

Key Barriers and Challenges

In our human-centered design session, we will examine the Journey Maps of different individuals in order to identify key gaps and opportunities to increase self-management behaviors, including physical activity and lifestyle change.

This document consolidates relevant information gathered through a landscape assessment of current challenges or boundaries for stakeholders and for patients with arthritis. It contains information specifically regarding key barriers and challenges that care team members, stakeholders, or patients with arthritis encounter. 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.

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Section 1: Function, Pain, and Physical Activity Screening

Limited provider time during patient visits reduces opportunities to screen.

This section suggests using patient-facing screening tools or utilizing CHWs as other members of the care team to provide basic physical activity-related screening measures to address limited time during patient provider interactions (pg. 18-19 of the 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.

Unwillingness to integrate Physical Activity as a Vital Sign into workflow and limited time with patients prevents providers from using the tool.

This section suggests considering the effectiveness and potential to ease provider burden by integrating PAVS into the clinical workflow (pg. 19 of the final report).

As noted above, a major barrier to using the PAVS tool in the clinical setting is the limited amount of time providers have with each patient. Increased provider education around PAVS—particularly communicating that it is a short, two-question assessment—might address provider concerns surrounding time constraints. Interviewees suggested providing opportunities for patients to complete screenings prior to seeing their physicians as one strategy to tackle limited provider time with patients. Other interviewees explained that some providers that are aware of PAVS are unwilling to integrate the screening tool into their clinical workflow, expressing that physical activity education was not part of their residency. For those who do have a low PAVS score, providers may not feel that they have an easy answer to counseling patients on getting more physically active. Efforts to show the effectiveness and the potential to ease provider burden that would result from integrating PAVS or other screening tools into the workflow should be considered.

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Obstacles exist to integrating physical activity-related screenings into electronic health records.

This section describes some challenges that health systems or state health departments face when integrating screening assessments into EHRs, which exacerbates bidirectional referral processes. This section also describes how screening questions should be slightly modified based on a patient's unique conditions, adding another potential layer to this barrier. (pg.19-20 of the final report).

The interviewees discussed some of the challenges with integrating screening assessments into EHRs. One interviewee explained that within EHRs, physical activity screening is typically located in the annual well check-up, creating a gap for patients who do not get an annual check-up. This is particularly an issue for Federally Qualified Health Centers (FQHC), where a lot of their patients do not get annual check-ups due to care access barriers.

Another obstacle to EHR integration is that many states do not have a single EHR system, which restricts the SHDs ability to efficiently collect and analyze data on arthritis referrals and makes bi-directional referral systems difficult to operationalize. As noted above, some health systems have custom-built PAVS into their EHR system, though there is not an established and consistent way to build this measure into different EHR systems. Streamlining the referral process through statewide registries could be an alternate path forward to reduce provider burden and improve care for patients with arthritis. One interviewee noted if they were able to build physical activity-related screening measures into their EHR system, they would be better positioned to receive reimbursement for their evidence-based interventions, though building measures into the EHR system is very time-intensive and difficult.

In some cases, screening questions should be slightly modified based on a patient's unique conditions. For example, asking patients who are wheelchair-bound about their walking activity would not be appropriate. This adds another layer of complexity to custom building screening components into an EHR. However, a provider at the University of Washington is working to adapt and modify the EIM model for patients with disabilities, which could represent an opportunity to apply their adjusted method for EHR integration elsewhere. Additionally, a simple two or three-item scale such as PAVS or EVS that assesses the number of days per week and minutes per day of moderate physical activity may make customizing efforts easier as they do not focus on a specific type of activity.

Lack of arthritis-specific measures prevents potential improvements in screening efforts.

This section specifically mentions looking to HEDIS measures for obesity or to The Care for Older Adults HEDIS measures to help address the lack of arthritis-specific measures for quality or reimbursement. (pg. 20-21 of the final report).

