and older) and adults who use tobacco. Individuals are helped to quit tobacco; connect with a certified counselor over the phone; get nicotine replacement therapy (NRT) gum, patches, or lozenges (only available to adults 18 and older); and inform their doctors on their progress. Funding: CDC

Walk With Ease
(www.health.ri.gov/find/services/detail.php?id=24)
Open to individuals 18 and older with a focus on anyone who has arthritis, chronic pain, or difficulty walking. This program teaches participants to safely make physical activity a part of everyday life. Taught over the course of six weeks, participants can join classes led by trained facilitators or enjoy a self-directed program. All participants receive a book from the Arthritis Foundation containing all lessons. Funding: CDC

In addition, CHN has a partnership with the WISEWOMAN program (www.health.ri.gov/programs/detail.php?pgm_id=1001), which provides referrals to all eligible women for health risk assessments, fitness programs, health coaching, and support for weight loss and management. Funding: CDC

Another option is the RIDOH Women's Cancer Screening Program (www.health.ri.gov/programs/womenscancerscreening/).

Outcomes and evaluation

The CHN has experienced a significant increase in overall referrals from 2013 to 2018. The number of practices utilizing the CHN has increased, on average, 13.95% per year, while the number of individual providers referring has grown, on average, by 35.5% per year.

During the same timeframe, the number of patients referred increased, on average, 115% per year, while the number of practices referring patients increased 130%.

Going forward, in addition to provider awareness/adoption and patient referrals, key success measures include

1. Reimbursement for sustainability

1.1 Number of funding sources, including grants
1.2 Number of CHN programs receiving insurance reimbursement

2. Stability and supply

2.1 The number of towns each program is held in, by month
2.2 The number of towns each program is held in, by year

3. Community-clinical linkages

3.1 Number of providers receiving feedback
3.2 Number of programs providing feedback
3.3 Number of EHRs with the CHN referral form embedded

4. CHN-wide communication

4.1 Number of CHN-specific communications sent to internal stakeholders
4.2 Number of referrals from CHN program coordinators/facilitators

5. Marketing CHN

5.1 Number of referrals
5.2 Number of self-referrals
5.3 Number of clicks on calendar

Environmental analysis

Funding and Operations

Currently, the CHN is funded through 2024 through CDC funding awarded to the Diabetes Heart Disease and Stroke Program at RIDOH. In the spirit of self-determination that is at the foundation of the CHN mission, CHN needs to consider and develop self-funding mechanisms, such as insurers, which would make CHN less dependent on federal grants. Sustainability of CHN operations is also dependent on the sustainability of the participating community-based programs, as CHN cannot exist without the individual EBLPs, including CDSME programs.

Market Demand

While provider participation and referral rates are increasing, provider engagement and referrals remain low relative to the known number of individuals with chronic conditions. A primary objective of this effort is to increase provider awareness of, and participation in, the CHN.

The CHN is the only such referral network in Rhode Island. There are no direct competitors; however, there are healthcare systems such as Lifespan that have internal capabilities similar to some of the programs offered through CHN. Competitive pressures come primarily from program/content alternatives and from certain inherent behaviors, such as

- Patient hesitancy to follow up on referral recommendations by providers;
- Physician reluctance to refer patients due to lack of information about CHN's offerings; and
- Barriers to patient participation such as lack of transportation and geographic locations of the program offerings.

Environmental Scan

Across the United States, state and local departments of health are seeking effective ways to increase provider referrals and patient compliance. Some examples of efforts underway in other states include

- Programs being tested in which the public sector is partnering with the private sector to address a specific health issue like hypertension;
- Development of a program brand that is employed to help raise awareness and clearly position the program among patients and physicians;
- Development of a presentation that provides insights into the infrastructure and effectiveness of a community health program, which could be shared with other states and local gatekeepers (in person or via a webinar);
- Creation of a digital home for the program to enable easy, online access to information;
- Creation of a system infrastructure for patient access and physician referrals; and
- Alignment of community health programs with identified public health issues.

