National Association of Chronic Disease Directors
CDC Arthritis Expert Advisory Panel Kickoff
November 18, 2022 @ 10:00 a.m. ET

Notes and Summary Document

- Meeting Recording: https://vimeo.com/776840250
- Additional information: Please visit the private Expert Panel web page for a link to the recording from today, summary documents and additional information and pre-reading materials for the January 10, 2023, Human Centered Design Session. https://chronicdisease.org/private-arthritis-expert-advisory-panel/.

Participants:

50 Total Participants (including presenters and facilitators)

Project Overview and Objectives:

The National Association of Chronic Disease Directors (NACDD) Arthritis Portfolio is working to develop an arthritis care model that supports innovative efforts that enhance healthcare provider awareness, knowledge, and skills in promoting physical activity as an effective, drug-free way to relieve arthritis pain, improve function, and limit arthritis progression.

- Develop and implement an evidence-informed arthritis care model to conduct function, pain, and physical activity screenings; patient counseling on the benefits of physical activity; and referrals to arthritis-appropriate physical activity and self-management programs and other evidence based "treatments."
- Pilot the arthritis care model in a healthcare system that serves diverse populations; demonstrate clinical outcomes and total cost of care savings; and reimbursement pathways and incentives for provider screening, counseling, and referral.
- Disseminate learnings on a national level and enhance healthcare provider awareness, knowledge, and skills to promote physical activity as an effective, drug-free way to relieve arthritis pain, improve function, and limit arthritis progression among adults with arthritis.

Kickoff Objectives:

- Recognize the expertise of Expert Panel members and the unique perspectives that they bring to the evidence-informed approach
- Discuss key elements of the arthritis care model to conduct function, pain, and physical activity screenings; patient counseling on the benefits of physical activity; and referrals to arthritis-appropriate physical activity and self-management programs and other evidence based "treatments."
- Describe the Human Centered Design sessions
- Establish a platform for peer-to-peer sharing, learning and networking

Pre-read:

- "Key Considerations and Barriers to Creating an Evidenced-Informed Approach for Screening, Counseling, and Referral to Arthritis Appropriate Evidence-Based Interventions: A Landscape Assessment" (Leavitt Partners Report)

Presenters

Marti Macchi, MEd, MPH, National Association of Chronic Disease Directors

- Chief Program Strategy Officer
- Welcome and vision for the work from an NACDD perspective

Erica Odom, DrPH, MPH, Centers for Disease Control and Prevention

- Lead, Arthritis Program
- Case for change & vision for the project

Nick Turkas, MS, Arthritis Foundation

- Senior Director, Patient Education/Community Connections
- Patient story – the journey of a patient with Osteoarthritis who is referred to Walk With Ease to increase physical activity and connect with others

Shalu Garcha, MPA, National Association of Chronic Disease Directors

- Senior Program Manager, Center for Advancing Healthy Communities
- Summary of what we are trying to accomplish through the Arthritis Case Model

Kirsten Ambrose, MS, Osteoarthritis Action Alliance

- Associate Director
- Recognition process for Arthritis Appropriate Evidence-Based Interventions

Heather Kitzman, PhD, UT Southwestern

- Baylor Scott and White Health and Wellness Center's experience coupling Walk With Ease with chronic disease efforts including Diabetes

Elizabeth Joy, MD, MPH, FACSM, FAMSSM, Intermountain Healthcare

- Senior Medical Director, Wellness and Nutrition
- Exercise is Medicine and experiences using Physical Activity Vital Sign as physical activity screening tool

Anita Bemis-Dougherty, PT, DPT, MAS, American Physical Therapy Association

- Senior Advisor, Scientific Affairs

- Role of Physical Therapists (PT) in primary care and opportunities for PTs to link patients to evidence-based interventions

Jonathan S. Kirschner, MD, RMSK, Hospital for Special Survey, United States Bone and Joint Initiative

- Spine and Sports Medicine
- Physiatry Fellowship Director
- Team-based care support to patients and the role of integrated practice units in helping patients manage chronic diseases

John Andrawis, MD, MBA, Torrance Memorial Medical Center & Harbor-UCLA Medical Center

- The time to treatment for a patient experiencing arthritis pain and algorithm for referral to UCLA Orthopedics

Tamara Huff, MD, MBA, FAAOS, FAAHKS, Vigeo Orthopedics, LLC

- The value and role of shared decision making in the arthritis care model and the opportunity to ensure that health equity is incorporated throughout the model

Patricia Doxey, Leavitt Partners, LLC

- Director
- Human Centered Design and expectations for the upcoming design sessions

<u>Audience Engagement:</u>

Where do we focus our efforts?