Providers can be encouraged to administer certain screenings (or services) if they are tied to specific measures that are used to assess quality of care and/or to calculate performance-based reimbursement. There are several measure sets in addition to MIPS Measures which are commonly used to evaluate the quality of healthcare, including Health Level Seven (HL7) and the United States Core Data for Interoperability (USCDI), and measures developed and endorsed by the United States Preventive Services Task Force (USPSTF) and the National Quality Forum (NQF). Across interviews with payers and providers, the Healthcare Effectiveness Data and Information Set (HEDIS) was most commonly identified as the measure set used to assess healthcare quality or to calculate performance-based reimbursement. However, there are currently no HEDIS measures directly related to arthritis. Tying the HEDIS measure to reimbursement via prevention and care metrics could also incentivize health systems to improve arthritis care.

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A representative of BlueCross BlueShield of Arkansas suggested turning to HEDIS measures related to obesity. They currently use HEDIS measures in shared savings programs and in patient-centered medical home models to encourage providers to perform certain screenings or services and to improve patient outcomes. While they do not include any incentives specific to arthritis, the payer does emphasize those measures related to treating obesity in patients. The Care for Older Adults (COA) HEDIS measure includes advance care planning, medication review, functional status assessment, and pain assessment for adults 66 years and older. While this measure is also not specific to arthritis, it ensures older adults receive care to optimize their quality of life—particularly through screening to identify functional decline—which could likely encompass arthritis-related concerns in relevant populations. Without existing arthritis-specific measures, incentivizing providers to perform screenings may be more challenging, particularly for those providers who are not participants of value-based care models where reimbursement is based on quality of care or health outcomes.

Lack of payer involvement prevents increased screenings.

This section describes the hesitancy among payers to be involved with function, pain, and physical activity screening efforts (pg. 21 of the 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

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

This section highlights examples from State Health Departments or National Organizations that provided supplement physical activity-related counseling education for providers to help providers achieve patient-driven outcomes (pg. 25 of the 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 the 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

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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.

Insufficient healthcare provider training prevents efficient and timely counseling.

This section included integration recommendations physical activity-related education. This section also highlights an example from USCM Greenville, where they are working to integrate "lifestyle is medicine" curriculum into their continuing education programming (pg. 25-27 of the final report).

Several interviewees highlighted insufficient healthcare provider training as a barrier to counseling patients on the benefits of physical activity. A major concern across the provider and health system interviews was that primary care providers specifically do not receive sufficient training surrounding diagnosing arthritis or physical activity counseling. One rheumatologist from Johns Hopkins emphasized the lack of training among primary care providers can delay treatment up to two years due to inaccurate diagnosis. An orthopedic surgeon added that the current system throws the bulk of the work on primary care providers that lack the necessary training surrounding musculoskeletal diseases. Another orthopedic surgeon noted that providing education for primary care providers on musculoskeletal diseases and warning signs may lead to more timely and appropriate specialist referrals.

One physician noted that many providers who do not receive adequate training during medical school will likely not implement it in practice, highlighting the importance of implementing training on physical activity counseling during medical school. According to several healthcare providers, medical schools' lack of training, education, and exposure to musculoskeletal health may lead to a delay in the diagnosis and treatment of arthritic conditions. Existing cultural barriers that can instigate fear among certain patient populations underscore the additional need for culturally appropriate healthcare provider training surrounding discussing culturally-specific concerns with patients. Given these concerns expressed across provider interviews, there is a clear opportunity to increase training efforts among primary care providers.

In a recent Morbidity and Mortality Weekly Report (MMWR), CDC encourages incorporating counseling into clinical training curriculums and continuing education programming as a method to encourage more healthcare providers to provide counseling on the benefits of physical activity. Several interviewees provided examples of where such efforts are taking place. For example, the University of South Carolina

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School of Medicine Greenville (USCM Greenville) is working to integrate the “lifestyle is medicine” curriculum into their medical school and provides training and education to physicians on the EIM model. Similarly, representatives from the Utah Department of Health noted efforts with the Utah Physician Assistant program at the University of Utah School of Medicine to educate aspiring medical professionals about arthritis.

