Arthritis Insights:

Findings From Focus Groups with State Legislators

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NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

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Table of Contents

Executive Summary

Arthritis is the most common cause of disability in the United States. It is estimated that 52.5 million U.S. adults (more than 1 in 5) have doctor-diagnosed arthritis. As the nation's most common cause of disability, arthritis limits the activities of 21 million Americans. Among U.S. adults with arthritis, nearly half (47%) have at least one other disease or condition. According to information in the CDC Arthritis Program website, people with arthritis are less likely to be physically active and being physically inactive increases the risk of developing other chronic diseases (e.g., heart disease, diabetes, and obesity).

Fortunately, there are ways that those with arthritis can manage and reduce their symptoms. Physical activities such as walking, bicycling, and swimming can have many benefits for people with arthritis. In addition, there are self-management education interventions, such as the Arthritis Self-Management Program or the Chronic Disease Self-Management Program that can teach people with arthritis how to manage their condition, lessen its effects, and improve their quality of life. However, these programs tend to be underutilized. In fact, it has been estimated that these programs reach less than 1% of the people who could benefit from them or need them. As a result, there is interest among many stakeholders in better understanding the barriers to greater adoption of these evidence-based programs for arthritis and other chronic conditions and identifying strategies for increasing use of these programs among those who can benefit from them.

In the summer of 2013, the National Association of Chronic Disease Directors (NACDD), and the National Conference of State Legislatures (NCSL) agreed to collaborate on a project to gather relevant information and insights from state legislators. As a way to gather information and insights, two concurrent focus groups were designed and conducted with a bi-partisan group of state legislators.

The key themes and findings related to addressing arthritis include:

- Legislators are interested in national and state-level statistics about arthritis and many are surprised by the number of people affected by arthritis and the number of people with arthritis who also have other chronic conditions. However, the statistics themselves do not seem to provide a call to action for legislators. Rather, the statistics seem necessary but not sufficient for compelling legislators to take action on arthritis.
- When legislators make a decision to take action on a particular health issue, perceived seriousness of the disease or condition and belief about whether intervening on the condition is likely to save the state money are two of the most important factors taken into consideration.
- Lobbyists and other advocacy groups are in a strong position to influence legislators' thinking about arthritis; however, very few legislators recall ever being contacted by or having conversations with arthritis lobbyists or advocates.
- Arthritis is not perceived by state legislators as a serious health issue, especially when compared to other chronic diseases such as diabetes and heart disease. Legislators

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attach more significance to diseases and conditions that are life threatening (e.g., diabetes and heart disease) than to conditions such as arthritis that are thought to affect only quality of life.

- By itself or as a stand-alone condition, arthritis is not perceived as compelling enough to warrant the attention of state legislators. Rather, legislators believe that the most effective way to address arthritis is to include it within a set of related chronic conditions (e.g., diabetes, heart disease, obesity).
- By itself or as a stand-alone condition, arthritis is not perceived as compelling enough to warrant the attention of state legislators. Rather, legislators believe that the most effective way to address arthritis is to include it within a set of related chronic conditions (e.g., diabetes, heart disease, obesity).
- Legislators readily agree that it is important to communicate about arthritis issues and believe that social media and traditional media could be better utilized for initiating and sustaining a dialogue about arthritis.

The key themes and findings related to advancing interventions include:

- There is some support for including coverage for evidence-based self-management education and physical activity interventions in state employee benefit plans and/or including the provision of such interventions as a requirement to be credentialed as a Medicaid Health Home; however, there is virtually no support for including such interventions in state-covered Medicaid benefits.
- Many legislators are unaware of evidence-based physical activity and self-management education programs that are intended to be delivered in the community setting, and have difficulty distinguishing them from clinical interventions.
- Many legislators believe that working on issues related to the built environment and supporting environmental approaches for promoting physical activity for people with arthritis and other chronic conditions is not within their scope of responsibility and suggest that such activities are best undertaken by local government and/or city planners.

Introduction

Arthritis is the most common cause of disability in the United States. It is estimated that 52.5 million U.S. adults (more than 1 in 5) have doctor-diagnosed arthritis[2]. As the U.S. population ages, the number of adults with arthritis is expected to increase sharply to 67 million by 2030[3]. As the nation's most common cause of disability, arthritis interferes with the activities of 21 million Americans[4]. For a third of all working age adults (aged 18–65 years), arthritis can limit the type or amount of work they do or whether they can work at all[5].

Among U.S. adults with arthritis, nearly half (47%) have at least one other disease or condition. In addition, nearly half of adults with heart disease (49%), diabetes (47%) or high blood pressure (44%), and nearly one-third who are obese (31%) also have arthritis[6,7]. Research has also shown that people with arthritis are less likely to be physically active because they might believe that being active will cause pain, make their symptoms worse, or damage their joints. Not being physically active is a risk factor for other chronic diseases (e.g., heart disease, diabetes, obesity) and makes it harder to manage these conditions[8].

Fortunately, there are ways that those with arthritis can manage and reduce their symptoms. Physical activities such as walking, bicycling, and swimming can have many benefits for people with arthritis. These benefits include less pain and better physical function, mental health, and quality of life. The Walk with Ease Program, the Arthritis Foundation Exercise Program, and the Senior Services' EnhanceFitness program are examples of community exercise interventions that have been shown to improve health among participants with arthritis. In addition, there are self-management education interventions, such as the Arthritis Self-Management Program or the Chronic Disease Self-Management Program that can teach people with arthritis or other chronic conditions how to manage their condition, lessen its effects, and improve their quality of life.

Despite the availability of low-cost, evidence-based interventions that have been shown to improve quality of life for people with one or more chronic conditions such as arthritis, these programs tend to be underutilized. In fact, it has been estimated that these programs reach less than 1% of the people who could benefit from them or need them. As a result, there is interest among many stakeholders in better understanding the barriers to greater adoption of these evidence-based programs for arthritis and other chronic conditions and identifying strategies for increasing use of these programs (e.g., legislation for federal or state reimbursement of such interventions) among those who can benefit from them.

In the summer of 2013, the National Association of Chronic Disease Directors (NACDD), and the National Conference of State Legislatures (NCSL) agreed to collaborate on a project to gather relevant information and insights from state legislators. Two concurrent focus groups were designed and conducted with a bi-

Barbour KE, Helmick CG, Theis KA, Murphy LB, Hootman JM, Brady TJ, Cheng YJ. Prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitation – United States, 2010-2012. *MMWR* 2013;62(44): 869-873.

Hootman JM, Helmick CG. Projections of US prevalence of arthritis and associated activity limitations. *Arthritis Rheum* 2006;54(1): 226-229.

