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Care Team Members for Patients with Arthritis

In our human-centered design sessions, our vision is to inspire a more expansive, flexible vision for how care teams can better collaborate with patients diagnosed with arthritis. The goal will be to think creatively and outside the boundaries of traditional care teams.

This document consolidates relevant information gathered through a landscape assessment of current guidance and approaches to integrating physical activity and self-management for arthritis. It contains information specifically regarding how different care team members could be included in the care for patients with arthritis, with references to different types of individuals **bolded** for easy identification. This text is taken from Key Considerations and Barriers to Creating an Evidenced-Informed Approach for Screening, Counseling, and Referral to Arthritis Appropriate Evidence-Based Interventions: A Landscape Assessment.

Contents

Section 1: Function, Pain, and Physical Activity Screening

Care teams should leverage community health workers in proactive screening processes

This section provides an alternative to screening processes within the care clinic by promoting CHWs to conduct screenings within the community itself. The section includes examples of different health systems utilizing CHWs within their care teams (pg. 16 – 17 of final report).

A common challenge for screenings conducted at the point of care is that they often only benefit patients that are already in the care setting and do not benefit the population beyond the care setting. A proactive approach to reach these patients in creative ways could benefit overall screening efforts.

For example, at Baylor Scott and White, one representative noted that community health workers (CHW) are integral to identifying and overcoming barriers that people in the community experience, especially those who are uninsured. Rather than waiting for patients to seek care at Baylor Scott and White clinics, CHWs work with local champions and the community to conduct outreach and encourage individuals to receive screening or to participate in one of the various programs available at the Baylor Scott and White Health and Wellness Center. A Montefiore Health System representative explained that Montefiore takes a proactive approach for patients who are not going to regular office visits by employing CHWs to provide outreach assistance in the community. CHWs are generally trained to conduct certain screening measures such as blood pressure screening, or simple behavioral health screenings, but they are not typically equipped to do clinical screenings. CHWs can be trained in different specialties and screening methods as they have a wide range of health-related conditions and are often needed for general patient support. Such proactive approaches allow providers to access additional populations and get a head start on arthritis screenings and treatments.

Limited provider time during patient visits reduces opportunities to screen

This section specifically points out that CHWs are another promising member of the care team to increase opportunities for screening in addition to screenings performed via technology (pg. 17 of final report).

A key barrier to screening for arthritis pain, function, and physical activity highlighted in our research is the limited time providers have with their patients. One interviewee noted that on average, physicians have around seven minutes with each patient, making it extremely challenging to conduct screenings on top of other priorities. Several interviewees noted they chose specific screening tools that are less time-intensive due to the time restrictions they have with patients.

To address this time barrier in the clinical setting, one interviewee recommended a patient-facing assessment or screening tool that could be completed in advance or in the waiting room. For example, a Johns Hopkins representative noted the PROMIS tool's integration into their EPIC health record system to deploy it during visits or even between visits through patients' MyChart portal. CHWs are another promising member of a care team, and community, who can perform basic screening activities and increase opportunities to screen patients with arthritis. CHWs are trained to understand a variety of programs and how to refer and connect people to the right resources. The Massachusetts Department of Public Health has been encouraging different health systems to include CHW salaries as part of their core-operating budget, moving away from reimbursement models and towards team-based care. Regardless of the strategy or activities chosen, addressing limited provider time with patients will be key to strengthening not only screening efforts, but counseling and referral efforts as well.

Lack of payer involvement prevents increased screenings

This section describes the unique opportunity that payers could have in enabling function, pain, and physical activity screening efforts through incentives and other methods such as offering care management or wraparound services to patients. (pg. 21 of final report)

While **payers** could have a unique opportunity to enable function, pain, and physical activity screening efforts through incentives and other methods, there is hesitancy among payers to contribute to such efforts. Each of the payer interviewees confirmed that payers do not provide specific guidance or incentives on screenings. One interviewee noted payers do not want to overstep their role and interfere with the providers' role in care decisions. This hesitancy extends beyond just screenings—payers are reticent to get involved in any aspect of healthcare traditionally under the purview of providers. Payers may offer care management or wraparound services to patients, but they conclude providers should decide which screenings to perform with patients and where to refer them.

