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

Session 3: Problem and Opportunity Matrix

OBJECTIVE: The overall objective of this session is to align on and explore opportunity areas, including actions to successfully implement the opportunities, various care team member involvement, and end outcomes that would indicate success.

TIME: Tuesday, March 14, 2023, 10:00am – 12:00pm ET

RECORDING LINK: Group Discussion link (Link)

MIRO BOARDS: Prioritizing Opportunity Areas to Explore (Link)

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Overall Summary

The third human-centered design (HCD) session focused on exploring key opportunities to increase self-management interventions that are viable, feasible, and desirable. The main session activity discussed the feasibility and impact of nine key ideas, as outlined below. The following recommendations—drawn from both the discussion and the responses from a follow-up form—highlight key considerations that could increase self-management behaviors, including physical activity and lifestyle change. These recommendations are discussed in more detail in subsequent sections.

Reimbursement for Non-Clinical Partners

- Consider a value-based approach and partnering with payers.
- Build the case to reimburse qualified healthcare professional (QHP) status for exercise physiologists.
- Advocate for the ability to pay for physical activity with Health Savings Accounts.
- Compensate non-clinical partners.
- Provide resources to referral partners.
- Look to other evidence-based programs.

Identifying and Eliminating Health Inequities

- Support rural populations.
- Engage with community experts and leaders.
- Understand the needs of the population.

Educational Resources

- Review existing resources.
- Patients should be guided to the materials that match their needs.
- Streamline access to a central repository.
- EHR solutions raise cost concerns.
- Materials should consider accessibility and cultural competency.

Unify Screening Methods

- A simple screening tool should be used to triage patient needs.
- A screening tool to identify early arthritis is needed.
- PROMIS can be a starting point.
- Simplify existing efforts.

Streamlining Referrals to AAEBIs

- Increase sustainability of community programs.
- Increase awareness.
- Provide a comprehensive platform.
- Self-directed programs can be a useful option.

Connecting PCPs with External Care Team Members

- Demonstrate the value of external care team members.
- Implement support systems.
- Support networks of CBOs.
- Integrate patient navigators to help patients connect with the right support.

Community Organizations to Support Follow-up

- A bi-directional communication platform should connect providers to organizations.
- CBOs need resources to implement platform solution.

Active Counseling

- Consider all possible care team members to provide counseling.
- Aggregate programmatic information to discuss real-time with patients.
- Develop a patient-centered decision aid tool.

Screening Before a Visit

- Screening tools should be patient centered.
- Communication should take advantage of multiple modalities.
- Help the clinicians understand the patient's lived experience.
- Increase incentives (both social and financial) to increase screenings.

Key Opportunities Deep Dive

Expert Panel members spent the balance of the session discussing possible opportunities for self-management behaviors, including physical activity and lifestyle change, ultimately improving function and quality of life. Ideas generated in Session 2 were consolidated and distilled to nine key ideas, which were both discussed during the session and reflected upon in an Impact & Feasibility Form at the end of the discussion. In both the discussion and the form, Expert Panelists were invited to reflect on the potential impact and feasibility of each idea and recommend ideas for increasing impact/feasibility. Although key takeaways are organized below under a specific topic, many of the discussion points, recommendations, and next steps could apply to more than one question.

Full comments discussed in the session are included in Appendix B: Complete Comments from Discussion.

REIMBURSEMENT FOR NON-CLINICAL PARTNERS

How might we identify reimbursement opportunities for non-clinical partners who are asked to implement components of the screening, counseling, and referral process?

A key item for consideration is thinking through how the participating non-clinical partners in the screening, counseling and referral process are reimbursed. One barrier to this reimbursement is a traditional fee-for-service (FFS) reimbursement model in which it is not always immediately apparent (or possible) to reimburse services that would ultimately help the patient. Often, services that could provide the needed support for arthritis patients do not have a clear reimbursement path, leaving non-traditional care team members such as community-based organizations (CBOs) relying on short-term grants to provide services. One Expert Panel member indicated that a value-based approach can incentivize providing patient access to the right services at the right time and make it easier to integrate other care team members (including exercise professionals) who could play an increased role for patients with arthritis. According to another member, UT Health Austin had discussed building condition-base bundling, which is an alternative to a traditional FFS payment model that could provide the flexibility to pay behavioral health specialists, physical therapists, and others to manage conditions until a surgeon is needed. While this type of alternative payment model could solve some of the challenges for better integrating different types of support for patients with arthritis, most existing contracts are FFS-based, and thus would need to add ancillary services as part of the care model. Payment model challenges also represent an opportunity for payers and accountable care organizations (ACOs) to play a role in reimbursing non-clinical partners.

If a new care model successfully increases referral opportunities, CBOs and other non-clinical partners will require sufficient resources to support lifestyle health improvement and social needs for people with arthritis. One member emphasized allowing them to practice at the highest level of their licensure or skillset with adequate compensation. These considerations will ensure a sufficient pool of partners to pull from building out reimbursement opportunities. Members also discussed looking to the National Diabetes Prevention Program (National DPP) lifestyle change program delivery practices, where lifestyle coaches need to complete a short training to deliver the program, rather than relying on doctors or nurses to administer. One member suggested that AAEBIs could expand delivery options through a similar accreditation process. However, another member added that AAEBIs would require resources to achieve such accreditation.

Key Takeaways:

- **Consider a value-based approach and partnering with payers:** While most existing payment models are FFS, a value-based approach could incentivize access to more expansive care team members, including non-clinical partners.
- **Build the case to reimburse qualified healthcare professional (QHP) status for exercise physiologists:** For systems that continue under FFS reimbursement, it will be important for exercise physiologists to be reimbursed.
- **Advocate for the ability to pay for physical activity with Health Savings Accounts:** Continued efforts in support of the Personal Health Investment Today (PHIT) Act will allow patients to utilize health savings accounts to pay for physical activity resources.
- **Compensate non-clinical partners:** All care team members should be permitted to practice at the top of their licensure or skillset while also receiving appropriate payment for the services provided to ensure it is economically viable.
- **Provide resources to referral partners:** Increasing referrals could place a strain on CBOs and non-clinical partners that assist people with arthritis. Ensuring these partners have adequate resources will allow them to best support an influx of referrals.
- **Look to other evidence-based programs:** The National DPP lifestyle change program provides short trainings to non-clinical lifestyle coaches that deliver the program. AAEBIs could consider similar delivery options via accreditation opportunities.

IDENTIFY AND ELIMINATE HEALTH INEQUITIES

How might we identify and eliminate health inequities in the screening, counseling, and referral process for self-management behaviors?

One member started the discussion by highlighting the inequities experienced by community-based hospitals and rural populations. While being mindful of gender, racial, and ethnic differences is important, access to care is a major concern, particularly in rural areas. Public-private initiatives or partnerships represent an opportunity to address inequities seen in community-based hospitals and rural areas. One solution includes speaking to community members about existing resources and/or gaps in resources. Additionally, ensuring the availability of AAEBIs in rural areas will improve referral pathways, including education on the availability of online, asynchronous programs.