Physical therapists are also working on increasing training and education opportunities to better support physical therapists in physical activity counseling opportunities. For example, the Springfield College Department of Physical Therapy developed a student coaching manual to guide the Doctor of Physical Therapy students through their role as a WWE coach and introduce key principles of the delivery model. The coaching manual includes population health and physical therapy background information, in addition to motivational interviewing and a behavior change model. APTA is currently working to conduct more knowledge translation of their clinical practice guidelines to make them more applicable and actionable for physical therapists. In the development of an evidence-informed approach, consideration should be given to increasing training and education opportunities among healthcare providers, or building off existing efforts similar to those described here.

Limited provider time during patient visits prevents effective counseling.

This section includes recommendations for increasing provider/patient interaction time, such as integrating other non-traditional care team members (pg. 27 of the final report).

Across interviews, a lack of time with patients was cited as a significant provider barrier to effective counseling, noting that some specialists may only get 10 – 15 minutes with each patient while primary care providers may only get seven minutes. The lack of time can therefore prevent more in-depth conversations to counsel patients on physical activity and appropriately refer them to physical activity-based interventions.

To supplement the limited time spent with patients in a clinical setting, providers may share resources that patients can access at home on their own time. For example, the Johns Hopkins Arthritis Center hosts a YouTube channel with a series of educational videos for patients with various forms of inflammatory arthritis. These videos share information about the symptoms and treatment for arthritic conditions, as well as advice to help patients navigate life with their disease. Another potential strategy to the limited time available to counsel patients and to encourage communication throughout the clinical care team and with individuals involved in administering lifestyle change programs is to conduct daily huddles to review lists of patients that may be eligible for certain programs. Montefiore Health System implemented such an approach and noted it has allowed providers to coordinate handoffs to one another and ensure that patients receive as many services as possible while they are in the office rather than needing to come back for an additional visit. The evidence-informed approach should include similar opportunities to address limited provider time with patients, as well as other strategies explored in this report (e.g., utilizing non-traditional care members like CHWs and health coaches).

Patient challenges to engaging in physical activity can impact counseling efforts.

This section describes different types of barriers a patient may experience when engaging in physical activity (pg. 27-28 of the final report).

Patient challenges to engaging in physical activity create additional barriers to counseling. Treating arthritis through physical activity relies on the ability of the patient to self-manage or care for themselves

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and their condition. While some approaches and innovations assist patients with arthritis, they can also reveal barriers for others. For example, one qualitative study revealed physical, psychosocial, social, and environmental barriers to exercise for patients:

- Physical barriers: pain, fatigue, lack of mobility, and comorbid conditions
- Psychological barriers: attitudes, beliefs, fear, and perceived negative outcomes
- Social barriers: lack of support, no one to exercise with, and competing role responsibilities
- Environmental barriers: lack of programs or facilities, environmental conditions, cost concerns, and lack of transportation concerns

Several interviewees further emphasized some of the same barriers above. For example, physical and environmental barriers for rural communities came up across interviews where they stressed the lack of programs, gyms, and other opportunities. Across interviews, fear of exercise increasing pain came up as a major barrier (discussed in further detail in the section below). Successful counseling techniques should include strategies to address such physical, psychological, social, and environmental barriers.

Patient fear of physical activity can challenge provider counseling efforts.

This section includes recommendations for addressing patient concerns and misconceptions about physical activity increasing pain (pg. 28-29 of the 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.

Arthritis is seen as lower priority compared to other conditions.

This section recommends leveraging other chronic disease needs when making the case for AAEBIs rather than solely focusing on arthritis (pg. 29 of the final report).