Arkansas

Community Team-Based Care for Hypertension Management Implementation Protocol (www.healthy.arkansas.gov/images/uploads/pdf/HTNProtocol.pdf)

This document outlines the implementation protocol for a community team-based care model being tested by an Arkansas Department of Health Local Health Unit and a private community physician to provide community team-based care for patients with uncontrolled hypertension. The protocol document is posted on the Blood Pressure (Hypertension) Resources for Professionals web page of the Arkansas Department of Health.

Maryland

Referral Form for Chronic Disease Self-Management Program (www.smchd.org/wp-content/uploads/Living-Well-Program-Referral-Form_3-2015_1.pdf)

Utilizing the Living Well: Take Charge of Your Health evidence-based program for chronic health conditions, this referral form allows clinicians to refer patients who are at-risk or high-risk for chronic disease to the Chronic Disease Self-Management Program.

New York

ASTHO Million Hearts Success Story: NY Develops Clinical Pathway to Identify and Manage Adult Hypertension (www.astho.org/Prevention/NY-Develops-Clinical-Pathway/)

Through the Association of State and Territorial Health Officials Million Hearts State Learning Collaborative, one local clinic in New York is working with the New York State Department of Health and other state and local partners to develop and implement a standardized clinical pathway to identify and manage patients with uncontrolled and undiagnosed hypertension.

Ohio

Check it. Change it. Control it. Public Health-Community Partnership Development (recording) (www.youtube.com/watch?v=FkLekmeWs0o&feature=youtu.be)

Summit County did a presentation about how its local health department offers residents free community services connections and assists them through the process of getting the help they need (view the slide deck; www.astho.org/Prevention/Million-Hearts/Summit-County-Public-Health-Community-Partnership-Development/).

Summit County Public Health Care Coordination (www.scph.org/care-coordination)

The website provides information about the services provided by the Summit County Public Health Care Coordination Unit. Some 40 programs can be accessed. (This could provide some ideas on developing RIDOH CHN's online presence.)

Creating Community-Clinical Linkages to Address and Prevent Chronic Disease (webinar) (www.naccho.org/programs/community-health)

In June 2015, the National Association of County and City Health Officials hosted a webinar featuring Summit County Public Health's robust referral networks linking primary care providers with public health and community resources. During this webinar, Summit County Public Health describes their experiences working with local and state partners to build bi-directional referral networks between public health and primary care physicians.

Oklahoma

Oklahoma Million Hearts Patient Process Flow (www.astho.org/Oklahoma-Million-Hearts-Patient-Process/)

The Oklahoma State Department of Health led a team of state and local partners to develop a protocol for identifying and referring individuals with hypertension into a public health nurse-driven care coordination system.

Heartland OK Patient Progress Report (www.astho.org/Prevention/Chronic-Disease/Million-Hearts/Million-Hearts-Tools-for-Change/Monthly-Patient-Progress-Report-Template-Oklahoma/)

This progress report form supports the Heartland OK referral system. On a monthly basis, the public health nurse care coordinator sends the completed form to each participant's provider. The form includes a summary of referrals made to community-based resources and the patient's progress in achieving their clinical management plan.

ASTHO Case Study: Oklahoma Million Hearts Learning Collaborative (www.astho.org/Prevention/Chronic-Disease/Million-Hearts/Million-Hearts-Systems-Change-Case-Study--Oklahoma/)

Through the ASTHO Million Hearts Learning Collaborative, Oklahoma is improving hypertension identification and control by establishing clinical referral and follow-up protocols, linking individuals with hypertension to clinical care and public health nurse care coordination resources, and exploring innovative payment models.

New Hampshire

Seacoast Public Health Network Improvement Plan (www.seacoastphn.org/community-health-improvement-planning.html)

In 2013, New Hampshire published the State Health Improvement Plan (SHIP) 2013-2020 that highlights 10 key health challenges facing the population. The following year, public health networks, including Seacoast, were tasked with creating Community Health Improvement Plans (CHIP). The website features six plans with specific action steps.

Operations and strategy

The following implementation strategy encompasses general management and daily operations of CHN, ongoing partnership/network development, and a series of strategic imperatives identified by the CHN planning committee.