Another consideration for identifying and eliminating health inequities is to engage with community experts and leaders. One Expert Panel member noted that addressing health literacy and bias should involve working more with community health workers, care managers, and/or family members. Other considerations include engaging with existing initiatives to address health equity at the local and federal levels and to better understand how barriers to physical activity should guide counseling and referral.

Key Takeaways:

- **Support rural populations:** Populations in rural areas can experience barriers to accessing care, specifically due to lack of transportation options. Consider public-private initiatives or partnerships to address rural inequities while also ensuring the availability of AAEBIs in rural areas. Additionally, assist rural areas with engaging the community to assess existing resources and/or gaps in resources.
- **Engage with community experts and leaders:** To understand how to overcome challenges in specific populations, speak to those already engaged with these populations.
- **Understand the needs of the population:** Health systems may not be able to solve systemic barriers immediately, but the screening, counseling, and referral process should account for and help overcome barriers (including social determinants of health).

EDUCATIONAL RESOURCES

How might we engage and empower care team members to best utilize educational resources (apps, handouts, web links) to increase physical activity?

Expert panelists believed that educational resources—both for providers to understand the benefits of physical activity and for patients to access educational content—could increase physical activity and other self-management behaviors. Johns Hopkins, for example, has developed patient-centered videos available on YouTube, which garner millions of views. Its exam rooms display QR codes that direct to the resource landing page with targeted information. Expert Panelists emphasized the importance of making resources—such as those available at Johns Hopkins, the Arthritis Foundation, and the Osteoarthritis Action Alliance—available for all health systems and accessible for patients. A central repository from a trusted source with up-to-date information (including the availability of AAEBIs) would increase uptake of these resources and ultimately increase physical activity. However, it's important that these educational resources be tied to specific diagnosis and patient needs. Accessing the wrong information could potentially increase pain, and it needs to be ensured that patients access the right information based on their health status.

The group agreed Electronic Health Records (EHRs) hold potential as an important tool for referrals to resources, but they also have inherent challenges. Within Johns Hopkins' EHR system, providers can prescribe the YouTube videos and add them to an after-visit summary linking directly to the video. One member noted that Physical Activity Vital Signs (PAVS) can alert the provider or care team to the amount of physical activity a person is engaging in, and that placing arthritis on the problem list would allow for EHR-integrated artificial intelligence to prompt the provider to address arthritis-related concerns and refer the person to evidence-based resources. EHR support would also address physician barriers related to lack of time and understanding of referral opportunities. In contrast, members highlighted that EHR-related solutions

could exacerbate inequities faced by rural hospitals and federally qualified health centers that lack the budget for expensive additions to their systems. One member emphasized the need to make educational tools freely available through as many EHR vendors as possible to address inequities.

Key Takeaways:

- **Review existing resources:** Consider existing resources and opportunities to expand or improve access to them. For example, Johns Hopkins' patient-centered videos available on YouTube could be shared by other health systems.
- **Patients should be guided to the materials that match their needs:** Accessing the wrong information could potentially hurt patients by encouraging them to engage in activities could worsen pain. Patients need to be guided to the resources that match their health status.
- **Streamline access to a central repository:** Organize arthritis-specific materials in a central access point/repository for patients and providers. Consider access for disadvantaged populations. This will allow resources to be easily sourced, evaluated, endorsed, and distributed.
- **EHR solutions raise cost concerns:** Though EHR-driven solutions may promote automation and referral processes, it is important to consider the cost-related barriers related to additions to EHR systems.
- **Materials should consider accessibility and cultural competency:** The development and sharing of materials should consider accessibility requirements, reading levels, and language/cultural considerations.

UNIFY SCREENING METHODS

How might we unify screening methods to standardize time of collection and method of capture, and screening components that support care team decisions in term of how to coordinate and interact with the patient?

A standardized screening could increase the number of patients being guided toward appropriate self-management behaviors, but there are a number of considerations that Expert Panelists noted.

For example, while we are specifically considering the need to screen for physical activity, the lack of a quality, arthritis-specific screening tool could complicate the issue. For example, Exercise as a Vital Sign (EVS), is an effective screening tool for physical activity levels, but not for early-stage arthritis, especially inflammatory arthritis diseases. An Expert Panelist noted that there could be a research call out for diagnostic screening tools for early arthritis stages, before chronic pain exists or before there is a quality of life (QOL) impact.

One physician noted their experience in sharing digital screening forms, specifically the Patient Reported Outcomes Measurement Information System (PROMIS), to asses pain or functionality issues and using nursing staff to support patients filling out questionnaires.

One member called for parsimony in screening questionnaires. This member explained that providers are already buried in screenings, so it may be helpful to think about short screening tools that support staff can mitigate but that also trigger more in-depth questionnaires for the patient. Another member cited the use of PROMIS as a good starting point for assessing the level of impact from the arthritis-related symptoms. There are metrics within PROMIS that ask about pain and function, and this member suggested utilizing this metric again after an intervention (such as an AAEBI) to assess health-related quality of life (QOL).

In thinking about PROMIS and the questions that screen for possible arthritis, one member suggested the possibility of adding questions to the PROMIS to screen for both physical activity and arthritis simultaneously. Assessing the health-related QOL of arthritis on a patient may help with more appropriate AAEBI referral or additional care. One member indicated that the screening tools need to be comprehensible and culturally relevant to patients, address or trigger more in-depth questionnaires, and lead to conversations around goals and accessible resources. There could also be a need to screen for other needs, such as mental health challenges often associated with chronic pain and other social determinants of health.

A barrier to increasing screenings, however, is the lack of reimbursement for these services, and there needs to be billing codes and/or penalties to incentivize aligning clinician behavior with desired outcomes.

Key Takeaways:

- **A simple screening tool should be used to triage patient needs**: A short, simple screening tool should be used first to identify patients, and then a more in-depth assessment can determine what clinical pathway a patient should follow.
- **A screening tool to identify early arthritis is needed:** More research is needed on arthritis-specific screening tools that can identify early-stage arthritis before it becomes chronic pain.
- **PROMIS can be a starting point:** PROMIS may be a good screening tool to consider using as a starting point for assessing the level of impact from arthritis-related symptoms and for continuous patient evaluation after an intervention.
- **Simplify existing efforts:** Providers often have many screenings and questionnaires to consider; a short screening could rule out other diseases or comorbidities and trigger a more in-depth health questionnaire or screening tool.

STREAMLINE REFERRALS TO AAEBIS

How might we streamline referrals to AAEBIs based on resources available within the community?

The inability to integrate available resources and programs in the community into clinical referral pathways is a known barrier for patients with arthritis and other chronic diseases. Expert Panelists surfaced some of these community-clinical linkage challenges as they relate to care for arthritis patients and offered some potential solutions.

One known barrier is that while AAEBIs provide a valuable service, CBOs are often provided grants to deliver and support these programs, leading to unsustainable program offerings. Some organizations have considered charging a fee for individuals to participate, but healthcare providers are hesitant to refer patients to programs with fees. Expert Panelists agreed that in order to leverage AAEBIs, there needs to be sustainable pathways for CBOs to provide these programs and other wraparound support without being reliant on grant funding or needing to pass along a fee to the individual participating in the intervention.