CDC. Prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitation -- United States, 2007-2009. *MMWR* 2010;59(39):1261-1265.

CDC. Racial/ethnic differences in the prevalence and impact of doctor-diagnosed arthritis -- United States, 2002. *MMWR* 2005; 54(5):119-123.

CDC. Arthritis: Meeting the challenge of living well. Available at: http://www.cdc.gov/chronicdisease/resources/publications/aag/arthritis.htm (accessed 9.19.13)

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partisan group of state legislators. The objectives of the focus groups were to:

- Assess factors that influence state legislators' decisions to take action on a particular health issue, such as arthritis.
- Assess the extent to which state legislators perceive the health and economic burden associated with arthritis to be compelling enough to motivate legislative action.
- Explore state legislators' reactions to policy-related strategies for advancing evidence-based self-management education and physical activity interventions at the state level.
- Explore state legislators' reactions to non-policy related strategies for advancing evidence-based self-management education and physical activity interventions at the state level.

The purpose of this report is to describe the methods used to conduct the focus groups and summarize the themes and key findings that emerged from the focus groups.

Methods

As a way to gather information and insights from state legislators on a variety of issues related to arthritis, two concurrent focus groups were conducted on August 11, 2013. The focus groups were held in Atlanta in conjunction with the 2013 Legislative Summit, an annual meeting hosted by the National Conference of State Legislatures (NCSL).

In the weeks leading up the Legislative Summit, NCSL staff invited 20 legislators and two senior legislative staff to participate in one of the focus groups. Legislators were invited to participate based on several factors including their leadership role as a national officer for NCSL's Health Committee, participation in the 2012 arthritis educational meeting that was held in conjunction with NCSL's Legislative Summit, and/or appointment to attend from the legislative presiding officer. Of those invited, 18 individuals participated in one of the two focus groups. All the individuals who participated in a focus group were legislators (n=16) or legislative staffers (n=2). Participants included Democrats (n=9), Republicans (n=6) and Independents (n=1) and represented the states and territories of Alabama, Colorado, Connecticut, Florida, Hawaii, Michigan, Mississippi, New Hampshire, North Dakota, Ohio, Oklahoma, Utah, Virgin Islands, Virginia, Washington, West Virginia, and Wyoming. Participants were assigned to one of the two focus groups in such a way that the groups were balanced with respect to distribution of Democrats and Republicans, males and females, geographic region of the country, and previous participation in the 2012 arthritis educational meeting at the NCSL Legislative Summit. A list of focus group participants is included in the Acknowledgement section of this report (see page 19).

Each focus group lasted approximately 90 minutes and was facilitated by an independent health researcher using a structured moderator guide that was collaboratively developed specifically for this project by NACDD, NCSL, and the independent health researchers after reviewing guidance documents related to arthritis and environmental/systems changes. The moderator guide is included in this report (see Appendix A). Each focus group was audio-recorded and a verbatim transcript was produced for each group. The transcripts were coded and analyzed using a qualitative software package (Dedoose®, available at www.dedoose.com). The moderator of each focus group independently coded the transcripts from each groups and then the moderators met to discuss the results and identify key themes and findings.

CDC. Arthritis: Meeting the challenge of living well. Available at: http://www.cdc.gov/chronicdisease/resources/publications/aag/arthritis.htm (accessed 9.19.13)

Key Findings

The findings in this report are organized to correspond with the broad topic areas covered in the focus group moderator guide. Within each topic area, themes are noted and a select number of quotes have been included where the inclusion of the quote serves to illustrate a key theme or finding. Additional quotes beyond those included in this section of the report are provided as Appendix B.

Factors Influencing Decision to Take Action on a Specific Health Issue

The first topic discussed by focus group participants was about factors that influence their decision to take action on a specific health issue. There was wide spread agreement among focus group participants that they are asked to take action on many different health topics and they must make decisions about which health topics they will take action on or otherwise support.

Perceived Seriousness

One of the most frequently mentioned factors that legislators take into account when deciding whether to take action on a particular health issue relates to their perception of the seriousness of the health issue. Most participants believed that arthritis is not a serious condition because "*arthritis doesn't kill*" and/or "*arthritis is an inconvenience*." Along these same lines, several participants concurred with the belief that arthritis just causes minor discomfort or inconvenience. As one participant remarked, "*Take a little Advil and you'll be fine*." Other chronic conditions such as cancer, heart disease and diabetes were consistently mentioned as being more serious conditions in which the "*stakes are higher*" and pose much bigger threats to public health.

> *"Everybody that I talk to about arthritis says you're going to get it anyway...you're getting older."*

Many participants also believed that arthritis is a natural and unavoidable part of aging. As one participant noted, "*When someone says to you 'arthritis', what do you think? Older person*." Nearly all participants, including some who mentioned being personally affected by arthritis themselves, seemed to agree that the perception of arthritis as an "*old person's disease*" and an inevitable result of aging made it difficult to consider arthritis as a health issue that warrants action and attention -- especially relative to other chronic conditions and public health issues.

Cost and Potential Cost Savings

Cost was the second most frequently mentioned factor that influences legislators' decisions to take action on a specific health issue. Many focus group participants wanted to be better informed about the cost of arthritis to the government, the cost of arthritis relative to other chronic conditions, and the cost of arthritis treatment. With regard to the cost of arthritis to the government, several participants were interested in knowing "*how much of the state budget we're spending*" on arthritis. Participants were also interested in better understanding the cost of arthritis and arthritis treatment relative to other chronic conditions and diseases. As one participant asked, "*How about the cost of arthritis versus other conditions?*" and then added, "*Am I going to save the state money by spending this (on arthritis)?*" Another participant reintroduced the idea of arthritis being less serious than other conditions by stating, "*I would like to know (more about the cost of treating arthritis) because if it's not really saving any money here and just making quality of life better versus saving somebody's life, then I'm going to be more willing to spend state*

> ***"How much bang for the buck am I going to get?"***

dollars on saving somebody's life more than a quality of life type issue." Yet another participant wanted to know about the cost of doing nothing and asked, "…*if we identify what the cause (of arthritis) is and what the cure is .... and it costs us $10 million and if we don't do it and it costs us $10 million, then why are we going through the effort?*"

Beliefs about the Role of the State

Several participants expressed their belief that the state may not have a role to play in every health issue. In some cases, this belief is driven by concern that the state might not be able to effect change. One participant expressed concern about whether or not the state can have an impact on a health issue and explained, "*I look at, well, number one, is it the state's responsibility? And number two, what effect can we really have on (the health issue)? I mean what action steps, what piece of legislation can we do that really makes a difference?*"

Several participants indicated their belief that health issues could be better addressed by encouraging personal responsibility to make behavior changes than by trying to mandate or encourage behavior change at the government level. As one participant noted, "*I think we've got to be really careful about not being unreasonably intrusive into people's choices. We have a right to make choices, even if they're bad ones*." However, other participants expressed their belief that the government has a role to play under certain circumstances and one participant noted, "*At some point in time the actions of the individual really do start impacting the whole. And it can impact their life, safety, and welfare. And so at what point is it up to state government to say you know what? We would really like you to do X because if you don't do X, the rest of us are going to pay for the fact that you haven't done X because we're going to be taking care of you*."