A. General CHN Management and Operations

CHN operates under the umbrella of RIDOH's Diabetes, Heart Disease, and Stroke Program (DHDS) and is managed day-to-day by the Community Health Network manager and sustainability manager for the DHDS Program. Overall program supervision is the responsibility of the chief of the Center for Chronic Care and Disease Management, Division of Community Health and Equity and the program administrator who oversees the CDC grant funding awarded to DHDS.

Additional guidance and support is provided by the CHN Advisory Council comprised of a representative from each of the following organizations: Rhode Island Health Center Association, Rhode Island Geriatric Education Center, YMCA of Greater Providence, Newport Health Equity Zone, Local Initiatives Support Corporation (LISC), Long Term Care Coordinating Council, RIPIN, Healthcentric Advisors, Community Health Worker Association of Rhode Island, Rhode Island Division of Elderly Affairs, and RIDOH's Arthritis/Chronic Disease Self-Management Education (CDSME) Program.

In addition to the CHN manager, CHN is supported by RIPIN staff and by staff at partner organizations. CHN patient navigators, who facilitate the patient referral process, are staffed by RIPIN.

This is the current workflow supporting CHN operations:

- Referrals from providers, individuals, caregivers, community-based organizations, or other sources are made to CHN via electronic medical records, fax, or telephone.
- CHN patient navigators contact patients by telephone and assess patient needs and any barriers to participation.
- Navigators contact providers to inform them of whether or not the patient has enrolled in a program.

Illustration of Community Health Network Workflow

B. Partner Relations

There are many stakeholders that partner with CHN, including Advisory Committee members, Care + Community + Equity practices, Care Transformation Collaborative of Rhode Island, Diabetes Education Partners, Diabetes Prevention Program Stakeholder Network, evidence-based programs, Health Equity Zones, Own Your Health Collaborative, RIPIN, Rhode Island Stroke Coordinators Network, RIDOH Chronic Disease Self-Management Education Program, RIDOH WISEWOMAN Program, Rhode Island Health Center Association, Rhode Island Medicaid Accountable Entities, Rhode Island Stroke Task Force, and State Innovation Model Work Groups.

C. Goals and Implementation

As discussed and discerned during this planning process, CHN faces a number of key strategic imperatives as it looks to sustain operations in the future:

Goal 1: Reimbursement for sustainability – Identify potential funding strategies and mechanisms to support the long-term sustainability of the CHN and the individual programs providing services.

Goal 2: Program stability and supply – Reduce geographic and seasonal variability in program availability that is tied to funding cycles.

Goal 3: Community-clinical linkages – Enhance the level and quality of case-specific, bi-directional communication between provider and program: referral process, use of electronic health records, improved tracking and sharing of outcome data, and increased feedback to providers.

Goal 4: CHN-wide communications – Enhance CHN communications by sharing information about policies and procedures, best practices, and additional resources with program facilitators, leaders, coordinators, patient navigators, and RIDOH staff.

Goal 5: Marketing CHN – Increase provider and public awareness of the CHN, with the goal of increasing enrollment in all EBLPs particularly in target populations at high risk for health disparities and inequality.

Strategic Goal 1: Reimbursement for sustainability

Identify potential funding strategies and mechanisms to support the long-term sustainability of the CHN and the individual programs providing services.

Objective 1.1

By January 2021, identify a self-sustaining funding stream that supports CHN operations and includes vital funding to the CHN community-based programs.

Action Steps

1.1.1 Form committee to focus on this payment plan.

1.1.2 Conduct field research:

- Meet with the Center for Healthcare Strategies.
- Meet with Greater Providence YMCA about their centralized billing program.
- Attend conferences to gain further intelligence (e.g., Administration for Community Living/National Council on Aging Conference).

1.1.3 Develop draft payment model.

1.1.4 Refine payment models based upon committee input.

1.1.5 Meet with payers to review payment proposal, gain their intelligence, and make refinements as needed.

Objective 1.2

By August 2021, develop a prototype of sustainable payment for future consideration and pilot.

