

WEST VIRGINIA



How did you create a system of referral to the evidence-based lifestyle change program?

An effective diabetes prevention referral system helps ensure optimal care for individuals at risk by connecting them to an evidence-based lifestyle change program provider. To develop such a referral system, the West Virginia Diabetes Prevention and Control Program (DPCP) partnered with West Virginia University Office of Health Services Research (WVU OHSR). The system they developed included an algorithm for identification of patients at risk for diabetes and intervention through the evidence-based lifestyle change program. It was pilot tested in three health centers. In addition, the DPCP worked with WVU Extension Service and local health departments in Community Transformation Grant (CTG) communities to link health centers to the lifestyle change program providers.

What was the State Health Department role?

- Contracted with WVU OHSR to create a diabetes prevention referral system
- Developed a screening/referral algorithm for prediabetes diagnosis and referral
- Partnered with West Virginia University Extension Service (WVU Extension) and local health departments to connect health centers with evidence-based lifestyle change programs and trained lifestyle change coaches
- Facilitated meetings between health centers and evidence-based lifestyle change program providers in order to establish a formalized referral process
- Drafted a service agreement between health centers and evidence-based lifestyle change program providers

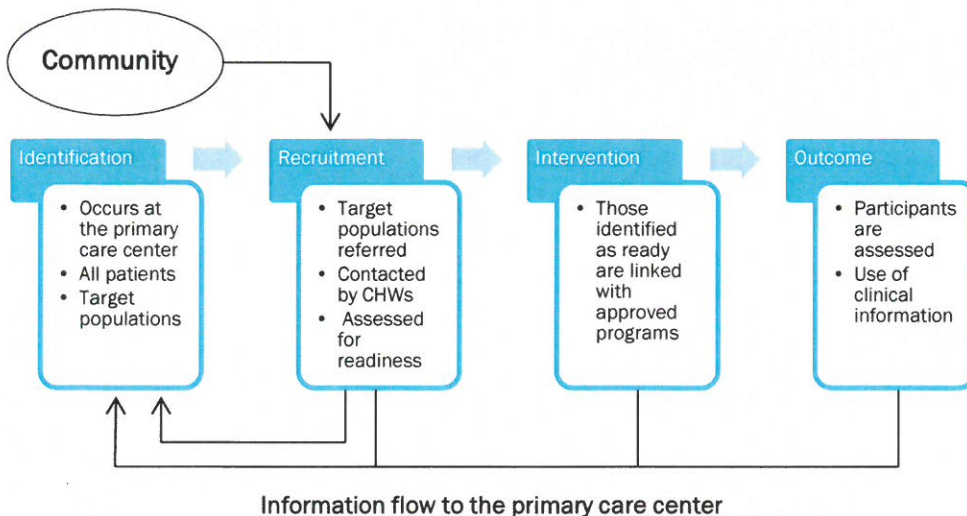
Achievements

5 Healthcare system partners

3,966 Adults with prediabetes living in the area covered by the referral system

261 Adults referred to the evidence-based lifestyle change program through the newly created referral system

Referral Process for Community-Clinical Linkages



What positioned you for success?

- Dedicated Funding: \$80,000
- Partnerships with health centers and evidence-based lifestyle change program providers
- 10-year history of quality improvement partnerships with WVU OHSR and health clinics

Source: West Virginia University School of Public Health | Office of Health Services Research

How did you create the referral system and algorithm?

The DPCP partnered with WVU OHSR to develop a referral system and algorithm for use in health centers. The referral system worked as follows: 1) at-risk patients identified through electronic health record (EHR) data or individual screening, 2) patients informed of their risk and the evidence-based lifestyle change program by the health center or lifestyle change program provider, 3) referral forms returned to lifestyle change program providers and patients provided a copy of the referral, and 4) patients enrolled in program. The DPCP expected these elements to remain relatively uniform across health centers, with slight differences in process and methods of communication used. The algorithm listed procedures for identification of patients at risk for diabetes and referral to the evidence-based lifestyle change program. The algorithm also provided two sets of instructions for follow-up with referred patients who either: a) participated in the program, or b) did not participate or were “no shows.” These follow-up instructions were aimed at both healthcare and lifestyle change program providers to ensure a closed loop referral and/or intervention. Following development, the referral system and algorithm were pilot tested at four health centers. To ensure there were sufficient lifestyle change program providers for pilot centers to refer patients, the DPCP partnered with WVU Extension. Staff from WVU Extension had community-level experience and pre-existing relationships with health centers, which helped connect centers to evidence-based lifestyle change program providers. In addition, a service agreement outlined a partnership between the health center, WVU OHSR, and the evidence-based lifestyle change program provider. The responsibilities of each partner were outlined, with the goal being for at-risk patients to receive the care they need and have that information funnel back to the health center. Forms were created for referral and quarterly review of indicators.

Challenges and Solutions

- Health centers and evidence-based lifestyle change program providers were not always located in the same area

The DPCP helped link health centers and evidence-based lifestyle change program providers

- Not all patients referred to the program were previously informed of their prediabetes risk

Recognized the importance of determining the process for patient contact and education, including the readiness assessment, recruitment, and referral roles

Helping to identify at-risk patients was only the first step. Helping to build a system whereby those patients could be referred for appropriate care, and that the results and progress of those patients are shared back to the referring physician, was key.

Adam Baus, WVU OHSR

What were the factors for success?

- Linked Federally Qualified Health Centers and evidence-based lifestyle change program providers
- Formed partnerships with WVU Extension Service and local health departments
- Connected with partners (WVU Extension and CTG local health departments) whose staff had been trained as lifestyle coaches and had pre-existing relationships with their local health centers
- Incorporated referral to the evidence-based lifestyle change program into health centers' existing delivery systems

Partners

- West Virginia University Office of Health Services Research
- Community Health Centers and Free Clinics
- West Virginia University Extension Service
- Community Transformation Grant Local Health Departments

For More Information

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See West Virginia Story C for more information on the pilot test of the referral system