"Not in (my state). We don't believe in mandates."

Advocacy

The majority of participants indicated that advocacy groups and lobbyists have a significant influence on their decision-making process. However, none of the participants recalled having ever been visited by an arthritis advocacy group or lobbyist. One legislator wondered, *"Who are the arthritis advocates? I can name the lobbyists for the lung association, for the heart association, cancer society, diabetes, all those folks. I know them, know them well. They're in my office and they've got legislation every year that promotes something. "But this participant was left wandering about who advocates for arthritis. Upon learning of the existence of the Arthritis Foundation, one participant asked, "There's an Arthritis Foundation?"*

Another participant added, *"I'm trying to think if I've ever had one visit from anyone in my office other than the employee at the state health department that deals with chronic conditions (come talk to me about arthritis). I don't think I've had one person in my office (to talk to me about arthritis) in nine years."* The general discussion continued with participants noting that arthritis advocates needed to be better organized, have a stronger lobbying presence, improve outreach and education and select a celebrity champion who could promote public awareness about arthritis.

"We're accustomed to the Cancer Society and all of these groups coming (to us) with all of the information. And that influences me."

Reaction to Statistics about Arthritis Prevalence

Participants were presented with a series of arthritis morbidity and mortality statistics, as well as CDC's Arthritis Wheel (which features state-level arthritis prevalence statistics). These numbers prompted wide-spread interest and many questions from the legislators. As one participant noted, *"The wheel gets me interested... but it doesn't answer all of my questions."* This seemed to be a sentiment shared by other participants, as several legislators wanted information about the various types of arthritis, some wondered why some states have a greater (or lesser) arthritis burden than other states, and some expressed interest in better understanding the causes of arthritis and the various treatment options. A few wondered if arthritis can be

prevented with behavior and lifestyle changes. As one participant asked, "*Do we have any idea of how much lifestyle is a predictor of arthritis?*" Another added, "*It would be interesting to learn if there was anything that we could do preventatively when we were younger*." Despite wide-spread interest in the arthritis statistics among the legislators, the statistics themselves did not seem to provide a true call to action for legislators. Rather, the statistics seemed necessary but not sufficient for compelling legislators to take action.

> ***"My reaction to the statistics is that we are totally oblivious to a major problem."***

Arthritis in Relation to Other Chronic Conditions

Participants were also presented with some statistics about the extent to which arthritis co-occurs with other chronic conditions, such as diabetes and heart disease. Some participants were surprised to learn that many people who have diabetes and/or heart disease also have arthritis. In response, several participants asked questions about the link between arthritis and other chronic conditions. One participant asked, "*Which came first, the heart disease or arthritis? Did the heart disease - the decrease in circulation - did that affect the joints?*"

Participants also seemed in agreement that arthritis by itself is not a condition that "rises to the top" or "grabs attention." Participants did not consider arthritis to be a strong "stand-alone" condition or disease; however, there was general agreement that it could be combined with other chronic diseases to promote awareness and possibly motivate people to take action to address risk factors, such as physical inactivity, that are associated with all the conditions. As one participant stated, "*I think in my mind, arthritis by itself doesn't do it. But in conjunction with all the other problems that we have that are a result of sedentary lifestyle, it's just another thing that we can add to get more people into trying to change that mindset.*"

> *"As soon as you talk about heart disease, diabetes, hypertension...they immediately take the forefront. And arthritis just gets swept under the rug."*

Evidence-based Interventions

Participants were provided with some information about evidence-based self-management education and physical activity interventions for people with chronic conditions, such as arthritis, diabetes, and heart disease. These interventions were described to the participants as prevention or treatment approaches that are validated by some form of documented scientific evidence -- as opposed to approaches that are based on tradition, convention, belief or anecdotal evidence. Participants were also told that there are a number of low cost, evidence-based programs that have been shown to improve quality of life for people with one or more chronic conditions, but that these programs tend to be underutilized reaching less than 1% of those who could benefit from them.

Participants were asked about their willingness to make these evidence-based self-management education and physical activity interventions available to people in their state using a variety of mechanisms. When asked about whether they would specifically support funding these evidence-based interventions, several legislators once again expressed that arthritis programs alone were less likely to be funded unless they were conducted in conjunction with programs for other chronic diseases. "*These two programs, these evidence based programs, physical activity promotion and community lay education, both of them are totally applicable to many other chronic conditions, whether it's diabetes or heart disease or many of the other ongoing chronic issues that should totally be part of the picture that we are trying to get to*."

> *"Programs need to get out of their silos and develop a program that helps a wide, broad base and actually brings in resources from a variety of groups."*

Several participants expressed a lack of understanding or skepticism about the effectiveness of evidence-based interventions and wanted additional information to help inform their decision about whether or not to support funding for them. One participant asked, "*Are we throwing money at it, or is there something that's actually proven that works?*" Another participant asked, "*How do we choose which treatment is more effective than another? Because you can read how one treatment works, and then three years later how that same treatment has other problems*."

The concept of personal responsibility also arose within the discussion of evidence-based interventions. Some participants indicated that individuals need to be motivated to "*do the right thing*" and "*live a healthier lifestyle*" as a way to manage arthritis symptoms and possibly even prevent the onset of arthritis and other chronic conditions. One participant summed by stating, "*I think at the end of the day, it all comes down to personal responsibility*." Another participant underscored the issue of non-participation in health improvement program and interventions, and stated "*…just because a program is available doesn't ensure that somebody is going to utilize it*."

One participant expressed concern that making a specific intervention available and/or promoting it might be construed as an intrusion by medical professionals. The participant stated, "*In (my state), we have a serious problem dealing with scope of practice and with telling doctors how to practice medicine."*

Medicaid Benefits

There were no legislators who believed they could be successful in including evidence-based self-management education and physical activity interventions as a state-covered Medicaid benefit. This proposed strategy was met with short, hesitant responses, which seemed to indicate that most legislators would not support increasing Medicaid funding for this additional benefit or would need more information about how such funding might be structured.

"...I would need to see a cost-benefit analysis on the Medicaid side."

Several other participants agreed that it would be very difficult, if not impossible, to add anything to Medicaid benefits if it meant that the cost of the program would increase. As one participant expressed, "*Would I try to get <evidence-based self management interventions included as a Medicaid benefit>? Sure, because it makes sense. Would I be successful? No*."