Interviewees agreed that payers can also have an underlying fear surrounding lost revenue due to improved member health outcomes, which prevents them from contributing to screening efforts specifically. More traditional payers may only choose to intervene with members' care once they become high cost, which could exclude members with arthritis that have lower costs associated with their claims.

Section 2: Counseling on Benefits of Physical Activity

Leveraging coordinated and integrated care teams boosts counseling opportunities

This section references the importance of a care team for arthritis/ chronic disease as a whole and provides different examples of stakeholder opportunities (i.e., health coaches, community health workers, using nurses as main providers of education rather than providers, etc.). (pg. 21 of final report)

Arthritic conditions are complex, and the impact of disease often extends beyond the musculoskeletal system to cause pain and damage to other parts of the body. Properly treating arthritis requires coordination across a **multidisciplinary care team**, which may include **rheumatologists, physical therapists, exercise physiologists, dieticians, social workers, CHWs, orthopedic specialists, sports medicine providers, nurses, and medical assistants**. Depending on the type of arthritis a patient has, the care team may look different. However, a common sentiment highlighted across interviews was the opportunity to leverage a more integrated and multidisciplinary care team to care for patients with arthritis.

An orthopedic surgeon from the Musculoskeletal Institute at The University of Texas (UT) Health Austin highlighted its tailored care pathways for the treatment of different chronic conditions—including inflammatory and autoimmune disease, and chronic conditions of the upper extremity, lower extremity, and back/neck —that describe which members of the care team should be involved. An advantage of having strong, integrated care teams is leveraging each individuals' strengths and allowing each team member to do what they do best. For example, a representative from the Johns Hopkins Division of Rheumatology noted efforts to optimize the limited time that physicians have with patients by having **nurses** educate patients about various aspects of their disease and administering certain medications. Such coordinated and integrated care team approaches can increase opportunities and time spent counseling patients with arthritis.

Health coaches, for example, could help relieve the burden from clinical staff by counseling patients on physical activity, identifying self-management, and other evidence-based interventions. A five-year CDC Arthritis grant was awarded to the North Carolina Center for Health and Wellness (NCCHW) to address

the impact of arthritis and to increase awareness of arthritis management in North Carolina. The work includes a dedicated health coach that works with older adults to identify opportunities for referral to AAEBIs, such as WWE.

Baylor Scott and White's Health and Wellness Center has extended their care teams beyond the traditional clinical members to include CHWs. CHWs use their network within the community to refer patients to programs and resources that fit their unique needs. Representatives from health departments also endorsed this approach, highlighting the important role that non-physician members of the care team can play in addressing arthritis, in particular by decreasing burden on physicians and improving the patient experience.

Although CHWs offer a promising way to counsel patients with arthritis, challenges to leveraging CHWs should be addressed if they are to be fully integrated into the care team. While CHWs are trained to understand a variety of programs and to connect people to the right resources, they often lack a strong support system that can direct and manage their workload. Additionally, health systems often use short-term grants to fund CHWs; once the funding cycle is over, health systems can lose the valuable skills and community relationships that CHWs developed. This presents an opportunity for health systems to better integrate CHWs into the care team to leverage their strengths in supporting screening, counseling, and referral efforts."

Although providers may understand the benefits of physical activity, they may lack the resources to instruct patients

This section describes the different opportunities that state health departments (SHD) may have to support the development and dissemination of resources. (pg. 25 of final report)

Interviewees revealed that physical activity as a general referral or recommendation has gained traction among providers. However, physicians may feel ill-prepared to prescribe exercise, emphasizing a need for additional assistance to make exercise recommendations and referrals. There are organizations that have either created or are creating such guidance. Representatives from ACR noted the organization is currently working on a clinical practice guideline that will complement the current guidelines for arthritis and include more counseling and treatment options for patients with rheumatoid arthritis that expand beyond pharmacological approaches, including physical activity. SHDs may also have opportunities to support the development or dissemination of available resources. For example, the New York State Department of Health developed an online health care provider toolkit to support providers in counseling adult patients on the benefits of physical activity. Additionally, national organization representatives from one listening session noted there are some resources to support providers in counseling patients, such as findhelp.org, which includes a catalog of available evidence-based programs by zip code, or the Evidence Based Leadership Collaborative (EBLC) site, which is a collaborative initiative to help find and implement evidence-based health promotion programs. However, availability of such tools is limited and focuses more on efforts to refer patients to evidence-based programs rather than resources geared at supporting provider efforts to counsel patients themselves on how to become more physically active.