A common sentiment discussed across interviews was that arthritis itself may not be as high of a priority for providers as other chronic diseases—such as obesity, heart disease, smoking cessation, and hypertension—and competing demands of managing patients with comorbidities can often cause providers to overlook arthritis. Patients with multiple chronic conditions, particularly older adults with

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arthritis, can require complex care, which can make counseling efforts more challenging. Providers are therefore challenged with prioritizing conditions with higher mortality rates when counseling patients with arthritis and may not have appropriate time to address a patient’s arthritis concerns.

When counseling patients on sometimes complex and competing health needs, it can be helpful if providers can reference options that address multiple needs rather than hyper-focusing on one condition. Multiple SHD representatives noted health systems and SHDs should take a broad approach and suggested that AAEBI referrals should be leveraged for other chronic diseases in addition to arthritis. Two additional state health agency representatives suggested making the case for AAEBIs without focusing solely on arthritis, but rather, overarching chronic disease needs. They noted that arthritis efforts may not have as many outspoken advocates with sufficient funding and recommended identifying higher profile organizations with access to funding to propel the work forward by connecting physical activity interventions to multiple chronic disease efforts.

There are limited coding and billing opportunities for arthritis counseling.

This section highlights opportunities for integrating coding and billing for arthritis delivery. This section also highlights additional barriers from that a payer may experience when integrating coding and billing opportunities (pg. 29-30 of the final report).

Coding and billing for arthritis care delivery is a major pain point, particularly for providers attempting to deliver physical activity counseling. The lack of a specific current procedural terminology (CPT) code for physical activity counseling makes opportunities to bill payers for those efforts challenging. However, in January 2020 the American Medical Association (AMA) approved a list of new category III CPT codes that are specifically designated for health and wellness coaching and include physical activity related CPT codes. Category III CPT codes are not federally regulated, and therefore, reimbursement by payers for these codes is optional and payers typically wait for Category I approval before beginning reimbursement. Additional opportunities may exist with leveraging CPT codes for self-management education programs—particularly those requiring a physical activity component—for diabetes patients. These CPT codes could represent a significant opportunity given estimates that among adults with diabetes, the prevalence of doctor-diagnosed arthritis was 47.1% between 2013 – 2015.

To address coding and billing concerns, physicians and physical therapists may use certain ICD-10 diagnostic codes (e.g., Exercise counseling (Z71.89), Physical deconditioning (R53.81), Muscular deconditioning (R29.898)). Most opportunities for using these diagnostic codes occurs within the context of other chronic diseases (e.g., type 2 diabetes, obesity, depression, etc.). Because there is no specific CPT code for physical activity counseling, providers may use therapeutic exercise codes when teaching patients exercises to develop muscle strength and endurance, joint range of motion, and flexibility. However, a Coding and Billing Tips sheet developed by EIM and the ACSM suggests that “Bill for Time” with Evaluation & Management (E&M) codes presents an ideal opportunity to receive reimbursement for counseling efforts. This allows a provider to bill payers if a certain percentage of the patient visit was spent on counseling the patient on physical activity and/or exercise.

On the payer side, interviewees noted each payer may have varying member benefits for physical activity (e.g., gym memberships, subscription to exercise programs, etc.) or “in-house” programs that their members may choose to join (e.g., UnitedHealthcare’s Renew Active program). While these added member benefits are helpful, members and their providers may not be aware of them. Additionally, billable events vary across payers where one payer contract may only consider the completion of a

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program as a billable event, and another payer contract may include outreach, sign-up, and program attendance as billable events. Therefore, an added complexity occurs when a provider must bill different payers at different moments during counseling and/or referral efforts depending on the patient's insurer and/or provider contracts.

There is a lack of value-based reimbursements for arthritis counseling.

This section highlights potential opportunities to incorporate value-based care models to support coordinated and patient-centered care (pg. 30-31 of the final report).