- While there are estimated to be more than 100 types of arthritis, **osteoarthritis (OA)** is the most common form of arthritis, affecting 32.5 million US adults.
- OA is the most common disease of the developed world and a leading cause of chronic disability, mostly because of **knee OA and/or hip OA**. Because of OA, an estimated 1 million knee and hip replacements are completed each year. Knee OA contributes to more than $27 billion in health care costs each year.
- **Primary care settings**, where most patients with OA are regularly treated, present an excellent opportunity to intervene and set patients on a path toward increased PA. Yet evidence shows that providers often fail to discuss PA during conversations with patients about OA.

Peer-to-Peer Sharing and Idea Generation:

Q: Would it be possible to expand the arthritis relevant outcomes used to evaluate AAEBIs to include common comorbid conditions that act as barriers to engaging in physical activity like depression and anxiety? The connection between chronic

pain and depression/anxiety is well established in the literature and addressing fear of increasing pain with physical activity is an important component.

Comment: This would be a great topic for the OAAA independent workgroup assessing AAEBIs to consider. Although I wouldn't want to exclude programs that have definite benefits for arthritis, I do think it would be beneficial to identify and have a tier or category of programs that are proven effective for managing arthritis and one or more other chronic conditions – be it a mental health condition or other common co-morbidity such as obesity, diabetes, or heart disease. Expanding in this way may help generate more interest in the AAEBIs/lifestyle management programs from colleagues and other professionals working to address these other conditions (which may be better funded than arthritis). This would also help respond to one of the barriers Leavitt and Partners identified regarding limited time/competing asks for providers.

Comment: Agree that OAAA can consider adding criteria. Notably, some of the currently recognized programs address emotional health and comorbid chronic conditions (CDSMP, CPSMP, EnhanceWellness, PEARLS, etc.) so while not necessarily stated criteria for program recognition at this time, individuals will learn about these important topics related to arthritis.

Q: Has the PAVS form element developed for the Kaiser system been made available to every Epic customer as a feature that can just be turned on with no additional programming or implementation cost?

Comment: Epic has integrated PA questions in the Social History tab. It is not universally available in the Vital Signs section of the EHR like it is at Kaiser. Similarly, Cerner has not integrated universally into the Ambulatory Comprehensive Assessment. This was an Intermountain customization. There is an effort underway, being led by the Physical Activity Alliance (PAA) to develop the PAVS as an HL7 standard. This effort is well underway.

Comment: Kaiser uses Epic, and it was a custom build in their rooming protocol, automatically calculating total minutes of PA with a flag indicating whether the patient is meeting the PAGA 2018 Guidelines. Epic now has the PAVS as the first question in its SDOH section universally with participation flags. We were unable to get it into the Epic rooming protocol but will keep trying. We were able to have conversations with Epic because one of their large customers had an EIM physician champion who helped us push PAVS forward - at least in SDOH.

Comment: My concern with many of these EMR customizations is that the software vendors often do them as 1 off projects making it impossible to standardize clinical workflows or data transmission between organizations. At Kaiser the PAVS is collected at every appointment. In some other Epic installations, it is in a completely different form collected annually. Then in other Epic installations that haven't implemented the optional SDOH module it isn't collected anywhere. Sending a patient from 1 system to a different system won't translate. The EMR system will not have the appropriate location to display previously collected data.