Action Steps

1.2.1 Develop a prototype based on bundled payments to reach a population (qualified by utilization, etc.).

- Establish the following roles for each of the stakeholders:
  - Providers to make referrals;
  - Payers to provide reimbursements;
  - CHN to create network of programs to support referring providers, navigate patient and provider through available program, collect and disseminate data to establish a value proposition; and
  - Programs to deliver services to patients and caregivers

Objective 1.3

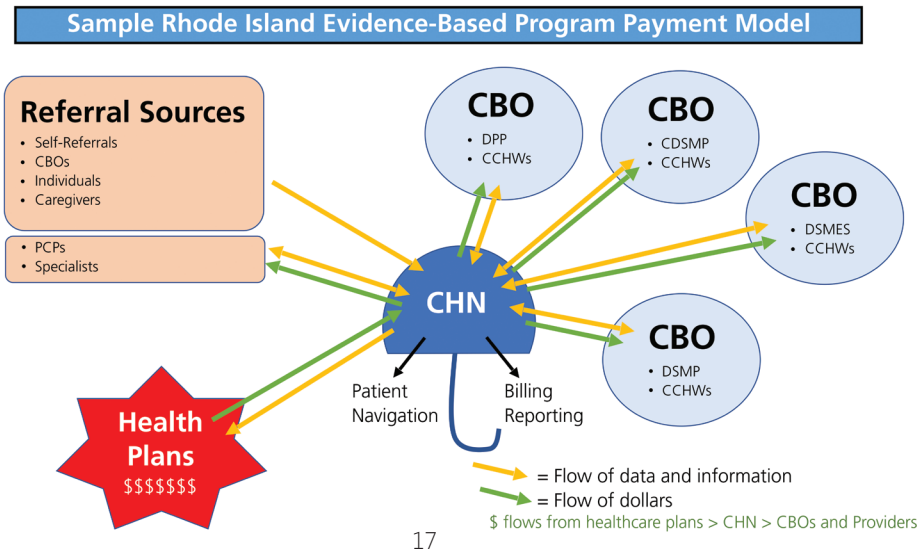
By June 2025, establish a roadmap for long-term adoption of system approach so as to move away from fee-for-service model (aligning with population-health trend).

Action Steps

1.3.1 Test a model to show that these services achieve desired outcomes and value proposition.

1.3.2 Take necessary steps to formalize reimbursement program.

1.3.3 Finalize program.



Strategic Goal 2: Program stability and supply

Reduce geographic and seasonal variability in program availability that is tied to funding cycles.

Objective 2.1

By December 2020, establish a system to capture the names and associated information for all registrants, no matter how they register.

Action Steps

2.1.1 Gather more information from workgroup participants.

- Create data-capture system.

Objective 2.2

By June 2022, generate two additional funding streams to support expansion of program offerings and training and promotional support.

Action Steps

2.2.1 Incorporate new payment model (see Goal 1).

2.2.2 Develop private-sector sponsorship program.

Objective 2.3

By June 2022, ensure that CHN consistently offers 75 workshops across all counties in Rhode Island, every six months (Data Source: CHN Calendar).

Action Steps

2.3.1 Host more workshops in leader communities.

2.3.2 Conduct participant focus groups to learn about barriers to participation, including disabilities, transportation, weather, and geography.

2.3.3 Build program calendars for the year, not workshop by workshop.

2.3.4 Strategize the organizations that CHN is outreaching to, targeting faith-based organizations and other appropriate groups providing information sessions.

2.3.5 Employ more targeted outreach by ZIP code/county.

Objective 2.4

By May 2025, increase the number of existing workshops currently being offered to 125, across all counties in Rhode Island, every six months.

Action Steps

2.4.1 Increase the number of workshops in leader communities.

2.4.2 Add new workshops with different focuses.

2.4.3 Continue to expand outreach effort to groups providing information sessions.

2.4.4 Analyze current workshop schedule location by ZIP code, identifying areas where there are no workshops. Look for opportunities to fill these gaps.

2.4.5 Build 2024 program calendar in Q4 2023, focusing on meeting goal.

Objective 2.5

By June 2022, address the shortage of session leaders by developing a sustainable program for recruiting workshop instructors to ensure coverage for continuous and expanded schedule of offerings.

Action Steps

2.5.1 Develop a program to recruit workshop leaders.

- Train more leaders (peer recruitment from workshops).
- Recruit more bilingual leaders.
- Provide opportunities for leaders to work with diverse populations.