One member noted that though the conversation around cost of delivery and referral systems is important, AAEBIs in general need to be more accessible and available to providers and patients. To increase awareness of AAEBIs, using an automated system within an EHR or another type of central repository could be leveraged to organize known resources categorized by programs, location, organization offering the program, etc. Another member suggested starting with EHRs may be too challenging, costly, and slow going, but utilizing an app could provide links to available evidence-based programs and resources available to patients at no cost.

Building on this idea, members again highlighted lessons that could be learned from the National DPP lifestyle change program. Specifically, the program has an online central repository that lists every CDC-recognized organization that offers the program and can be organized by state, down to the specific address where the organization is located. One member highlighted how they have identified patients with a pre-diabetes diagnosis and worked with providers to refer them to the National DPP lifestyle change program. A similar process to identify individuals who qualify for AAEBIs could be implemented. Others agreed and recommended starting with what programs are known to work well and are more easily accessible (e.g., online self-management programs) and then scale up to additional programs.

Key Takeaways:

- **Increase sustainability of community programs:** Consider sustainable pathways for CBOs to provide AAEBIs and other wraparound support without being reliant on grant funding.
- **Increase awareness:** Using a central repository to categorize all available interventions and resources may be one effective way to increase awareness for providers and patients of available AAEBIs.

- **Provide a comprehensive platform:** Streamlining the referral mechanisms will be difficult and unreliable if both ends of the communication pathway are unstable; consider creating one platform or digital tool with bi-directional referrals and data sharing that is compliant with HIPAA requirements.
- **Self-directed programs can be a useful option:** Consider self-directed evidence-based interventions that are widely available, do not require a trained professional to deliver, and are at no cost to patient as a viable option for referral when other options for AAEBIs are not available.

CONNECTING PCPS WITH EXTERNAL CARE TEAM MEMBERS

How might we intentionally connect PCPs with outside non-traditional care team members (e.g., CHWs, health coaches, health advocates), CBOs, and other partners to alleviate time crunches?

A key step to integrating non-clinical partners is to build trust between clinical and non-clinical organizations. Clinicians want to feel that they can entrust the care of their patients to referral partners, and they may be hesitant to refer to or include other entities into a care process if they are not confident in their ability to understand the nuances of arthritis.

One member noted that providers need to understand what non-traditional care team members and the evidence-based programs they deliver offer patients before referring patients to them. A health system that one member represents actively tracks providers and practices who refer their patients to the National DPP lifestyle change program and identifies those who are doing this well and why. They then take this information to educate other providers and practices who are not actively referring patients on these referral opportunities to encourage connection with outside organizations and increase referrals.

Given primary care providers are already strapped for time, additional support systems and resources are likely needed to effectively connect with non-traditional care team members and CBOs. One member suggested partnerships with state and local health departments that can support health systems by connecting them to AAEBIs in local communities and other programs delivered by community experts.

Another key aspect in connecting PCPs and non-traditional care team members that builds trust is ensuring a bi-directional communication process is in place. However, this has been a long-standing challenge particularly between the healthcare and public health systems. While platforms like UniteUs can be integrated in an EHR to help providers connect to CBOs and provide bi-directional communication, there are vendor permission challenges and HIPAA business agreements that make this process difficult. One member noted that an increasing number of CBOs are collaborating as local, regional, or statewide networks to work with health systems to co-design a platform to remove burdens inherent in the referral process. They emphasized the importance of involving all key players in the design of such a platform.

Often, a patient who could benefit from participating in an AAEBI has more immediate needs that prevent them from enrolling or actively participating in the program. Community health workers (CHWs), health coaches, and patient navigators are key non-traditional care team members who could be embedded in the care team to help alleviate primary care provider time crunches and support a patient with connecting to the right resources, programs, and places.

Key Takeaways:

- **Demonstrate the value of external care team members:** Primary care providers need to know what the various providers could do for their patients; consider tracking data showing referrals and program participation to link ROI to program referrals.
- **Implement support systems:** Consider implementing support systems, resources, and partnerships to boost PCP connection with non-traditional care team members and CBOs to offset limited provider time.
- **Support networks of CBOs:** Consider co-creating a local, regional, or statewide network or platform that can support referrals and enrollment to AAEBIs and includes lines of communication between health systems and external organizations.
- **Integrate patient navigators to help patients connect with the right support:** Utilize CHWs, health coaches, and patient navigators to get patients to the right resources, programs, and places.

COMMUNITY ORGANIZATIONS TO SUPPORT FOLLOW-UP

How might we create opportunities for community organizations to support proactive follow-up to help people navigate to services following an appointment with their PCP?

Members noted that follow up from CBOs would help reinforce the referral process and keep AAEBIs and other educational opportunities in the forefront of providers minds. However, to successfully follow-up with individuals, a clear communication channel with bi-directional information sharing capabilities will be necessary. Such communication pathways can support the building of trust between provider organizations and external organizations or programs. Members also highlighted the need for financial support for staff to follow-up with patients, both on the healthcare system side and the community organization side.

The feasibility of proactive follow-up will depend on the type and amount of follow-up needed. Less resources are necessary if the follow-up consists of simply contacting the patient after a referral. However, we know that many barriers can stand in the way of an individual enrolling in a program, and follow-up may require activities to address those barriers. In these cases, additional resources are necessary, such as additional staff and funding, and feasibility may be harder.

Key Takeaways:

- **A bi-directional communication platform should connect providers to organizations:** Consider a communication pathway for bi-directional sharing between healthcare settings and community organizations where their patients are referred.
- **CBOs need resources to implement platform solutions:** Consider the type of follow-up and the resources needed to support follow-up activities.

ACTIVE COUNSELING

How might care teams best provide active counseling to patients with arthritis according to their specific diagnosis?

Counseling patients with arthritis on what they can be doing to improve quality of life is an important part of the ideal model. Preferably, this counseling would help identify and overcome barriers and be a joint process between a clinician and the patient to work toward patient-driven outcomes. However, PCPs rarely have adequate time during patient visits to do extensive physical activity counseling, and Expert Panelists highlighted opportunities to use other care team members to deliver counseling. Examples include nursers, peer educators, health coaches, CHWs, and exercise physiologists. One member mentioned the chronic disease management model that uses nursers to provide coaching to patients outside of their appointments.

Beyond which care team members offer counseling to patients, a question remains around what counseling to provide based on a patient's specific diagnosis and needs. Members noted that this first starts with a solid understanding of available interventions and programs. One member highlighted a decision aid used by physical therapists to help them identify programs best suited for their patients, inclusive of a description of each program, the target population, program content, intensity of activities, the format of the program classes, patient baseline activity level, and program length. However, physical therapists in rural communities still had a hard time identifying available programs in the area. Another member suggested a slightly more generic and higher-level decision tree for specific clinicians (primary care provider, rheumatologist, orthopedic, etc.) that identifies when to refer to physical therapy, physical activity, or behavioral and cognitive support. It was noted that a simple and practical tool like this would likely be preferred by clinicians. Another member highlighted the importance of addressing adherence in a decision model they created in a large health system. This model focused on two factors—patient complexity and patient activation—to consider health and wellbeing, social determinants of health, health literacy, and service coordination to encourage removing barriers and activating patients to be involved in their own care.