Comment: The Physical Activity Alliance, with ACSM and EIM's involvement, is currently engaged in an action plan re: HL7 to develop universal assessment standards and EMR health info exchange standards around PA. http://www.hl7.org/implement/standards/index.cfm?ref=nav

Comment: It's hard to rely on any vendor (and really ALL vendors are needed if this model is going to be broadly generalizable) to do this sort of work without a demonstrable benefit to their business model.
Comment: If this work is successful, it would apply to all EMR vendors.
Comment: It could apply to all EMR vendors if it can be tied to CEHRT certification. Additionally, if the format of the PAVS data collection can be adopted as the standard for UDS or HEDIS measure reporting annually then widespread use for all children under 18 and adults over 64 can be required by already established reporting requirements.

Question: Do we know what proportion of care for arthritis is delivered by primary care mostly or all, specialists mostly or all, or in a shared care model?

Comment: Many people with joint pain wait too long to have a serious discussion about it with a healthcare provider.
Comment: The patients with the mildest and/or early symptoms where the likelihood that these fantastic programs would most benefit patients functionally and perhaps prevent progression are likely virtually all managed by PCPs. Focusing purely on specialty-based care will miss a huge population with a large potential for significant impact.
Comment: We will also need to consider that a large percentage of people with early joint pain symptoms and likely pre-imaging recognizable early-stage arthritis don't get annual physicals so having this discussion with patients needs to be woven into acute care mindsets in primary care.
Comment: Patients need to be encouraged to speak up about arthritis pain and providers need to take this pain seriously and offer meaningful treatment/referral.
Comment: There is evidence that joint pain is the first domino of chain reaction of chronic disease.
Comment: If only 40% of patients report getting prescribed exercise by their PCP, then the opportunity in primary care is 60% x the amount of care for arthritis provided by PCPs. I suspect this is massive and if it prevents patients from needing surgery, then we won. At least I think so.

Comment: The Knee Injury and Osteoarthritis Outcome Score (KOOS) is a self-reported outcome measure assessing the patient's opinion about the health, symptoms, and functionality of their knee. It is a 42-item questionnaire, including 5 subscales: symptoms, pain, ADLs, sports/recreation, and quality of life.

Comment: KOOS JR is a 10-question score. Mostly, that's all we use these days. The 42-item questionnaire was too long to implement in the clinic.
Comment: We used this score in an endocrinology clinic and it was fascinating. We found better diabetic control also improved patients Knee scores stressing the importance of how co-morbidities impacts so many other things.

Comment: I love Dr. Huff's emphasis on a physical activity that in inclusive, supportive, and FUN.

Comment: Conversations often center on "patients should do x, y, z …" but we are not talking enough about how we can close gaps by meeting patients where they are. Culture is one of the many aspects we need to consider

when getting individuals to the appropriate interventions to improve QoL/HRQoL.

Comment: Should we focus the pilot on knee OA and/or hip OA?

Comment: Many attendees agreed to focus on knee OA and/or hip OA for the pilot project.

Comment: We may have to plan to include lumbar spine with Hip OA just due to the frequently seen overlap of these conditions and the constellation of symptoms when presenting to the PCP. Very often hip issues are described as low back pain.

Comment: We do need to think about how we support physical activity and falls prevention for those who have spine/lumbar. Especially as it relates to pain management and the additional impact that can have on their ability to live healthier.

Comment: Lumbar spine and hip OA often overlap

Resources:

- List of Arthritis Appropriate Evidence-Based Interventions - https://oaaction.unc.edu/aaebi/
- Osteoarthritis Action Alliance Lunch and Learn Webinar on arthritis management programs - https://oaaction.unc.edu/webinar/intro-to-arthritis-management-programs-november-16-2022/
- National Recreation and Park Association's map of Park and Recreation agencies offering AAEBIs (2013-present, updated annually), https://experience.arcgis.com/experience/4d6bc2b1b9434a9aa72a0d0f293b5efe/
- Article on Shared Decision Making: Development of a personalized shared decision-making tool for knee osteoarthritis and user-testing with African American and Latina women - https://journals.lww.com/jfmpc/Fulltext/2022/09000/Development_of_a_personalized_shared.77.aspx

Evaluation:

- **Poll Question**: After attending today's session, I can describe the key elements that impact arthritis care.
  - 80% Strongly agree
  - 20% Agree
- **Poll Question**: After attending today's session, I understand the next steps regarding how my input may contribute to the model
  - 60% Strongly agree
  - 40% Agree