2.5.2 Develop incentive program to recruit peer ambassadors.

2.5.3 Establish motivational interviewing (MI) training.

Objective 2.6
By May 2025, add seven new evidenced-based programs by bringing in existing programs not already in CHN and by creating new programs to address unmet needs.

Action Steps
2.6.1 Add questions to participant surveys.

- Request recommendations for new host sites and associated contact information.
- Ask what health insurance participants have.
- Include consent form to share participant photos and success stories.

2.6.2 Identify key people for referrals.

2.6.3 Establish provider in-services/CEUs around evidence-based programs such as Chronic Pain Self Management Program and Diabetes Prevention Program.

Objective 2.7
By May 2025, refine scheduling, outreach, academic detailing, and data collection workflows for all programs under CHN, in order to reduce work duplication, increase program efficiency, and expand the reach of CHN.

Action Steps
2.7.1 Convene all CHN program coordinators and managers in a temporary sub-group to review processes.

2.7.2 Review all meetings and identify the purpose of each, to remove unnecessary meetings.

2.7.3 Review all processes to identify areas of overlap.

2.7.4 Propose new processes to larger group.

Strategic Goal 3: Community-clinical linkages

Enhance the level and quality of case-specific, bi-directional communication between provider and program: referral process, use of electronic health records, improved tracking and sharing of outcome data, and increased feedback to providers.

Objective 3.1

By March 2021, establish a process for ongoing feedback from programs to providers.

Action Steps

3.1.1 Develop an infrastructure for collection and sharing of participant information (note, each program within CHN has established success metrics).

3.1.2 Group together prototype work plan.

3.1.3 Capture data from workshop leaders, establish operational management and training within CBOs, define who is responsible for feedback.

Objective 3.2

By May 2025, enhance the scope and quality of patient-centered, specific, bi-directional communication among providers (all relevant care team members) and program administrators.

Action Steps

3.2.1 Establish a greater number and type of programs to afford greater reach into the community.

- Establish a linguistically appropriate program.
- Establish a broad-geographic program, focused on providing accessibility to CHN for all patients.

3.2.2 Establish greater quality management and shift focus among providers from managing chronic disease to preventing chronic disease.

- Improve satisfaction with CHN.
- Standardize bi-directional feedback process mechanism.
- Identify preventive programs for inclusion in CHN.

3.2.3 Develop system in which to capture feedback on program outcomes, attendance (including barriers to attendance), and attrition; establish a secure process for the exchange of data.

3.2.4 Establish a dependent project management system, prioritizing which task comes first and what the task order needs to be.

3.2.5 Explore integration with Health Information Exchange (HIE) technology and social services databases and explore the possibility of generating real-time information to add innovation to work.

3.2.6 Develop synergy between classes and social determinants of health (SDOH) services (access to transportation, good food, etc.).

3.2.7 Define outcomes data criterion and collection of program outcomes data.

3.2.8 Develop surveys with self-reported data for classes that do not currently have one. These surveys should be based on existing surveys in current programs and should be collecting information at different intervals of the program, such as pre-test, post-test, and at the six-month mark following the end of the program.

3.2.9 Educate CBO staff and patients on data submission/collection/improvement in care.

3.2.10 Train CBO staff.

- Prepare CBO staff to know needs of incoming patients.

3.2.11 Develop equitable allocation of program benefits.

3.2.12 Collaborate on developing an action plan with provider, program, navigator, and patient involvement (to the extent possible); establish a regular feedback system from all stakeholders around these types of planning and idea-generating efforts.

Objective 3.3

By May 2025, increase feedback from providers to programs, which are part of the healthcare system. The programs need to be considered part of the integrated care effort/team.

Action Steps

3.3.1 Increase satisfaction with CHN.

3.3.2 Share best practices for referral and share outcome data.

3.3.3 Develop electronic health record (EHR) interface and establish associated fees (when interfaces are available); develop technology interface.

3.3.4 Position CHN/referrals as part of the team-based care (TBC) approach. CHN programs get inserted into the integrated, team-based approach to care.