Key Takeaways:

- **Consider all possible care team members to provide counseling:** Primary care providers have limited time to offer counseling to patients; consider using other care team members to deliver counseling.
- **Aggregate programmatic information to discuss real-time with patients:** The impact of counseling could be improved by ensuring broadly available interventions to counsel on.
- **Develop a patient-centered decision aid tool:** Develop a decision aid tool to help various clinicians determine which program or intervention is best suited to a patient, and asses the patient's ability to engage in the plan.

SCREENING BEFORE A VISIT

How might we integrate arthritis screening questions into the PCP appointment prior to visit creating a wrap-around approach where screening is done before the PCP visit (e.g., integration of questions through EMR/patient portal)?

The group agreed that the time with the provider is limited, and being more efficient in gathering this data before the office visit allows for more shared decision making with the patient. One member suggested using other care team members, such as the nursing staff, to support patients filling out screenings and questionnaires prior to seeing the provider. To streamline pre-visit screenings and questionnaires, members noted building it into a patient-reported information request which patients can indicate if they would like to discuss the results with the physician. Another member noted the need to offer different screening modalities to address potential barriers such as poor broadband, discomfort with technology, and distrust among patients. Such modalities could include emails, texts, or provider or care team phone calls to their patients prior to a visit.

Screening questions prior to a visit is an ideal opportunity to collect patient reported information and outcomes. Members suggested including questions that help providers and care teams better understand arthritis and its impact on health, function, and quality of life.

Key Takeaways:

- **Screening tools should be patient centered:** Build the screening into a patient-reported information request, where patients can indicate if they want to discuss the results with the physician.
- **Communication should take advantage of multiple modalities:** Create a standard, quick form with more than one way to access it such as emails, texts, or calls.
- **Help the clinicians understand the patient's lived experience:** Given the prevalence of arthritis, lobby for inclusion of questions that help providers and care teams to better understand arthritis and its impact on health, function, and quality of life.
- **Increase incentives (both social and financial) to increase screenings:** Consider providing financial incentives to patients and providers for completing screenings and sharing the health system's overall percentage of screening completion to encourage via positive peer pressure.

Appendix A: Attendees

ADVISORY COUNCIL

Name	Organization
Adam Burch, DC, MPH	New Hampshire Department of Health and Human Services
Alisa Vidulich, MPH (absent)	Arthritis Foundation
Anita Bemis-Dougherty, PT, DPT, MAS	American Physical Therapy Association
Clifton O Bingham, III, MD	Johns Hopkins Arthritis Center
Elizabeth A. Joy, MD, MPH, FACSM, FAMSSM	Intermountain Healthcare
Erica Anderson	Humana
Gail Hirsch	Massachusetts Department of Public Health
Gregory J. Welk, Ph. D.	Iowa State University
Heather Hodge, M.Ed	YMCA of the USA
Heather Kitzmanm Ph.D.	UT Southwestern Medical Center
Jennifer Raymond	AgeSpan, Massachusetts
John Andrawis, MD/MBA	Torrance Memorial Medical Center & Harbor-UCLA Medical Center
Jonathan S. Kirschner, MD, RMSK	Hospital for Special Surgery/ USBJI
Katie Huffman	Osteoarthritis Action Alliance.
Kirsten Ambrose (absent)	Osteoarthritis Action Alliance.
Lesha Spencer-Brown, MPH, CPH, PMP (absent)	Administration for Community Living
Lisa Gabel (absent/resigned)	Humana
Mamta Gakhar, MPH	YMCA of the USA
Nick Turkas, MS	Arthritis Foundation
Paul Woods, MD MS CCFP	Orcinus Health Solutions
Raquel Masco	SingleMoms Created4Change Advocacy & Empowerment Center
Robyn M. Stuhr, M.A., ACSM-CEP, FACSM	Exercise is Medicine®
Serena Weisner	Administration for Community Living
Starla H. Blanks, MBA, MPH	American College of Rheumatology
Tamara Huff, MD, MBA, FAAOS, FAAHKS	Vigeo Orthopedics, LLC.
Tiff Cunin (absent)	National Recreation and Park Association
Timothy P. McNeill (absent)	Freedmen's Health
Tonya Horton (absent)	Patient Representative

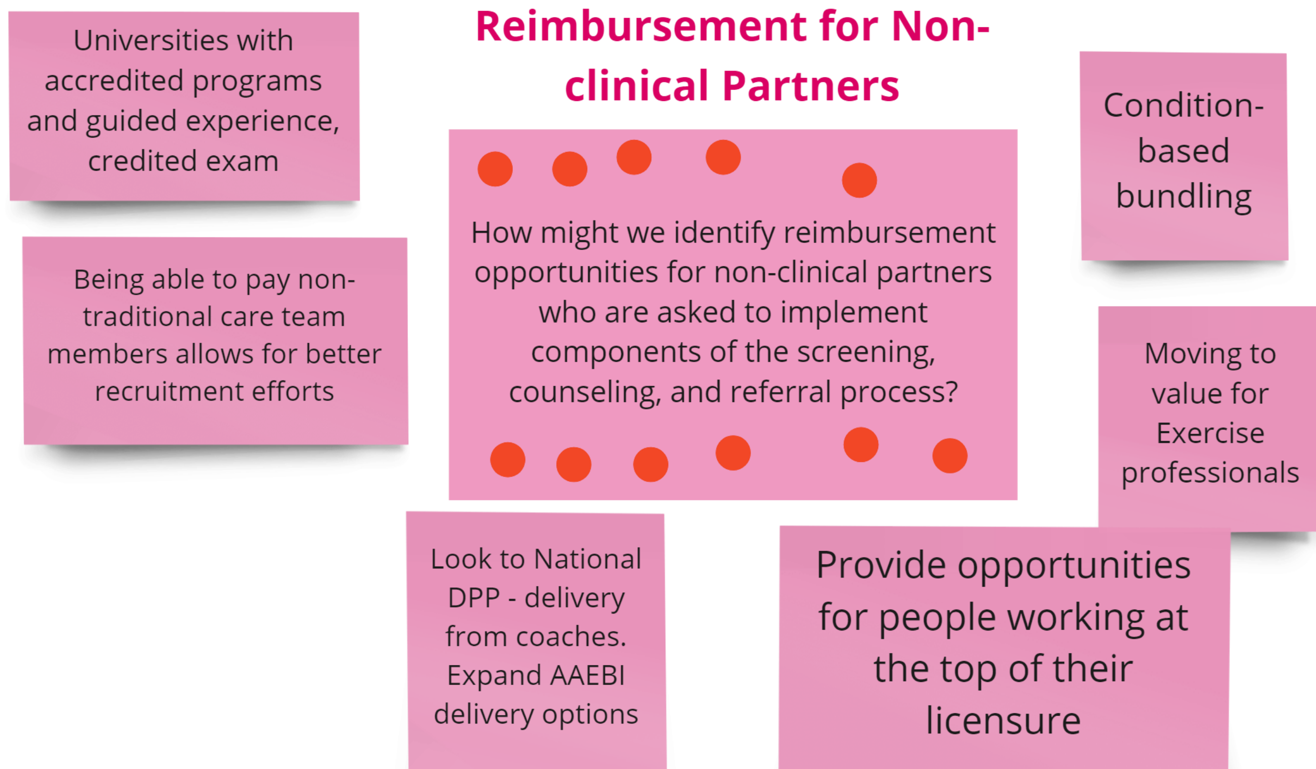
Travis Salmon (absent)	Patient Representative
Yvonne Dorsey	Humana