As noted above, counseling efforts should include a process to solicit a patients' own health goals, what success means to them, and what they would like to be able to do. This patient-driven outcomes discussion should be followed by a tailored recommendation from healthcare providers to help patients achieve those goals. However, providers likely need more resources to support implementing such a tailored, patient-centric approach to counseling patients with arthritis.

Patient fear of physical activity can challenge provider counseling efforts

This section briefly mentions CHWs are other care team members that could be used to provide instruction and education on physical activity. (pg. 28 of final report)

Movement and correct modification of exercise activity can reduce arthritic pain, but there are misconceptions or counterinformation positing that physical activity can be detrimental and increase pain. This represents a major barrier to counseling patients on the benefits of physical activity expressed across interviews, specifically patients fear of increasing their arthritis pain with physical activity. In some cases, patients may use this fear to push back on provider physical activity counseling efforts. Cultural beliefs can also increase fear of pain from physical activity, creating an additional need to address these fears with culturally appropriate approaches.

Interviewees agreed on the need to address patient concerns and misconceptions about physical activity increasing pain and provided potential solutions to address patients' fear:

- Develop additional patient education, including information on how to manage pain through physical activity, and teaching exercise modifications.
- Use additional care team members—including occupational and physical therapists, health coaches, and CHWs—to instruct patients on safe and protective methods for physical activity.
- Provide details on the benefits of physical activity with a particular focus on the benefits of exercise in the long run.

Section 3: Referral to Physical Activity-Based Interventions:

Connecting individuals to community-based work is a popular strategy for improving access

This section provides a unique example of the CDC partnering with the National Parks and Recreation Association to implement a referral process between CBOs and healthcare organizations. This section also describes other examples in which partnerships with different community-based stakeholders provided positive results. It also provides different perspectives for Advisory Panel members to think about (e.g., transportation, United Healthcare partnership with YMCA, and meeting the community within their own environment). (pg. 33 – 34 of final report)

From April 2018 through December 2019, the CDC partnered with the National Parks and Recreation Association (NPRA) to implement a referral process between CBOs and healthcare organizations. The goal of this intervention was to strengthen relationships between healthcare providers and CBOs to better deliver AAEBIs. Of the 3,660 referred patients, 29 percent (1,063) engaged in an AAEBI. The success of the referral engagement rate was attributed to increased awareness of the availability of AAEBIs, improved credibility for AAEBIs due to provider involvement, a sense of community cohesion and trust for the park and recreation agency, and a reduction in barriers—such as cost and transportation—to participation in AAEBIs.

Many interviewees noted the importance this type of effort to connect community members to the right resources to enhance referral efforts to evidence-based interventions. For example, a UnitedHealthcare representative noted that the payer utilized their partnerships with YMCAs to pilot member access to YMCA condition-based programs because they see YMCA as a trusted health and wellness advisor for patients. Similarly, a representative from Y-USA highlighted the Bidirectional Services eReferral (BSeR) project, which includes FHIR standard interoperability language and focuses on six disease condition domains that help facilitate referrals from the clinical environment to the community. While arthritis is

one of the six disease condition domains for the BSeR project, none of the current pilots are focused on arthritis. A representative from Humana noted the payer utilizes care managers and social workers to connect patients to resources and guide them to community programs. A representative from Montefiore Health System stated the importance of meeting the community where they are and addressing their unique needs and challenges, adding this can be a way to leverage community-based programs to deliver lifestyle change programs. They felt this was a great way to target niche communities and tailor health information in culturally appropriate ways. They found that participants joined sessions to receive health-related information in addition to an opportunity for social interaction. These examples show the role that payers and providers all can play in referring individuals to community-based programs, including physical activity-based interventions.

Centralized referral models ease provider and payer burden

This section provides examples of using different stakeholders to implement referral models that were successful. The different stakeholders mentioned in this section could provide a unique perspective for Advisory Panel members. (pg. 34 – 35 of final report)

One strategy for facilitating referrals to physical activity-based programs is having a centralized source for referrals that allows providers or payers to have a single point of contact rather than identifying and developing workflows or contracting with multiple CBOs to provide a variety of programs.