Strategic Goal 4: CHN-wide communications

Enhance CHN communications by sharing information about policies and procedures, best practices, and additional resources with program facilitators, leaders, coordinators, patient navigators, and RIDOH staff.

Objective 4.1

By January 2021, improve communications and information sharing across CHN, elevating the understanding of all CHN offerings, focusing on such areas as

- How to provide feedback to providers;
- Sharing of success stories; and
- Updates on CHN progress.

Action Steps

4.1.1 Develop a communications system and channels that enable the sharing of information such as policies and procedures, best practices, and available resources.

- Assess current online properties for internal use.
- Determine whether to continue to stratify communications by program or develop communications across all programs.
- Create a master list of facilitators across all programs.
- Develop criteria for communication, possibly linked to availability of classes.

4.1.2 Establish a message platform based upon defined communications strategy.

4.1.3 Develop consistent resources for all program facilitators.

4.1.4 Finalize the communications infrastructure and timeline for regular communications.

Objective 4.2

By June 2022, build awareness of CHN, its purpose and its offerings, within program facilitators, leaders, coordinators, managers, patient navigators, and RIDOH staff.

Action Steps

4.2.1 Compile an annual report capturing total participation, outcomes, and success stories for distribution to all audiences (programs, payers, participating providers, RIDOH stakeholders).

- Payers;
- Participating providers; and

  - Physicians, nurses/case managers:
    - Define CHN and outline how to refer to CHN;
    - Define what information CHN requires;
    - Post programs on CHN calendar; and
    - Close feedback loop with provider after completing a CHN program; encourage patient to follow up with his/her provider (link patient to care at every step)

- RIDOH stakeholders

  - Identify key gatekeepers (statewide office holders, RIDOH administration, healthcare industry leaders, etc.).

Goal 5: Marketing CHN

Increase provider and public awareness of the CHN, with the goal of increasing enrollment in all EBLPs particularly in target populations at high risk for health disparities and inequality

Objective 5.1

By May 2023, increase the number of CHN non-provider referrals and self-registrations by the public, particularly with populations at high risk for health disparities and inequality.

Action Steps

5.1.1 Address consistent technology access and transience (e.g., housing instability) when making outreach decisions.

5.1.2 Overcome language barriers by providing translations of all material and utilizing plain language. Focus on communications with hearing impaired and intellectually and developmentally disabled; need to establish accessibility for all people.

5.1.3 Develop and implement consistent patient satisfaction surveys upon completion of all EBLPs to inform quality improvement initiatives.

Objective 5.2

By May 2025, increase utilization of the CHN among providers.

Action Steps

5.2.1 Analyze existing database to develop profiles of providers and patients who have participated or are participating in CHN. Establish a baseline to measure awareness and utilization.

- Establish a benchmark/baseline for provider and patient awareness for ongoing measurement.
- Analyze existing database of providers and patients and develop segmentation profiles.

5.2.2 Segment target audiences, and create personas and journeys with outreach tactics/messaging that best reach each segment (further segment within each category).

- Providers
  - Primary care physicians;
  - Nurse navigator;
  - Nurse case manager;
  - Physician coordinator;
  - Medical assistant;
  - Administrator;
  - Specialists; and
  - Urgent care
- Community-based organizations (providers, hosts), focused on the underserved
- Public
  - Has primary care physician (PCP);
  - Doesn't have PCP; and
  - Has language differences
- Facilitators of programs
- Payers
  - Determine who should be approached at each plan (underwriters, nurse care managers, case managers, leadership, etc.)

5.2.3 Develop an integrated communications plan in order to maximize effectiveness.

- Gather all existing CHN marketing materials; conduct communications audit; review existing material for consistency in graphic presentation, messaging, and plain language.
- Assess online properties for external use.