Value-based care models promote and support coordinated and patient-centered care. A rheumatoid arthritis-focused roundtable held in 2018 by the National Committee of Quality Assurance (NCQA) discussed efforts and barriers to developing a value-based care model for rheumatoid arthritis. Three barriers identified include the financial cost of practice transformation, the administrative investment required for practice transformation, and complications arising from a heterogeneous patient population. While opportunities for value-based arthritis care are rare and more work needs to be done to design contracts that incentivize and enable value-based care, the lack of value-based opportunities can be seen as both a barrier and an opportunity to improve arthritis counseling efforts.

A representative from APTA noted that payment for physical therapist screening, counseling, and referring activities is a barrier and bundled payment models may enable physical therapists delivering arthritis care. The UT Health Austin Musculoskeletal Institute currently has one bundled payment contract which covers a large portion of their population. However, they are not compensated under a value-based contract for the bulk of their effort to improve outcomes and avoid unnecessary costs. Another interviewee highlighted a current value-based model related to screening for obesity, which could represent an opportunity to encourage efforts to counsel patients on physical activity, and a potential example for applying this to patients with arthritis. A representative from Intermountain Healthcare also studied self-reported physical activity data and healthcare utilization and cost among patients with various cardiovascular and chronic diseases. They found much lower healthcare utilization among patients who were meeting the recommended levels of physical activity and the data and results significantly influenced the benefit design at SelectHealth, Intermountain's healthcare insurance company. These and other value-based care models, including the challenges and barriers, should be examined in efforts to create an evidence-informed approach to bill for services.

One interviewee noted that value-based arrangements could address payer concerns surrounding lost revenue due to improved member health outcomes. There may also be opportunities to partner with research arms within payer organizations around value-based arrangements. Additionally, arthritis may be a good candidate for the Value-Based Insurance Design (VBID) Model process with the Center for Medicaid and Medicare Services (CMS) because it is a chronic disease that requires more time to evaluate the impact of an intervention.

Section 3: Referral to Physical Activity-Based Interventions:

Access to programs is limited in rural areas.

This section describes utilizing telehealth and leveraging CBOs as potential solutions to providing AAEBI-related services to patients with arthritis in rural areas (pg. 35-36 of the final report).

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Arthritis affects nearly one in three adults in rural areas and several interviewees noted that rural communities often face increased barriers to accessing physical activity interventions compared to urban areas (e.g., gyms, programs, AAEBIs, or other opportunities). As a result, CDC recommends targeting interventions to address rural disparities among patients with arthritis.

One orthopedic surgeon noted that referral efforts often depend on an institution's location and resources. For example, institutions in urban areas typically have access to care navigators that can take on referral efforts and increase referral capabilities. In rural areas, providers likely do not have access to care navigators and therefore must play a bigger role themselves in seeking out opportunities for their patients. However, the limited time available with each patient makes this challenging. Providers in rural areas and smaller communities may therefore prefer to leverage community-based organizations (CBOs) (e.g., churches and local groups) who can facilitate program outreach efforts.

One potential solution to rural disparities is the use of telehealth. A few studies have shown positive results with using videoconferencing and other various forms of telehealth to provide services to patients with arthritis in rural communities. While telehealth can be cost-effective and advantageous for some patients, there may be potential technological barriers to consider among rural populations as well. The CDC also promotes the remote delivery of self-management education and physical activity programs that may offset some of the burden for providers and challenges of rurality, including transportation and program access and availability. Examples of AAEBIs that can be delivered remotely include WWE – Self-Directed or online Chronic Disease Self-Management Programs (CDSMP). For example, the Oregon Health Authority's Arthritis Program is partnering with Oregon State University (OSU) Extension Service to bring the self-directed version of WWE to rural communities in Oregon. The OSU Extension has developed tools to enhance the self-directed WWE program, such as weekly emails from a trained leader and links to additional resources. Each participant commits to self-directed walking sessions three times a week. For people in rural areas, the classes break down barriers to in-person WWE classes, including time and travel. Both the self-directed and group WWE programs allow participants to go at their own pace, on their own time, to improve their arthritis symptoms.