One provider from Johns Hopkins discussed the role an arthritis advocacy organization played in the past as a centralized, trusted referral source to connect providers with AAEBIs. The organization had strong connections to community resources, including CBOs and AAEBIs, and providers trusted them to assist patients who they referred to the organization. Having this centralized referral partner was a huge benefit to the health system. Similarly, Silver Sneakers acts as a centralized source for Medicare patients to engage in programs hosted at CBOs. One payer representative described the convenience of partnering with the Sliver Sneakers organization. Rather than negotiating individual contracts with each CBO delivering the program across the country, the payer has a single contract with Silver Sneakers, which manages downstream contracts with CBOs on behalf of the payer. This way, all patients on the Medicare Advantage plan can get access to the Silver Sneakers program in their area with very little effort from their payer or providers.

The Minnesota Department of Health found a comparable solution for connecting older adults with chronic diseases to evidence-based classes in their area by providing patients access to Juniper, a platform for patients to find and enroll in classes that fit their needs. The platform also allows providers to refer patients to programs and collects data on the patient's participation. A representative from The Healthy Living Center of Excellence in Massachusetts described their efforts towards maintaining a bidirectional referral process. They contract with a managed care organization (MCO), where their providers refer patients into a wide variety of evidence-based programs. The Healthy Living Center of Excellence signed a plethora of Health Information Portability and Accountability Act (HIPAA) and Business Associate Agreements (BAAs), and the MCO provides an internal registry of around 100 people they are interested in referring that month. The two organizations work on collaborative outreach to those patients and utilize motivational interviewing to pull them into the programs. Within this same contract agreement, the Healthy Living Center of Excellence sees self-referrals where a patient attends a workshop, and the patient's healthcare provider is contacted to see if they would be a good fit for the program and subsequently referred. Incorporating a centralized referral platform or model similar to those described here should be considered in the evidence-informed approach as one method to reduce provider and payer burden around referral efforts.

Payer efforts to refer members to programs are limited

This section highlights examples of opportunities for payer involvement in referral processes such as, using predictive analytics to look at claims data and predict which members are good candidates for physical activity-based interventions, and one payer taking steps to create their own fitness program. (pg. 38 of final report)

Each of the payer interviewees confirmed that payer referral efforts are limited to varying extents by several factors, and that payers typically prefer to remain hands-off. They added payers do not normally offer guidance to providers on how to refer members, and only provide benefits or reimbursements for physical activity (e.g., Silver Sneakers), not arthritis-specific interventions. These programs are generally covered for only Medicare Advantage (MA) members as well. This lack of benefits or reimbursements for physical activity may be related to payer hesitancy surrounding care beyond hospitals; one payer noted that it is difficult to convey that healthcare is more than just provider interactions. The interviewees noted payers also face challenges in demonstrating cost avoidance for programs, which can make it difficult to prove their value and expand their reach. Some of the major barriers to payers piloting a program, for example, include showing the value of the benefit and then funding the pilot.

Although payer referral efforts are limited, interviewees posited some payers' current efforts signify future opportunities. For example, utilizing payer care and case management to connect members to resources and guide them to community programming could indicate an opportunity to refer patients to programs through existing payer resources without increasing provider workloads.

An interviewee from Humana Kansas highlighted another potential opportunity to use predictive analytics to look at claims data and predict which members are good candidates for physical activity-based interventions and programs. This data could then be given to healthcare providers (perhaps those with risk sharing contracts) or even care or case managers to connect members to interventions and programs. For example, Humana Kansas partners with provider groups to refer members to the National Diabetes Prevention Program lifestyle change program (National DPP). The payer sends the provider groups lists of members that are exhibiting risks related to pre-diabetes and diabetes and guides the providers to send members to the National DPP. Similar predictive analytics capabilities could be coordinated by payers and applied to identify members that could benefit from physical activity-based interventions and programs specific to patients with arthritis. However, while payers could engage in data-sharing efforts to identify referral opportunities, the interviewee added they may be hesitant to share such data (with providers, specifically); payers generally prefer not to share proprietary information on members.