- Define the role of the Aging and Disability Resource Center (ADRC) (a resource center for older adults and/or people with disabilities) within CHN and develop a plan for how its role is communicated to partners. (ADRC is an umbrella term as the program is referred to as The Point and run by 211.)
- Train individuals working with the Senior Health Insurance Program (SHIP), Senior Medicare Patrol (SMP), and Aging and Disability Resource Center on available programming during existing quarterly meetings.
- Educate meal site participants about CHN, establish referral channel from CHN to meal sites, determine whether to refer to any Social Determinant of Health programs or to 211.
- Share joint list with the Community Health Worker Association of Rhode Island (CHWARI).
- Educate the SHRM (Society for Human Resources Management) network about CHN for employees with chronic diseases
- Develop communications plan content, including:
  - Personas/segmentation;
  - Audience journeys, including driving people to a website page and tracking their activity while on the site;
  - Message development for each segmented audience; compilation of patient and provider testimonials to help guide messaging;
  - Tactical implementation for each audience including paid search analysis/set up, social media audit, paid media plan, grassroots outreach opportunities, and earned media outreach;
  - A focus on use of the online calendar of programs to encourage regular use by providers during patient appointments, and to raise awareness among patients for ongoing use;
  - A focus on relationship building between CHN and providers, focusing on decision makers within the practices; and
  - The promotion of health information exchange (HIE) technology and social services databases; work with Strategic Priority 3.

5.2.4 Establish a budget to guide the development of the communications program.

5.2.5 Address provider fatigue (information fatigue) and develop material that is focused and succinct.

5.2.6 Work within HIPAA confidentiality guidelines under the guidance of legal and/or compliance counsel.

5.2.7 Utilize the provider toolkit created by the Chronic Disease Self-Management Education Program manager to promote the use of CHN to providers.

Conclusion

The purpose of this Strategic Plan is to provide a focused and detailed roadmap for the next five years to assure that the CHN continues its critical work in helping to successfully manage chronic diseases in Rhode Island. A stronger, more impactful CHN, in turn, will have a positive impact on RIDOH's CDSME programs, which are the foundation of the CHN.

Most importantly, a sustainable CHN will help to improve the quality of life of the large segment of the Rhode Island community struggling with chronic diseases. All Rhode Islanders deserve the opportunity to live full, active, and satisfying lives while managing their chronic health conditions.

RIDOH extends its sincere appreciation to all who contributed to the development of the CHN Strategic Plan and thanks RIPIN for its ongoing support as a critical and active part of CHN.

Appendix A: Glossary of terms

Care + Community + Equity: An innovative approach to health systems intervention that targets federally qualified health centers and free clinics in Rhode Island. This initiative allows practices to choose between three scopes of work: self monitoring of blood pressure, cardiovascular disease management and prevention, or diabetes prevention and management.

Chronic Disease Self-Management Education Programs: An umbrella term used to describe the programs overseen by RIDOH's Chronic Disease Self-Management Education Program manager. These programs are funded by CDC and the Administration for Community Living. The individual programs that fall under this umbrella are Chronic Disease Self-Management Program, Chronic Pain Self-Management Program, Diabetes Self-Management Program, and Walk with Ease.

Health Equity Zones: Rhode Island's Health Equity Zone initiative is an innovative, place-based approach that brings communities together to build the infrastructure needed to achieve healthy, systemic changes at the local level. Health Equity Zones are geographic areas where existing opportunities emerge and investments are made to address differences in health outcomes. Through a collaborative, community-led process, each Health Equity Zone conducts a needs assessment and implements a data-driven plan of action to address the unique social, economic, and environmental factors that are preventing people from being as healthy as possible. www.health.ri.gov/publications/brochures/HealthEquityZones.pdf

High Burden Populations (as described by CDC): Those populations affected disproportionately by high blood pressure, high blood cholesterol, diabetes, or prediabetes due to socioeconomic or other characteristics, including inadequate access to care, poor quality of care, or low income.

Own Your Health Collaborative: A group of representatives from RIDOH, Federal Hill House, RIPIN, Rhode Island Geriatric Education Center, and Healthcentric Advisors, that comes together to align their work in evidence-based programming. Each of these entities is awarded funding from different sources for evidence-based programming, and together, they are able to leverage their funds and streamline outreach efforts to produce a greater reach across the state.

This publication was supported by the grant or cooperative agreement number DP006531-01-03 and DP006618-01-01, funded by the Centers for Disease Control and Prevention (CDC). The contents are the responsibility of the authors and do not necessarily represent the official views of CDC.