Leveraging CBOs and telehealth represent just two potential methods to increase referrals to physical activity-based interventions in rural communities.

Integrating referral processes into existing workflows can be difficult for providers and community-based organizations.

This section describes the various barriers to integrating referral processes into a clinical workflow including CBO infrastructure needed to accept referrals, potential to increase provider burnout, or various technology-related difficulties (pg. 36-37 of the final report).

Several studies have evaluated the effectiveness of integrating referral efforts to physical activity programs into the clinical workflow. One study examined effectiveness of a clinic-based PAVS assessment and referral protocol to YMCA exercise programs compared to PAVS alone. The study found improvements in self-reported physical activity after twelve weeks in the PAVS plus referral group. Several other meta-analyses and systematic reviews found that physician counseling and exercise referral programs improve patient's physical activity for up to twelve months.

While providers may understand the important role physical activity can play in the treatment and management of arthritis and despite evidence of improved physical activity among patients referred to

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physical activity-based programs, significant challenges were raised in our interviews. A representative from Montefiore Health system noted that if processes to screen and refer patients to programs that support physical activity are not well-integrated into existing workflows, execution will be inadequate and may increase provider burnout. An Intermountain Healthcare interviewee pointed to difficulties in asking providers to screen patients and refer them to community-based physical activity programs, particularly if EHRs are not set up to capture data from screenings or communicate with CBOs for referral. This barrier was so significant for another provider that they decided to forgo external programs entirely, opting instead to build physical activity-based treatment programs internally in order to facilitate better data visibility and closed-loop referrals. Some providers even face difficulties referring patients to other providers when workflows are not set up to appropriately facilitate referrals (e.g., handoffs between primary care providers and physical therapists). While there is strong evidence for integrating referral efforts into the clinical workflow, an evidence-informed approach will need to address the challenges described above.

In addition to integrating referral processes into the clinical workflow, physical activity-based interventions are often hosted by CBOs who need to stand up the infrastructure to receive these referrals. Many of these community organizations currently receive referrals through fax. Updating processes to integrate digital referrals requires significant effort and resources, particularly if the CBOs must prepare to receive referrals from several different providers. Oftentimes, these organizations do not have the infrastructure or resources to update their systems or purchase a technology referral platform that aligns with the providers referral system. As efforts to integrate referral processes into clinical workflows are discussed, consideration should be given to the challenges that might arise from the organizations that are receiving the referrals.

Payer efforts to refer members to programs are limited.

This section includes examples on how payers are working to address limited referral efforts such as looking at claims data, further communicating in-house benefits for members, and utilizing outreach teams (pg. 37-39 of the 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

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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.

Opportunities for reimbursement and funding for referral efforts are limited.

This section explains that opportunities for reimbursement and funding for referral efforts are limited and includes recommendations for health systems when designing referral procedures (pg. 39 of the final report).

A primary barrier preventing the referral of patients to physical activity-based interventions is the lack of reimbursement or sustainable funding for the referral to and delivery of these programs. Frequently, even if providers are aware of AAEBIs and have processes to refer patients to programs, these efforts are uncompensated by payers. Organizations administering these programs are typically funded through a blend of grant funding and payments from participants. Furthermore, grants from SHDs face competing funding priorities and are not always guaranteed from one grant cycle to the next. When reimbursement opportunities do exist, a representative from Montefiore Health System recommended including the coding and billing departments within health systems when designing referral procedures to ensure seamless reimbursement occurs.

As noted previously, the Exercise is Medicine Coding and Billing Tips Sheet provides some helpful advice on securing reimbursement for screening, counseling, and referral for exercise-based interventions, particularly by using evaluation and management codes. However, while some providers may be able to access some reimbursement for referral efforts by documenting evaluation and management codes, this reimbursement often does not represent the level of effort put toward referral processes and the codes

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are not available to all providers. For instance, surgical or post-operative providers may have a particularly difficult time garnering reimbursement through these codes.