FACILITATION AND SUPPORT

Name	Organization
Cheryl Schott, MPH	Centers for Disease Control and Prevention, Contractor
Beth Fallon, MPH, Ph.D., CHES	Centers for Disease Control and Prevention
Margaret Kaniewski	Centers for Disease Control and Prevention
Erica L. Odom, DrPH, MPH (absent)	Centers for Disease Control and Prevention
Heather Murphy	NACDD
Shalu Garcha (absent)	NACDD
Lisa Erck	NACDD
Heidi Milby	NACDD
Vish Vasani	NACDD
Karen E. Schifferdecker, PhD, MPH	The Dartmouth Institute and Community and Family Medicine at the Geisel School of Medicine, Dartmouth College
Kathy Carluzzo, MS (absent)	Center for Program Design and Evaluation at Dartmouth (CPDE)
Katrina Seipp-Lewington, MPH	Comagine Health
Theresa Kreiser, MS (absent)	Comagine Health
Tracy Carver (absent)	Comagine Health
Kerstin Edwards	Leavitt Partners
Patricia Doxey	Leavitt Partners
Brooke Zollinger	Leavitt Partners
Chloe Chipman	Leavitt Partners
Morgan Wilson	Leavitt Partners

Appendix B: Complete Comments from Discussion & Form

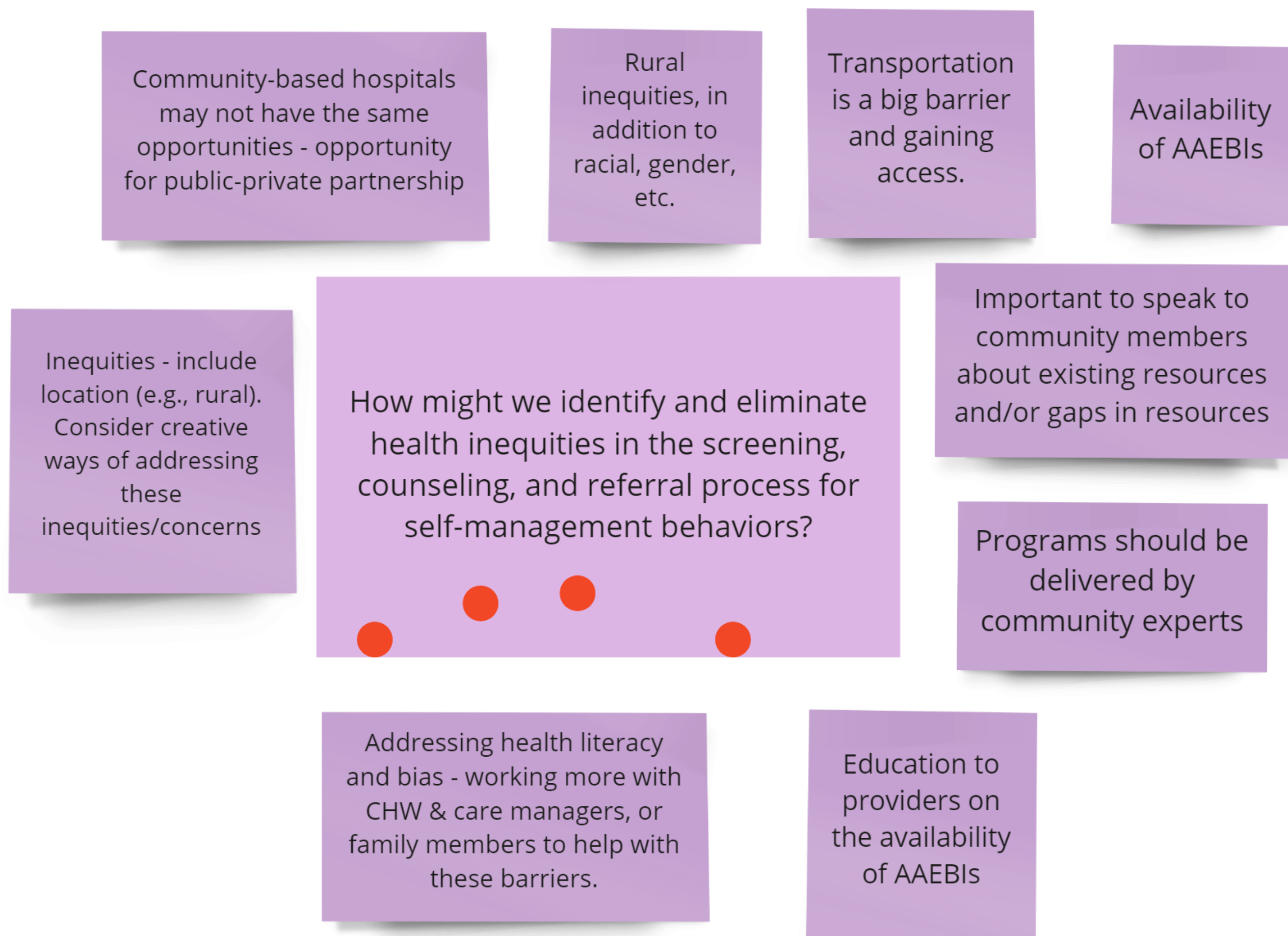
REIMBURSEMENT FOR NON-CLINICAL PARTNERS



Comments Provided via Form

- Systemic support for the value of these partners.
- Getting insurers onboard with reimbursing CBOs for delivering AAEBIs
- Reimbursement that is built into existing systems and is sustainable
- This is linked to billable codes will these recommendations be linked to MIPPS?
- Grant funding for coordination and participation
- Working with CMS and insurance companies to demonstrate the importance of incentivizing this care through appropriate reimbursement
- Bringing stakeholder to the table to have the conversation and understand the needs and barriers to change. Co-creating the reimbursement and piloting the plan.
- Bundled payment
- Funds that clinics receive for improving patient care (through referrals and follow-up care) should be returned to CBOs that deliver the programming. Hub models enable this type of solution to the common 'Wrong Pocket Problem'
- Document ROI and make case with CMS and private payers if ROI shows promise.
- increased behavior outcomes
- In a fee for service environment, it remains difficult for exercise professionals to receive reimbursement from a 3rd party payer. In a value-based environment, the utilization of exercise professionals and health coaches is aligned financially. Continued efforts in support of the PHIT Act will allow patients to utilize $ in their HSAs to pay for physical activity resources.
- Collecting cost savings data from all locations that have piloted reimbursement efforts and capturing similar data from evidence-based interventions that are reimbursed for other chronic diseases. Compare the costs of the expensive interventions and the costs of AAEBI delivery so that you can draw parallels.
- Payers are cutting payments to providers so trying to get others to get payment for services particularly through CMS will be tough.
- Methodically building a case for qualified healthcare professional (QHP) status for exercise physiologists to the AMA and key decision-making bodies. Evaluating/updating CPT codes to accommodate the service and who is authorized to provide it. Using the DPP model to recognize PA programs that meet certain standards and could be on a database/easily accessible by providers and patients.