Although one participant indicated that it might be possible to add evidence-based interventions to Medicaid benefits if there was an anticipated cost savings elsewhere (such as in reduced emergency room expenses), none of the participants believed that it would be possible to achieve such savings. There was also concern among some participants that even programs that show cost savings are susceptible to being cut during subsequent legislative sessions. As this participant said, "*I think you're going to find it may work for like two minutes and then the next year they're going to cut it because they're not going to understand the dollars saved*."

State Employee Benefit Plans

Participants agreed that there was a better chance of getting evidence-based interventions included as a covered benefit in state employee health plans than as part of Medicaid benefits. Several participants indicated that one way to get the interventions included would be to demonstrate savings from decreased absenteeism and increased productivity. As one participant asked, "*What do we lose in productivity? What does that cost us?*"

"Productivity is a big issue. If you can show an impact on that then maybe you can get a little traction."

Some participants also stated that being a self-insured entity (as states often are) would also make it easier to add coverage for evidence-based interventions. As one participant explained, "*We're self-insured, so we could definitely (include coverage for evidence-based self-management and physical activity interventions) in the state health plan*." Another participant concurred by saying, "*It's definitely more possible (to include coverage for evidence-based interventions) for the state health plan in our state than Medicaid*

because I mean, like I said, we're self-insured so we set our own benefits."

Medicaid Health Homes

Participants expressed some support for the concept of including the provision of evidence-based self-management and/or physical activity interventions as a requirement to be credentialed as a Medicaid Health Home because other chronic disease management programs are already included. There was wide-spread agreement that the premise of the Medicaid Health Home was to take proactive steps to keep individuals healthy by receiving preventive care and services that can help them manage health risks and symptoms. As one participant noted about Medicaid Health Homes, "*We'll be able to make adjustments in the types of care that we get based on whether or not the treatments are efficacious or whether it's a good way of managing the care*." Another participant added, *"(Medicaid Health Homes) have a chronic disease management program with really wonderful outcomes... And so it's really important to get the providers engaged in this as well so that when they're looking at the individuals who might have any of those other conditions, they're also paying attention to whether or not arthritis is a part of the picture*."

> *"(Medicaid Health Homes) are going to have a lot to say about the kind of direction we're going with regard to preventable disease."*

Health Insurance Exchanges

Participants were asked whether or not they would be supportive of requiring all insurers that enter into a state or federal health insurance exchange to offer evidence-based self-management education and physical activity interventions as a covered benefit. However, there was a tendency among participants to confuse health insurance exchanges with Medicaid managed care plans. With regard to Medicaid managed care plans, some participants expressed hesitancy to mandate coverage for any specific interventions because doing so was believed by some to compromise the capitated payment arrangement inherent in such plans. As one participant noted, "*You've got to understand that the thing about managed care or capitated programs is you have a finite amount of money and there are a number of providers, not just docs, who are already trying to provide the best possible care and the best possible outcome. And of course the incentive is to treat that patient as efficiently as possible because that's the way you make a profit on it*." Virtually none of the participants offered insights that were truly about health insurance exchanges.

Laws and Mandates

Participants were asked two questions related to laws and mandates to establish, promote, and/or maintain evidence-based self-management education and physical activity interventions for people with one or more chronic conditions, such as arthritis. The first question had to do with enacting legislation to mandate education to raise awareness about arthritis, such as the Arthritis Prevention and Education laws already enacted in several states, including Florida and West Virginia. The second question focused on willingness to dedicate state funds to enact legislation to support evidence-based self-management education and physical activity interventions.

Feasibility of Enacting Arthritis Legislation

There was very little support among legislators for enacting legislation to establish, promote and/or maintain evidence-based self-management education and physical activity interventions. Many participants questioned the appropriateness of enacting legislation for this purpose. One participant noted that although there was support for the intent of the legislation, it would be better to try to achieve the same effect without going through the legislative process. As the participant stated, "*I would like to try to not do it legislatively because it always comes back to bite you when you pass a law*." In addition, several participants restated their opposition to mandates in general.

As an alternative to legislation, several participants talked about using other (non-legislative) approaches to promote awareness of arthritis and provide self-management tools and education to those who have arthritis. Several participants noted that their states make educational materials about a variety of health

topics available to the general public and they did not think it was necessary to pass legislation to conduct further education. As one participant explained, "*I think it's a communications issue as much as a legislative issue. If we had public health doing campaigns for arthritis as we had them do for immunizations, tobacco and other issues... then I think we could make progress*."

Feasibility of Funding Legislated Arthritis Programs

Due to the lack of support for enacting legislation to establish, promote, and/or maintain evidence-based self-management education and physical activity interventions, there was very little subsequent discussion about the feasibility of dedicating state funds to support such legislation. Despite the brevity of the discussions on this topic, it was clear that it would be very difficult to convince legislators to allocate funding to support legislated arthritis programs. Although some participants did note that enacting legislation without funding would be quite ineffective, most participants agreed that it would be very difficult to obtain any new funding for arthritis programs in the current political and economic environment.

> ***"You have to fund it or you might as well not have a law."***

Non-Policy Strategies

The focus groups included discussions about the types of non-policy strategies that legislators might be willing to use in their state to advance arthritis issues. In particular, legislators were asked about the extent to which they would be willing to engage in non-policy activities such as hosting town hall meetings, writing about arthritis in constituent newsletters, encouraging or requiring state health departments to develop plans to address arthritis issues, and meeting with state employee health benefit officials and/or Medicaid officials to discuss the arthritis issues.

Town Hall Meetings

Several participants thought that it would be "fun" or "informative" to hold a town hall meeting or other type of event (e.g., health fair) in which arthritis was a featured topic or one of several topics included as part of a broader health discussion. While this idea appealed to some legislators, some were quick to point out that arthritis as a "stand alone" topic might not be compelling enough to address on its own outside of a health fair or other event. This participant noted, "*I honestly can't think of anybody I know, even good friends, who would come to a workshop I was having where I was going to use a flip chart and talk about arthritis*."

Constituents Newsletters

When asked whether or not they would be willing to write about arthritis in a constituent newsletter, legislators readily agreed that this is something that they could easily do. There was no subsequent discussion among the legislators to provide any additional detail about how arthritis would be included in such newsletters.

State Health Departments Plans

Participants were asked how they felt about encouraging or requiring state health departments to develop plans to address arthritis or include arthritis in their existing strategic plans. While some legislators expressed willingness to encourage state health departments to address arthritis in strategic plans, several legislators expressed skepticism about whether state health department plans are actually used to inform and guide decisions about priority health topics.

