WEST VIRGINIA

B C D E

How did you generate healthcare provider referrals to the evidence-based lifestyle change program?

The West Virginia Diabetes Prevention and Control Program (DPCP) worked with three health centers to pilot test a diabetes prevention referral system. The aim was to embed referral processes, including prediabetes identification and evidence-based lifestyle change program referral, into the delivery systems currently used by healthcare providers. These processes helped providers engage in conversations with patients about prediabetes risk and inform them about how they might benefit from the evidence-based lifestyle change program.

What was the State Health Department role?

- Selected three pilot sites to test the referral system
- Provided CDC risk assessment, marketing materials, and talking points to health centers and evidence-based lifestyle change program providers
- Identified metrics of interest for health centers, such as how referrals fulfill the goals of Meaningful Use and Patient Centered Medical Home (PCMH) models
- Encouraged the development of formalized and clear policies, procedures, and partner roles for each referral system
- Convened meeting of trained coaches and other diabetes prevention partners to address barriers and solutions learned in implementing the evidence-based lifestyle change program
- Maintained ongoing communication with health centers to discuss issues and successes of the referral process
- Assessed the utilization of diabetes prevention referral processes within pilot sites

Achievements

3 Healthcare system partners

8 Healthcare delivery sites

32 Primary care health providers

11,332 Adult patients served by these providers

2,270 Adult patients identified as at-risk for prediabetes

261 Adult patients referred to evidence-based lifestyle change program

"We have more energy! We feel a lot better! We are both in the Group Life-Style Balance Program at work and have each lost 34 pounds! We love it!"
Lisa & Robert Adams

Most of the health centers did not have to change their current referral system to incorporate referrals to the lifestyle change program. This effort promises to be very sustainable.
Jessica Wright, WV DPCP

What positioned you for success?

- Dedicated Funding: $109,000
- Partnerships with health centers
- Partnerships with evidence-based lifestyle change program providers
- Access to health center electronic health records via the West Virginia University Office of Health Services Research (WVU OHSR)

How did you individualize referral processes for health centers?

The DPCP partnered with three health centers to pilot the referral system. At project onset, the DPCP met with health center leadership to discuss how to address prediabetes in their patient population. Two factors facilitated health center buy-in: 1) better understanding of prediabetes and its impact on their patients, and 2) recognition that referral processes could help them achieve PCMH status or Meaningful Use goals. In order to accommodate the unique needs of each health center, the DPCP worked with them independently and suggested modifications to their current referral processes. While these varied, the overall system sought to first select start dates for the evidence-based lifestyle change program then refer eligible patients. The DPCP and WVU OHSR also applied an algorithm to mine electronic health record (EHR) data in order to help identify at-risk patients. The referral processes were evaluated throughout the project and revised as needed. A key revision was closing the "feedback loop." The DPCP helped establish center-specific procedures to provide feedback to referring healthcare providers, including the type of information and frequency of feedback. Part of this process was the creation of a referral form that obtained patient consent to release information about their progress back to their referring provider. This change helped to sustain the referral processes by letting health centers and providers see the successes of the patients and the program.

What were the factors for success?

- Achieved necessary buy-in from pilot partners
- Tailored modifications to the health centers' current referral processes to allow for often minimal changes palatable to their healthcare providers
- Provided individual support to meet each health center's unique needs
- Evaluated and adapted processes continuously to adjust for challenges
- Recognized how provider referrals can meet PCMH standards, achieve Meaningful Use goals, and fit Affordable Care Act provisions
- Developed feedback protocol that aided in closing the "feedback loop"
- Facilitated the addition of the evidence-based lifestyle change program to the list of referrals within EHRs in order to create referrals electronically
- Developed a process whereby EHR data was exported to a patient registry and analyzed to identify patients at risk for prediabetes/diabetes

Challenges and Solutions

- Participant progress was not relayed back to their providers

  Worked with the evidence-based lifestyle change program partners to close the feedback loop and supply patient information to the referring healthcare provider

- Some health centers voiced difficulty in recruiting patients who would commit to the program
- Providers wanted to know the location of evidence-based lifestyle change program sites in their area; the DPCP did not have a coordinated way to collect or provide this information

  Evidence-based lifestyle change program providers were given the option to include their information on a Google Map created by a local health department and linked to the DPCP's website

Partners

- West Virginia University Office of Health Services Research
- Community Health Centers and Free Clinics

For More Information

Jessica Wright
(Jessica.G.Wright@wv.gov)

Tony Leach
(Tony.M.Leach@wv.gov)

See West Virginia Story D for more information on referral system development