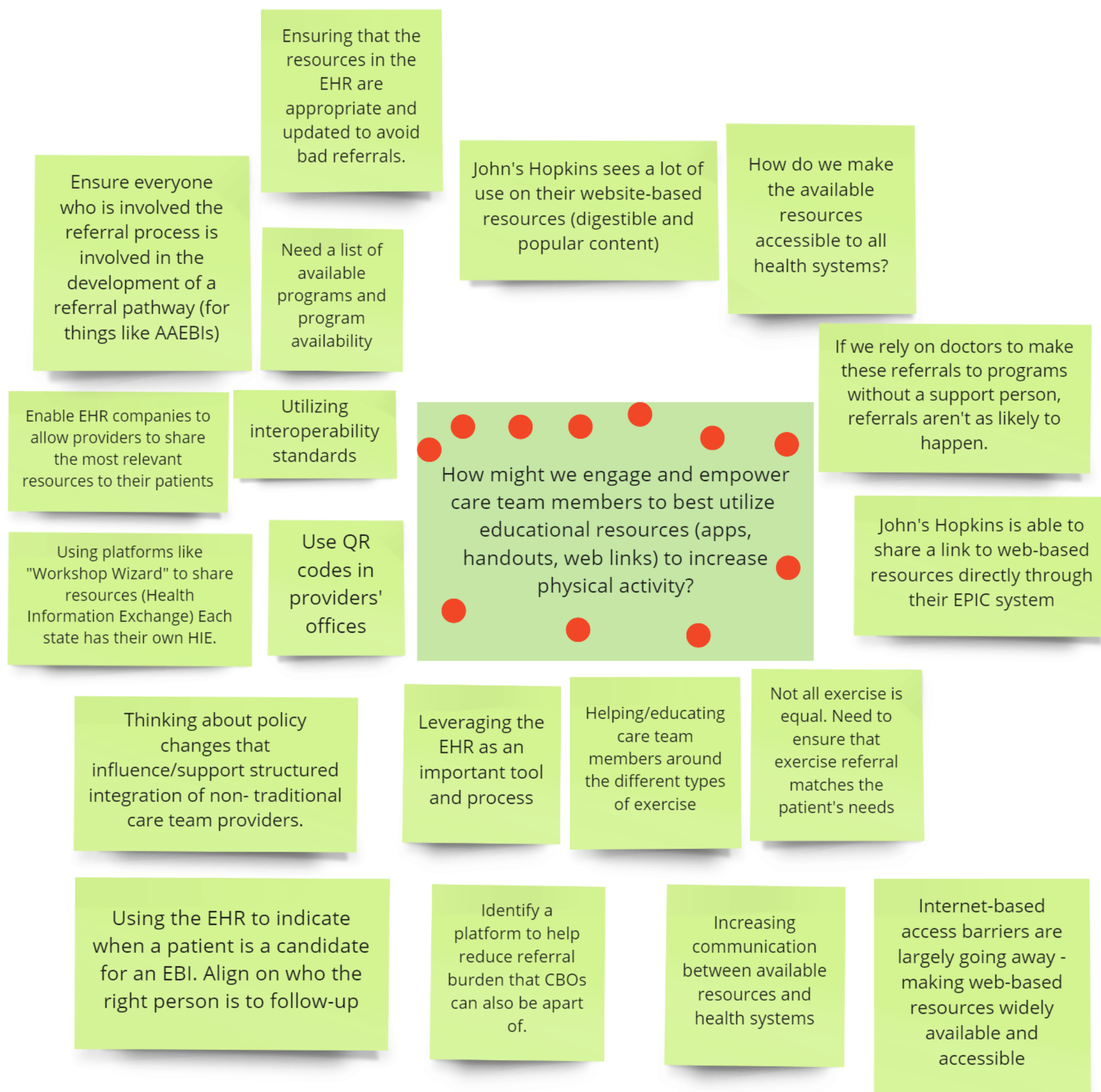
IDENTIFY & ELIMINATE HEALTH INEQUITIES



Comments Provided via Form

- Depends on community resources plus financial model of the healthcare system (e.g., FQHC more focused/more resources for under-resourced patients/communities
- The availability of AAEBIs and the requirements i.e., diagnosis, a referral from physician, and payment status will be critical. While there are many interventions an emphasis needs to be placed on online and self-guided interventions first to expand reach in an equitable manner
- Data sharing participation in screenings, referral, and program participation
- Once you have engaged Partners within the community, consider choosing one area of an equity at a time to engage. I would strongly recommend starting with the social determinants of health, particularly access to care in a particular area.
- This can be difficult as not all persons want to self-identify.
- Screening for SDOH could be done by CHWs or Navigators instead of clinicians.
- Tap into existing initiatives funded by Fed/Foundations.
- I think we should assume that MOST patients do not have access to AAEBIs - that said, there are definitely populations that have even greater challenges in accessing assessment and care for their arthritis.
- identifying ways to eliminate transportation and payment barriers to accessing any part of the patient care continuum.
- This is not impossible despite my low feasibility score, but it is a mountain to overcome - we have a system that is designed to promote/perpetuate inequities and still a lot of people who are not on board with eliminating inequities. it is vital work, though.
- This is difficult. MIL has been trying to do this.
- It is important to identify unique barriers to PA among groups and in individuals that can inform advice and referral. However, it's unrealistic to expect a provider or health system to solve systemic, community problems and inequities that are very complex and out of our control (require changes in community policies, access, safety, cultural values, etc.)