Meetings with Health Benefit Representatives

Participants were asked to talk about the circumstances under which they would be willing to meet with Medicaid officials and state employees health benefit officials to discuss arthritis issues. Legislators were generally receptive to the idea of meeting with such officials, but they tended to view the purpose of such meetings as solely for information sharing or gathering, as opposed to advocacy. As one participant noted, "*I'd be happy to say, okay, what are we doing? How much is it costing? Is it effective? I'd be happy to visit with them*." However, this participant went on to indicate that he would not use the opportunity

> *"It would be a waste of my effort <to meet with the State Employee Benefit Representative> if I didn't have the Appropriations Chair with me."*

to advocate for arthritis interventions by adding "*I don't know that I would reach out to them and say hey, we've got to do a better job on this, do whatever it takes*." Other participants agreed that meeting with representatives, such as the state employee benefit representative, would only be productive if funds were made available to address arthritis issues and/or the Appropriations Chair participated in such meetings.

Working with the Media

Building on a widely held belief among legislators that lack of awareness about arthritis is a problem that needs to be addressed, many legislators suggested increased media involvement as the solution to the problem. There was widespread agreement about the potential value of working with the media to "*get the word out about arthritis*." Many participants view the media as natural partners with whom they could work to raise awareness about arthritis issues. As one participant noted about collaborating with the media, "*This is the kind of thing that I actually think legislators, if they have good relationships with the media, could actually do. They could plant story ideas (about arthritis).... and then the conversation could take off on its own and have nothing to do with me*."

> *"The media should be a natural partner for getting the conversation going."*

Some legislators mentioned the possibility of using social media, including Facebook and Twitter, to raise awareness about arthritis and "*increase the discourse*." To this end, the legislator noted, "*We're not seeing anybody really pleading about arthritis. It's not really on Facebook. We're talking about social media now kind of taking over the whole world... How do you inject yourself into that conversation?*"

Environmental Approaches to Promote Physical Activity

To segue into the discussion about environmental approaches to promote physical activity, focus group participants were reminded about the connection between arthritis and physical activity. They were also asked to think about how the ways that communities are planned, zoned, and built can impact physical activity.

Participants noted both challenges and opportunities related to supporting environmental approaches to promote physical activity. Some participants focused their remarks on the opportunity to educate the public about the importance of physical activity. As one participant suggested, "*I think maybe we could do a massive educational program for the country on limiting chronic diseases through physical activity*..." Some participants also pointed to collaborative projects, such as Safe Routes to School and Rails to Trails, as examples of successful efforts to use environmental approaches to promote physical activity.

> *"I really don't view my job as telling (my city) how many bike lanes to have and how much to do in terms of walking trails."*

Other participants focused more on the challenges associated with supporting environmental approaches to promoting physical activity. Among these challenges is the feeling expressed by some legislators that working on issues related to the built environment is not within their scope of responsibility. One participant noted, "*I don't feel like it's my job, nor appropriate for me, to tell (my town) how to zone*." Other legislators agreed with the belief that it is not within their sphere of influence to work on issues related to the built environment and several indicated that working on environmental issues is a more appropriate activity for local government and city planners.

Another challenge participants expressed relevant to supporting environmental approaches to promote physical activity is the sentiment that "*you can build it but they still won't come*." This sentiment was expressed by several legislators who expressed their belief that personal and community commitment to make lifestyle changes might be more important that environmental approaches such as building more sidewalks and bike lanes. As one participant noted, "*Just because you put a green beltway or a bike path down the side of a major thoroughfare, it doesn't mean people are going to use it*."

Summary of Key Findings

The focus groups provided valuable information and insights about factors that influence state legislators' decisions about whether to take action on a particular health issue, such as arthritis. The focus groups also shed light on policy and non-policy related strategies for advancing evidence-based self-management education and physical activity interventions at the state level.

The key themes and findings related to addressing arthritis include:

- Legislators are interested in national and state-level statistics about arthritis and many are surprised by the number of people affected by arthritis and the number of people with arthritis who also have other chronic conditions. However, the statistics themselves do not seem to provide a call to action for legislators. Rather, the statistics seem necessary but not sufficient for compelling legislators to take action on arthritis.
- When legislators make a decision to take action on a particular health issue, perceived seriousness of the disease or condition and belief about whether intervening on the condition is likely to save the state money are two of the most important factors taken into consideration.
- Lobbyists and other advocacy groups are in a strong position to influence legislators' thinking about arthritis; however, very few legislators recall ever being contacted by or having conversations with arthritis lobbyists or advocates.
- Arthritis is not perceived by state legislators as a serious health issue, especially when compared to other chronic diseases such as diabetes and heart disease. Legislators attach more significance to diseases and conditions that are life threatening (e.g., diabetes and heart disease) than to conditions such as arthritis that are thought to affect only quality of life.
- By itself or as a stand-alone condition, arthritis is not perceived as compelling enough to warrant the attention of state legislators. Rather, legislators believe that the most effective way to address arthritis is to include it within a set of related chronic conditions (e.g., diabetes, heart disease, obesity).
- By itself or as a stand-alone condition, arthritis is not perceived as compelling enough to warrant the attention of state legislators. Rather, legislators believe that the most effective way to address arthritis is to include it within a set of related chronic conditions (e.g., diabetes, heart disease, obesity).
- Legislators readily agree that it is important to communicate about arthritis issues and believe that social media and traditional media could be better utilized for initiating and sustaining a dialogue about arthritis.

The key themes and findings related to advancing interventions include:

- There is some support for including coverage for evidence-based self-management education and physical activity interventions in state employee benefit plans and/or including the provision of such interventions as a requirement to be credentialed as a Medicaid Health Home; however, there is virtually no support for including such interventions in state-covered Medicaid benefits.
- Many legislators are unaware of evidence-based physical activity and self-management education programs that are intended to be delivered in the community setting, and have difficulty distinguishing them from clinical interventions.
- Many legislators believe that working on issues related to the built environment and supporting environmental approaches for promoting physical activity for people with

arthritis and other chronic conditions is not within their scope of responsibility and suggest that such activities are best undertaken by local government and/or city planners.

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APPENDIX A: Moderator Guide

NCSL/CDC/NACDD Arthritis Focus Group

Research Objectives:

- Assess factors that influence state legislators' decisions to take action on a particular health issue.
- Assess the extent to which state legislators perceive the health and economic burden associated with arthritis to be compelling enough to motivate legislative action.
- Explore state legislators' reactions to policy-related strategies for advancing evidence-based self-management education and physical activity interventions at the state level.
- Explore state legislators' reactions to non-policy related strategies for advancing evidence-based self-management education and physical activity interventions at the state level.