A UnitedHealthcare representative noted that they have taken steps to create their own fitness program. While Renew Active is not designed specifically for patients with arthritis, many of the fitness and related services in the program, which is available to Medicare Advantage members, could be beneficial for these patients. The primary benefit included in Renew Active is free access to a network of 23,000 gyms across the country, but patients also gain access to digital workout videos, virtual classes, and a personalized fitness plan. Outreach teams at UnitedHealthcare work with providers to ensure they are aware of the benefit and can offer it to eligible patients. The interviewee added the payer is also hoping to create a pilot program based on YMCA's condition-based programs. Once studied and reviewed for success and value, these efforts could be used as a model when approaching pilot programs, specifically focusing on addressing important needs for target populations, compensation contracts with fitness centers, and connecting with providers on available resources. Utilizing care and case managers, leveraging predictive analytics to identify eligible members, and including gym membership and other program membership or

opportunities as a member benefit all represent opportunities for payers to contribute to physical activity-based intervention referral efforts."

Section 4: Key Considerations for Development of an Evidence-Informed Approach

Increase integration efforts

This section includes integration recommendations for screening, counseling, and referral. This section also highlights the examples of integrated care teams and stakeholders and the different roles that they can play. (pg. 40 of final report)

Screening

A variety of discussions in interviews and listening sessions revealed opportunities to encourage and increase screening integration into the clinical workflow. For instance, the Montefiore Health System interviewee noted focusing on initial clinical leadership buy-in to further encourage their arthritis-related screening integration. They also determined screening integration would require both formal and informal leaders to champion change.

One interview suggested that implementing screening strategies that physicians are already familiar with—such as the SBIRT model—may simplify the process. The EIM model represents another beneficial opportunity; it was developed to fit within existing clinical workflows where healthcare providers are already familiar with such a process, circumventing the need to teach a new provider approach. Identifying simplified and streamlined models and processes could likely aid screening integration efforts, particularly as they relate to provider satisfaction and comfort.

As noted previously, several health systems have successfully integrated PAVS into their EHRs. However, they described these efforts as very time-intensive and difficult. According to one interview, if these challenges can be overcome, integrating screening measures into EHRs might better position providers to receive reimbursement. Increased reimbursement could thus help to make the case for screening integration.

An evidence-informed approach should consider obtaining diverse leadership buy-in, leveraging familiar models and processes to minimize provider disruption, and preparing for challenges around EHR integration efforts by identifying the benefits of increasing screening integration efforts. Keep in mind additional chronic diseases that could benefit from increased arthritis-related screening efforts and include them in decision-making processes where relevant. For example, 33.7 percent of adults who have arthritis also have diabetes, and 36.4 percent of adults who have arthritis also have heart disease.

Counseling

Increasing arthritis-related counseling integration efforts largely revolves around the care team. Encouraging other care team members—particularly **non-physician care team members**—to screen, counsel, and refer patients can relieve burden on providers. The evidence-informed approach should consider including an **integrated care team inclusive of physicians, nurses, physical therapists, occupational therapists, exercise physiologists, care coordinators, CHWs, mental health specialists, health coaches, and others** who are well-coordinated to provide patient-centered care.

Emphasizing patient-centered care can also assist with increasing counseling integration efforts. Patient-centered care refers to working with each patient to identify their unique goals and priorities and

considers their level of readiness for various treatment and management options. An evidence-informed approach should work to develop an integrated, coordinated care team focused on patient-centered care, as it can significantly improve and increase counseling integration efforts.

Referring

Working to increase arthritis-related referral integration efforts includes ensuring referrals are made and documented, and that follow-up with the patient occurs to see if they attended the program they were referred to. Follow-up with physicians (when their patient joined a program) and how their patient did (progress throughout the program), increases confidence and trust in the referring provider. Montefiore Health System accomplished this with their National DPP where they provided patient progress or success story data back to the referring provider. This data served as a positive reinforcement tool for providers as they could see the progress of their patients. Representatives from APTA also expressed the desire for a closed-loop referral system so **physical therapists** can hear about the success of the programs or patients that enrolled in them.

Interviewees expressed difficulties achieving a two-way referral system. For example, one interviewee noted that their patients are typically referred to **CBOs**, which likely do not have the necessary infrastructure or resources to incorporate a bi-directional referral process. They added that some program management platforms with bi-directional referral capabilities may be more feasible for CBOs. Additionally, integrating a bi-directional referral process that is feasible for both providers and CBOs (or other organizations) will be a challenge; however, it could add significant value for involved parties and increase referral integration efforts.