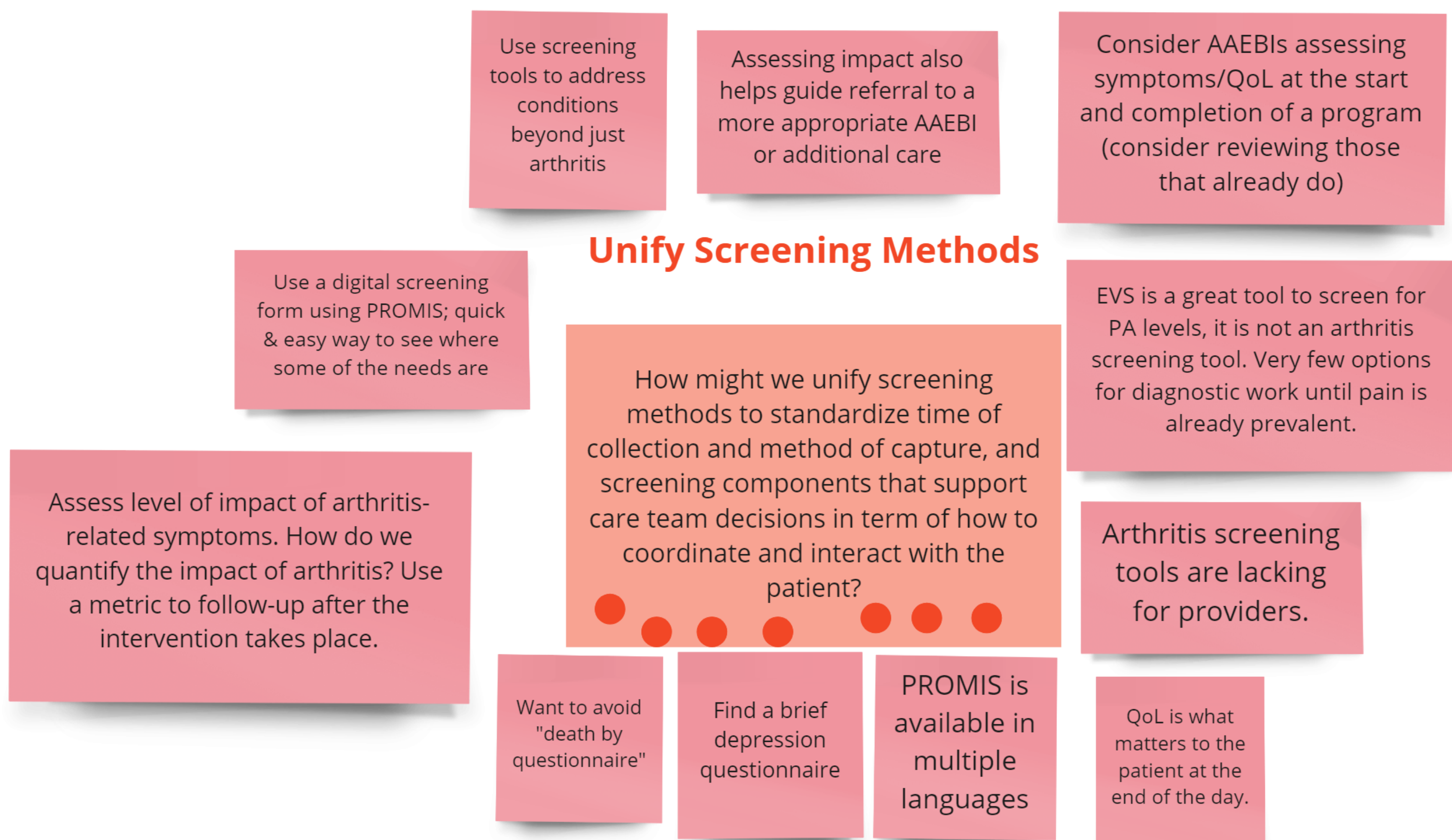
EDUCATIONAL RESOURCES



Comments Provided via Form

- Evidence for education alone is not strong
- careful, targeted marketing
- The material is a available it just needs to be organized in an accessible manner.
- funding for the development of resources
- Ensure that consideration of disadvantaged populations and how they access these is undertaken. Otherwise, they can widen health disparities.
- The ideas to create QR codes and share links after visits would be a more efficient system than traditional handouts.
- CDC funding, other funding.
- Providing a handout is pretty easy, but in my experience completely insufficient.
- Educational resources could be easily sourced, evaluated, endorsed and distributed if a central easy to navigate access point was selected.
- Many great resources exist already, including avenues for delivery (e.g., EMRs, websites, apps, community organizations). Increasing awareness and ease of access to these resources among HCPs who can provide to patients or refer them to programs is key.
- A central repository where providers and patients can find educational materials geared toward patients with arthritis rather than "generic" educational materials.
- Having a suite of materials and options, created with health literacy and diversity in mind, to offer via multiple platforms (EMR, handouts, apps, etc.). Also offer in Spanish.

UNIFY SCREENING METHODS



Comments Provided via Form

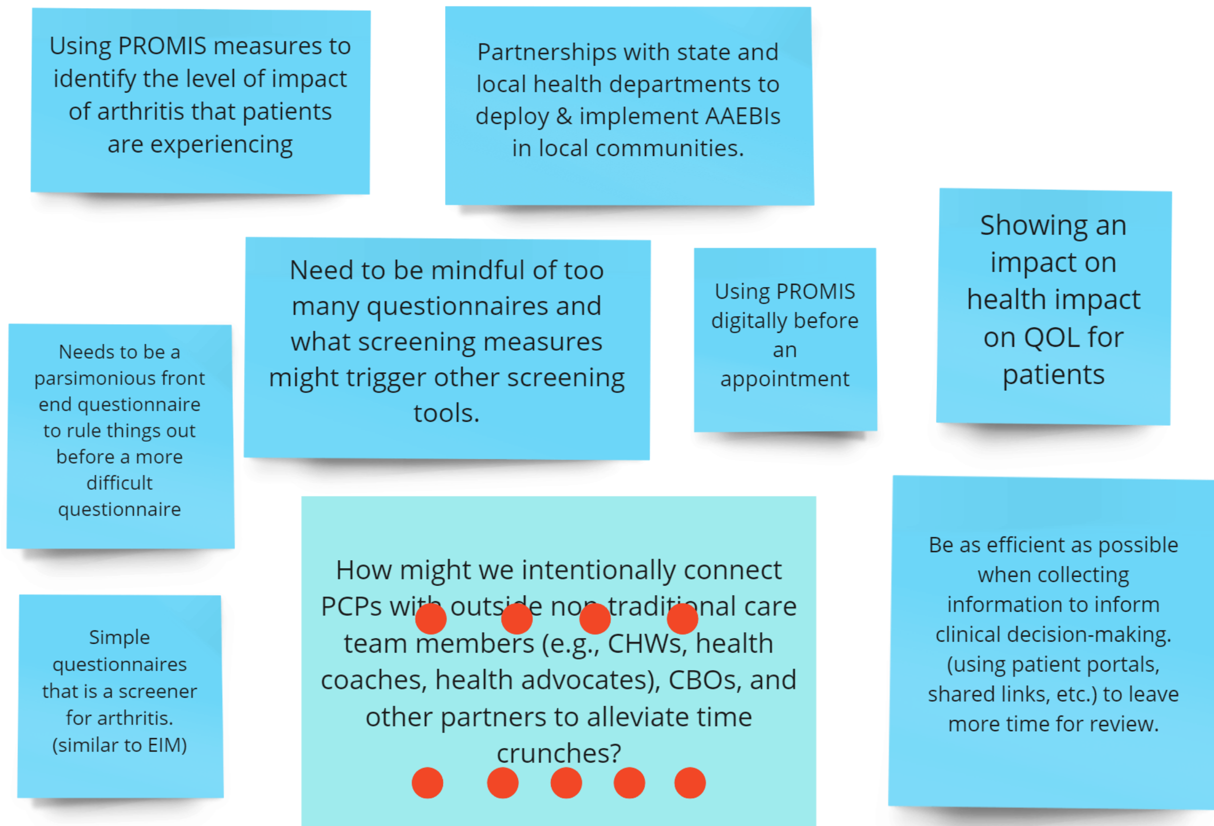
- incentivizing them will billing codes or penalties like MIPS
- If the health system/practice is already using and has a system to integrate screening
- Simplifying the tools increases the impact of limited time and maximum impact
- "Feds requiring its use by law - stick
- Financial incentives - carrot"
- Encouraging programs/organizations to partner together
- Bringing all voices and stakeholders to the table to co-create and or understand the importance of adopting or developing a standard method and adopting the method as well. A pilot to test the method and screening also would support the data claim as well as the adoption moving forward - depending on the data.
- Simplify the screening method.
- Simple 'survey' items of pain / fatigue that could work similarly to the PA Vital Sign questions.
- Success in the EHR Interoperability Processes currently underway. Start with pilots. Each health group is different. Have a few pilots to address the diversity.
- Need to work with EHR vendors to make it easy for the assessment and documentation of PA and other arthritis-relevant data.
- Selecting a short list of already evaluated tools that have already been integrated in at least 1 electronic health record to endorse. If it's never been incorporated before it will be more difficult to unify it across provider organizations.
- Use 1 tool that is patient centered and you can measure outcome and is reliable and valid. Like PROMIS tools.
- Support for the PAVS in HL7 and associated arthritis-specific function and barrier measures (PROMIS29 or EQ5D) will be important. Must be short, able to be assessed before the visit or in the waiting room before the encounter (digital pad or paper form). The PAVS can be located in a separate place in the screening from the pain/function questions but combined using AI to determine patient behavior and challenges.