Introductions and Housekeeping: (5 minutes)

Hello, my name is <_____> and I am an independent health researcher. I have been asked by the National Council of State Legislators and the National Association of Chronic Disease Directors to have a discussion with you about some of the issues surrounding arthritis programs and policies. I'm not an expert on the topics we'll be discussing this afternoon, so I might not be able to answer all the specific questions you might have but I'm sure we will still have an informative discussion. I'm here to pose some questions related to arthritis programs and policies and listen to your ideas and thoughts on these issues so that we can better understand how to help those with arthritis.

We have only have 90 minutes for this discussion, so I have a few requests to help make the best use of our time. Please refrain from taking phone calls, texting or checking email. There are no breaks scheduled, but if you need to use the facilities, they are located <insert directions here>.

I'm going to make every effort to keep the discussion focused and stay within the time we have allocated for each set of questions. If too much time is being spent on one question or topic, I may move the conversation along so we can cover all of the questions. In a focus group, there are no right or wrong answers, only opinions, and I'd like to hear from all of you equally. It's important that I hear what each of you thinks, because your thoughts may be similar to those of many other people who aren't here at this table today. Please feel free to speak up even if you disagree with someone else. We want to hear everyone's point of view. In addition, we ask that just one person speak at a time.

We have some other research team member here observing and taking notes. We will also be audio taping this session so we can accurately capture your comments. Although a report of focus group findings will be prepared to help inform decision-making by NCSL and NACDD, none of the comments made during this focus group will be attributable to specific focus group participants and your name will not appear in the report unless you provide specific permission to include it.

Does anyone have any questions before we begin?

Let's start by going around the table, tell us your name and the state you represent.

Objective 1: Factors that influence decisions to take action (10 min.)

We realize that state legislators receive requests to take action on numerous health issues and many factors can influence a legislator's decision about whether to take action on a particular health issue.

1. **What factors do you (or the state legislators with whom you work) consider when deciding whether to take action on a particular health issue?**
    - Does prevalence of the disease or condition play a role in decision-making?
    - Does the cost (to the state) of the disease or condition play a role?
    - Do personal life experiences, such as knowing someone who has the disease or condition, play a role?
    - Does knowing whether practical and effective programs are readily available to address the disease or condition play a role?

Are there any other factors that were not discussed that play a role in this decision?

Objective 2: Perceptions that lead to action (15 min.)

I would like to share some national statistics about arthritis with you.<Facilitator will draw attention to flip charts printed with factoids for this section.> I also am giving each of you this wheel, which contains data about arthritis specific to your state. Please take a moment to find your state and look at the data.

2. Do you find any of these statistics to be compelling or motivating enough for you take any type of action to address arthritis issues in your state? If so, which statistics?

- What does knowing this information mean to you?
- Does knowing this information cause you to want to do something to reduce the burden of arthritis in your state?
- What kind of facts and figures would help inform your policy-making decisions about arthritis? (Prompt as necessary: data on direct or indirect costs, morbidity and mortality rates, cost-benefit of interventions)

Now I'd like to share some information about how arthritis is associated with other chronic conditions. <Facilitator will draw attention to flip charts printed with factoids for this section.>

3. Does knowing that people with arthritis often have other chronic conditions make you feel any more or less motivated to take action? Why?

- Does knowing that arthritis creates a barrier to physical activity influence the way you think about arthritis?
- Does knowing that the physical inactivity resulting from arthritis puts those with arthritis at increased risk for other chronic diseases influence the way you think?

Objective 3: Reactions to policy strategies (40 min)

In this next question, we will be using the term "evidence-based intervention". When we use this term, we are referring to prevention or treatment approaches that are validated by some form of documented scientific evidence -- as opposed to approaches that are based on tradition, convention, belief or anecdotal evidence. Here are a few key facts about evidence-based interventions that are relevant to our discussion today:

- *There are a number of low cost, evidence-based programs that have been shown to improve quality of life for people with one or more chronic conditions, such as arthritis, diabetes, and heart disease.*
- *Self-management education programs are taught by trained lay leaders in community settings. These workshops teach people how to better manage chronic conditions through exercise and nutrition education, communication skills, and goal setting. After completing the course, participants*

report improvement in physical functioning/mobility, decreases in depression and anxiety and reduction in symptoms such as pain.

- *Another set of evidence-based programs focus on increasing physical activity as a mean of improving mobility and preventing other chronic conditions such as obesity.*
- *These programs are underutilized, reaching less than 1% of the people who could benefit from them or need them.*

4. Does knowing that there are low cost, evidence-based programs that can improve the quality of life for people with chronic conditions, and hearing that few people currently have access to these programs, compel you to make these interventions available to people in your state? If so, what action(s) would you be willing to take and why? If not, why?

- Would you be willing to dedicate state funds to implement these programs in your state? If not, why?
- What type(s) of additional information would you need, if any, to help you decide whether or not to dedicate state funds for these evidence-based interventions (i.e., cost of programs, program effectiveness, return on investment, other)?

The next few questions are about benefits for Medicaid-enrolled individuals and those covered by state employee benefit plans.

5. Under what circumstances, if any, do you think you and/or other state legislators would be willing to include evidence-based self-management education and physical activity interventions as a state-covered Medicaid benefit?

- Would you consider including evidence-based self-management education and physical activity interventions only if they were federally covered benefits, or would you consider including these even if they were not federally covered benefits? Why?

6. Under what circumstances, if any, do you think you and/or other state legislators would be willing to include evidence-based self-management education and physical activity interventions as a covered benefit within the state employee benefit plan?

- If you knew that costs associated with treatment for arthritis (and/or other chronic conditions) constituted a significant percentage of total health costs for state employees how would that information impact your response?
- Would knowing whether evidence-based self-management education and physical activity interventions are covered benefits under the federal employee benefit plan have any bearing on your response? Why?

7. How would you feel about including the provision of evidence-based self-management education and/or physical activity interventions as a requirement to be credentialed as a Medicaid Health Home?

- Under what conditions, if any, do you think you and/or other state legislators would be willing to include evidence-based self-management education and physical activity interventions as a covered benefit within the state Medicaid health Home?

8. Would you be supportive of requiring all insurers that enter a State or Federal Health Insurance Exchange to offer evidence-based self-management education and physical activity interventions as a covered benefit?

- If so, under what circumstances? If not, why?

9. How would you feel about enacting a law in your state to establish, promote, and/or maintain evidence-based self-management education and physical activity interventions for people with one or more chronic conditions, such as arthritis? Why?

- What challenges do you see with regard to enacting such a law?
- What would need to happen to change your opinion about enacting such a law in your state?

- Would knowing about arthritis policies or legislation that other states have introduced influence your decision to take action? Why?