Finally, access to a centralized source for referrals has proven to be of significant value to providers. A central referral platform allows providers to have a single point of contact rather than identifying and developing workflows with several programs across multiple CBOs, and thus reducing provider burden. Given the value of a bi-directional referral system and a centralized referral platform expressed from several providers across interviews and listening sessions, an evidence-informed approach should include these as components to increasing referral integration efforts.

Figure 1: Care Team Members Mentioned in the Final Report

This figure includes a list of both traditional and non-traditional care team members that may have an opportunity to impact the care continuum for a person with Osteoarthritis.

Care Team Member	Areas of Opportunity
Arthritis Advocacy Organization (AAO)	• Serve as a centralized, trusted referral source to connect providers to CBOs or AAEBIs
Care Managers/Social Workers	• Work with payers, providers, or care coordination teams to help identify community programs and resources to connect to patients • Identify self-management and other evidence-based interventions for referral
Community Based Organizations (CBO)	• Serve as a bidirectional referral hub for physical activity-based or evidence-based interventions and providers • Host/Conduct physical activity-based or evidence-based interventions • Perform physical activity-related screenings or provide physical activity-related counseling (depending on CBO)

	• Conduct proactive patient outreach
Community Health Workers (CHW)	• Conduct physical activity-related screenings • Conduct proactive patient outreach • Identify self-management programs and other evidence-based intervention for referral • Help overcome challenges related to social determinants of help • Provide culturally-relevant solutions
Dietician	• Support self-management counseling efforts (related to healthy eating) • Identify self-management and other evidence-based interventions for referral
Exercise Physiologist	• Conduct physical activity-related screenings • Support physical activity-related counseling efforts • Identify self-management and other evidence-based interventions for referral
Health Coaches	• Conduct physical activity-related counseling • Identify self-management and other evidence-based interventions for referral
Medical Assistants (MA)	• Conduct physical activity-related screenings • Support physical activity-related counseling efforts • Conduct proactive patient outreach
National Organizations (e.g., CDC, ACR, APTA, EIM, etc.)	• Develop arthritis-related education resources • Develop clinical practice guidelines • Develop or promote physical activity-based or evidence-based interventions • Identify funding opportunities for states or other organizations for activities such as research, chronic care management, AAEBI promotion, etc.
Nurse	• Conduct patient outreach • Participate in physical activity-related screenings or counseling efforts • Identify self-management and other evidence-based interventions for referral
Occupational Therapist (OT)	• Conduct physical activity-related screening or counseling • Identify self-management and other evidence-based interventions for referral
Orthopedic Specialists	• Conduct physical activity-related screening or counseling • Identify self-management and other evidence-based interventions for referral • Identify primary care provider or specialist (i.e., PT, Orthopedic Specialist, Rheumatologist) referral opportunities
Payers	• Enable function, pain, and physical activity screening efforts through various incentives and other methods • Offer care management or wraparound service incentives, guiding members to community services • Utilize predictive analytics to look at claims data to possibly predict which members may be good candidates for physical activity-based interventions.

Physical Therapist (PT)	• Conduct physical activity-related screening or counseling • Identify self-management and other evidence-based interventions for referral • Identify primary care provider or specialist (i.e., Orthopedic Specialist, Rheumatologist) referral opportunities
Primary Care Provider (PCP)	• Serve as the point of coordination • Conduct physical activity-related screening or counseling • Identify self-management and other evidence-based interventions for referral • Identify specialist (i.e., PT, Orthopedic Specialist, Rheumatologist) referral opportunities
Rheumatologist	• Conduct physical activity-related screening or counseling • Identify self-management and other evidence-based interventions for referral • Identify primary care provider or specialist (i.e., PT, Orthopedic Specialist) referral opportunities
Sports Medicine Providers	• Conduct physical activity-related screening or counseling • Identify self-management and other evidence-based interventions for referral • Identify primary care provider or specialist (i.e., PT, Orthopedic Specialist, Rheumatologist) referral opportunities
State Health Departments (SHD)	• Promote and aid in the dissemination of evidence-based arthritis-related resources • Identify arthritis or physical activity-related funding opportunities (e.g., grants)