10. Would you be willing to dedicate state funds to support a law in your state to establish, promote, and/or maintain evidence-based self-management education and physical activity interventions for people with one or more chronic conditions, such as arthritis?

- What challenges do you see with regard to dedicating state funds for this purpose?
- What would need to happen to change your opinion about dedicating state funds for this purpose in your state?

11. Are there any other policy-related actions that you would consider to be practical or feasible for promoting evidence-based self-management education and physical activity interventions for people in your state who have arthritis or other chronic conditions?

- If so, what type(s) of actions and why?

Objective 4: Reactions to non-policy strategies (15 min.)

Now I would like to get your thoughts about some of the non-policy strategies that could be used for advancing self-management and physical activity interventions at the state level.

12. Under what circumstances, if any, do you think you and/or other state legislators would be willing to engage in the following activities at the state level:

a) Host a town hall meeting (or listening session) to draw attention to arthritis issues and/or get constituent input on arthritis
b) Write about arthritis in constituent newsletters to draw attention to arthritis issues
c) Encourage or require the state health department to develop a plan to address arthritis issues
d) Meet with key state employee health benefit officials
e) Meet with key Medicaid officials to discuss arthritis issues
f) Other suggestions or ideas?

There are several environmental approaches to promoting physical activity. The way our communities are planned, zoned and built can significantly impact physical activity levels. For example, building sidewalks and improving roads could make it safer and more appealing for people to walk or bicycle.

13. Does understanding the importance of physical activity in controlling the negative health impacts of chronic diseases, and knowing that there are environmental approaches to promoting physical activity make you want to take any specific action(s)? If so, what action(s)?

- If not, what else would you require (or need to know) before feeling compelled to take action?

Initiatives to promote the planning, zoning and building of communities that promote physical activity often involve collaboration and partnership among many types of people including community residents, public health officials, urban planners, and policy-makers at the state and local level.

14. Under what circumstances, if any, do you think you and/or other state legislators would be willing to engage in collaborations or partnerships that support environmental approaches to promoting physical activity?

- Would you be willing to work with state and local governments to examine, and adapt as necessary, planning and zoning regulations to promote physical activity?
- Would you be willing to encourage planners to utilize planning incentives offered by federal programs to states that incorporate active living principles into planning and zoning standards?

Final thoughts and wrap up (5 min.)

As we come to the end of the discussion time, I have a few final questions.

15. Is there anything else you think a state legislator could do to address the burden of arthritis in their state?

16. Is there anything else that anyone would like to share before we end this FG session?

Thank you so much for your time and willingness to share your thoughts on this important issue. We will be using what we learned here today to guide future arthritis programming and policy. **15. Is there anything else you think a state legislator could do to address the burden of arthritis in their state?**
16. Is there anything else that anyone would like to share before we end this FG session?

Thank you so much for your time and willingness to share your thoughts on this important issue. We will be using what we learned here today to guide future arthritis programming and policy.

APPENDIX B: Additional Notable Quotes

FACTORS INFLUENCING DECISION TO TAKE ACTION ON A SPECIFIC HEALTH ISSUE

A. Perceived Seriousness

- Natural part of aging
  - "I think that part of the problem perhaps is that a lot of the population that has arthritis is older. So I think that we just associate it naturally as a part of aging."
  - "Everybody that I talk to about arthritis says you're going to get it anyway, you're getting older. It's a getting old disease, and that's the way they think.
  - "When someone says to you arthritis, what do you think? Older person."
- Doesn't cause death
  - "Arthritis is an inconvenience..."
  - "Take a little Advil and you'll be fine."
- Other chronic conditions are more serious
  - "Compared to cancer, compared to COPD, compared to autism, compared to diabetes, where do you –" (switch to different person) - "Those things kill you. Arthritis doesn't kill."
  - "(Referring to statistics on prevalence of arthritis)…those numbers are huge. I've been doing this for 20 years in three different states and nobody has ever mentioned arthritis as an issue."

B. Cost of Arthritis

- Cost of Treatment
  - "I would want to know because if it's not really saving any money here and just making quality of life better versus saving somebody's life, I'm going to be more willing to spend state dollars on saving somebody's life more than a quality of life type issue."
- Cost to Medicaid/Medicare
  - I would like to know how much of that $226 million for D.C. or $12.1 billion for California or states in general, how does that breakdown in terms of the cost? Are you talking hospitalizations, are you talking medications, to flesh it out a little bit more would be helpful."
- Cost of Arthritis Relevant to Other Chronic Conditions
  - "How about the cost of that disease versus others?"
- Return on Investment
  - "So how much bang for the buck am I going to get? Am I going to save the state money by spending this? Or am I going to spend this and not save the state anything and we're going to be out the same amount?"

- "As callous as it sounds, we've got priorities and we don't have an unlimited pot of gold from which to spend."

- Cost of Doing Nothing
  - "I want to know what the cost of not doing anything is, as well. I mean, okay, so if we identify what the cause is and what the cure is or the management, and so if we do it, and it costs us $10 million and if we don't do it and it costs us $10 million, then why are we going through the effort?"

C. Attitudes about the Role of the State

- Ability to Effect Change
  - "I look at, well, number one, is it the state's responsibility? And number two is what effect can we really have on it? I mean what action steps, what piece of legislation can we do that really makes a difference?"
- Mandates versus Personal Responsibility
  - "Not in <my state>. We don't believe in mandates."
  - "At some point in time the actions of the individual really do start impacting the whole. And it can impact their life, safety, and welfare. And so at what point is it up to state government to say you know what? We would really like you to do X because if you don't do X, the rest of us are going to pay for the fact that you haven't done X because we're going to be taking care of you."
  - "My point is it's a personal choice thing. There may even be some people beside me in this room for whom health insurance pays for a gym membership, but we're not doing it because if I don't want to, I'm not going to if that's my thing or not. So I mean, we're back to personal responsibility."

D. Advocacy

- Lobbying
  - "I'm trying to think if I've ever had one visit from anyone in my office other than the employee at the state health department that deals with chronic conditions who I officiated her wedding, other than that person, I don't think I've had one person in my office in nine years –"
  - "Who are the arthritis advocates? I immediately went, well, I guess AARP just by default. And I can name the lobbyists for the lung association, for the heart association, cancer society, diabetes, I can – all those folks, (I) know them. (I) know them well. They're in my office. They've got legislation every year that it promotes something."
  - "We're accustomed to like the cancer society or all of these groups coming with all of the information. And that influences me."
  - I've been doing this for 20 years in three different states and nobody has ever mentioned arthritis as an issue."
- Champions
  - "I think it's they need to be better organized as a grassroots organization. I don't know if there's an – I mean, there's an Arthritis Foundation?"
  - "And not to be insensitive to the Arthritis Foundation, but any foundation, when I meet with these groups. To me, part of their responsibility is to educate the general public because then the general public, if they want it, they'll pressure us as policy makers to

do something about it. And so part of their job or their responsibility is not only to find ways to keep the organization going, but it's to fulfill their mission."

REACTION TO STATISTICS ABOUT ARTHRITIS PREVALENCE

- More Information needed on cause, prevention, solutions
  - "Arthritis, are there behavior changes, lifestyle changes you can make, dietary changes you can make?"
  - "It would be interesting to learn if there was anything that we could do preventatively when we were younger."
  - "Do we have any idea of how much lifestyle is a predictor of arthritis?"

ARTHRITIS IN RELATION TO OTHER CHRONIC CONDITIONS

- More Information needed on cause, prevention, solutions
  - "Which came first, the heart disease or arthritis? Did the heart disease, the decrease in circulation, did that affect the joints? … And so which came first, the diabetes or arthritis? Is arthritis a side effect of diabetes or is arthritis causation for other diseases?"
  - "I was just going to say that different chronic disease states have more of a preventable factor. For example, although it's a little tough, it's a little tough to do prevention with arthritis. There are some certain things, exercise and activity certainly helps."
- Arthritis as a condition worthy of attention by itself (a "stand alone" condition)
  - "I think in my mind, arthritis by itself doesn't do it. But in conjunction with all the other problems that we have that are a result of sedentary lifestyle, it's just another thing that we can add to get more people into trying to change that mindset."
  - "But for ordinary, garden variety sore hands and knees, it's going to be something that isn't as life threatening as the diabetes and the heart disease."

EVIDENCE-BASED INTERVENTIONS

- Awareness and Understanding
- Program Efficacy
  - "Are we throwing money at it, or is there something that's actually proven that works?"
  - "These two programs, these evidence based programs, physical activity promotion and community lay education, both of them are totally applicable to many other chronic conditions, whether it's diabetes or heart disease or many of the other ongoing chronic issues that should totally be part of the picture that we are trying to get to."
  - "Do we choose which treatment is more effective than another? Because you can read how one treatment works, and then three years later how that same treatment has other problems."
- Personal Responsibility
  - "I think at the end of the day, it all comes down to personal responsibility."
  - "…just because a service is available doesn't ensure that somebody is going to utilize it."

- "… in <my state>, we have a serious problem dealing with scope of practice, of telling doctors how to practice medicine. And I think your edging up on to the legislature deciding what's evidence-based practice."
- "We have a right to make choices, even if they're bad ones, and that becomes a bit of an issue as well."

MEDICAID BENEFITS

- Feasibility of Including Coverage for Arthritis Programs
  - "I would want to do a cost benefit analysis on the Medicaid side with that."
  - "And you call me all you want about the cost of Medicaid going up because – or whatever the state investment in healthcare costs are, so they ought to have a right to tell people what to do. But I think it's really a tough sell."

STATE EMPLOYEE BENEFIT PLANS

- Feasibility of Including Coverage for Arthritis Programs
  - "We're self-insured, so we could definitely put that in the state health plan, as long as they're agreeable."

MEDICAID HEALTH HOMES

- Feasibility of Including Coverage for Arthritis Programs
  - "When I passed the medical home legislation four years ago, you could have called up evidenced based programs to reduce or to manage arthritis. But it isn't that specific. But you've put it overall."
  - "We'll be able to make adjustments in the types of care that we get based on whether or not the treatments are efficacious or whether it's a good way of managing the care with the person centered medical homes."
  - "I'm sure every place else has got the same thing, they have a medical home chronic disease management program with really wonderful outcomes that have been shown. And it's dealing with those other chronic diseases we're talking about. And so it's really important to get the providers engaged in this as well so that when they're looking at the individuals who might have any of those other conditions, they're also paying attention to whether or not arthritis is a part of the picture."

HEALTH INSURANCE EXCHANGES

- Feasibility of Requiring Coverage for Arthritis Programs
  - "You've got to understand, too, about managed care or capitated program is you have a finite amount of money and there's a number of providers, not just docs, you've got a number of providers built into that organization that is trying to provide the best possible care and the best possible outcome. And of course the incentive is to treat that patient as efficiently as possible because that's the way you make a profit on it."

LAWS AND MANDATES

- Feasibility of Enacting Arthritis Legislation
  - "Not in <my state>. We don't believe in mandates."

- "I look at, well, number one, is it the state's responsibility? And number two is what effect can we really have on it? I mean what action steps, what piece of legislation can we do that really makes a difference?"
- " … I would like to try to not do it legislatively because it always comes back to bite you when you pass a law."

- Feasibility of Funding Arthritis Programs
  - "Money wise, the only way I think you could get traction is if you get them not to use ER services."
  - "I think you're going to find it may work for like two minutes and then the next year they're going to cut it because they're not going to understand the dollars saved."
  - "You have to fund it or you might as well not have a law."

NON-POLICY STRATEGIES

- Town Hall Meetings
  - "I honestly can't think of anybody I know, even good friends, who would come to a workshop I was having where I was going to use a flip chart about arthritis."
  - "If you go out and try to do a town hall meeting on arthritis, you may not have anybody show up."
  - "Arthritis is a part of the bigger problems that we see here. And I really think the health professionals, in my opinion, have missed the whole boat because we don't support public education through physical education and health education, which is the answer."
- Working with the Media
  - "This is the kind of thing that actually I think legislators, if they have good relationships with the media, could plant story ideas.... and then it has a conversation on its own that has nothing to do with me
  - "…because the media is much better about taking that conversation on…"
  - "I think it's a communications issue as much as a legislative issue, personally If we had public health doing campaigns of public education as we have with immunizations, as we have with tobacco and other issues, I think we could make progress."

ENVIRONMENTAL APPROACHES TO PROMOTE PHYSICAL ACTIVITY

- Opportunities
  - "…I think maybe we could do a massive educational program for the country on limiting chronic diseases through physical activity, do it that way."
  - "How do you inspire community commitment to any issue, and specifically with regard to healthcare, with regard to prevention and preventive healthcare?"
- Challenges
  - "I do have control over the city county health department if they're merged, or the county health department, which for a lot of our rural areas is a huge factor. But telling <city planners in my state> that they need to have bicycle lanes just isn't in my job description to me."

- “I don’t feel like it’s my job, nor appropriate for me to tell <cities in my state>, population 2,300 how to zone.”
- “It’s a division of responsibility in many ways. I really don’t view my job as telling the <cities in my state> how many bike lanes to have and how much to do in terms of walking trails.”
- “Legislatively our health committees don’t deal with say our local government committee where zoning issues and infrastructure decisions are being made.”