STREAMLINE REFERRALS TO AAEBIS

Comments Provided via Form:

- The feasibility comes down to physician education on the availability of referrals and the actual availability of the AAEBIs. This is central to increasing awareness and referrals.
- A program locator, ideally one that is connected to other health services
- Encouraging programs/organizations to partner together and create a database for resources.
- Ideally need one platform, bi-directional feed and data sharing.
- More programs should move to self-directed programs.
- Fund a national portal with HIPPAA and other requirements that is accessible through digital tools.
- I think the biggest gap here is that most providers don't know what an AAEBI is, or where it is, or what affect it might have on their patient's health. Until we solve for that, we won't make much headway in referrals.
- Addressing health inequity barriers like cost and need for transportation, sustainable availability of AAEBIs and communication networks first would greatly increase both the impact and feasibility. Streamlining the referral mechanisms will be difficult and unreliable if both ends of the communication pathway aren't very stable.
- Streamlining referral to AAEBIs would have a huge impact in exposing and encouraging more patients to partake and encouraging more PCPs to refer! The feasibility is lower due to PCPs, themselves, being unaware of AAEBIs or lacking the ease/time/resources to educate patients about them and refer. EMRs are a great idea, generally/in concept, but vary widely around the country to facilitate ease of adapting/adopting an AAEBI referral model. This is worth exploring, though, given the infiltration of EMRs in many markets/geographic locations. Up-to-Date is also a great idea given the vast number of PCPs that use this platform. Community-based AAEBIs are challenging to identify given the high variability of local class offerings and known challenges in maintaining an accurate locator. Individual/virtual AAEBIs are potentially easier to refer to but still requires that PCPs are aware of them, and patients can access. In the end, the referral process must be simple, fast, and obvious for PCPs to learn about and then do. If it is perceived as "one more thing" PCPs have to do, they won't.
- We have trouble finding where patients can go to access AAEBIs and often select self-directed walk with ease as the easiest.
- Integration into the EMR of a dropdown referral box and utilizing patient navigators or health coaches to follow up.

CONNECT PCPS WITH EXTERNAL CARE TEAM MEMBERS



Comments Provided via Form:

- Support systems, resources and education for all team members.
- Think this is difficult without dedicated staff for doing this
- If AAEBIs are available at no cost to the patient (supported by payors) and funded in a sustainable manner this will have the greatest long term impact on persons living with arthritis
- "Data showing referrals and program participation
- Linking ROI to program referrals"
- PCPs are overwhelmed. How can we help?
- Needs to be co-created. Need to understand holistically what ALL players need.
- Payment and benefit design;
- Coordination through Community Care Hubs can help in referrals and enrollment.
- Engage non-physician professionals. Will differ by medical group. No one solution fits all.
- This is essential. We continue to struggle with reimbursement for these types of services, but there are success stories that we need to learn from.
- Connecting with additional care team members within the same organization will be easy, outside organizations will need to have reliable lines of communication established like health information exchanges and that means that every org will need some kind of system that can use those connection tools.
- Clinical care, alone, is insufficient to optimize arthritis management. Keeping PCPs and external care providers connected is important for PCPs to understand and promote the breadth of their patient's care, may provide an avenue for reimbursement if referral is made/endorsed by a PCP(??), and provides a level of continuity of care or comprehensiveness of care that benefits patients and better meets their needs. PCPs in clinics with fewer immediate resources (they may be a care team of 1) can expand their 'team' by including other external care members to provide care that is beyond their scope.
- PCPs would need to know what the various providers could do for their patients (benefit their patients) and also where to find these providers.
- Education and accredited certification of all exercise professionals. The inclusion of exercise physiologists as qualified health professionals who are eligible for referral, coding and billing. One click referral system in the EMR. Utilizing patient navigators and health coaches to get patients to the right resources: programs, professionals or places.

COMMUNITY ORGANIZATIONS TO SUPPORT FOLLOW-UP

This topic was addressed during discussion of other topics.

Comments Provided via Form:

- Using a bi-directional referral system
- Given the funding limitation the role oof CBOs is valuable just under-resourced
- Need a reporting infrastructure for bi-directional sharing. Need updated portal to ensure resources are up to date.
- Use of HIE to integrate
- The needs of CBOs need to be more directly considered instead of just what clinicians and hospital systems need and will do.
- use of Medicare Waiver Forms, engage Medicaid to argue case for reimbursement, engage medical institutions to take a leap of faith to support this work, raising awareness about AAEBIs and other interventions, making communication easier.
- This is an interesting question. I do not know if there is any literature demonstrating that CBO f/u increases participation in an AAEBI or improves outcomes.
- Depending on the type and amount of follow up needed this varies. If follow up is thought about in its narrowest definition of contacting the patient after referral, then this is very feasible but low impact if it can't address barriers to access. If it addresses barriers to access it will be dependent on other resources.
- Follow up from CBOs will help reinforce the referral process and benefit and keep AAEBIs or other educational opportunities in the forefront of PCPs minds and make it easier for PCPs or their care teams to refer. Feasibility really depends on the CBO personnel being invested in the effort to offer AAEBIs and stay connected with local PCPs. This will vary widely across CBOs, even within a single CBO that may have high turnover or few paid staff.
- To have a community partner would be great but not sure how to find them and what they are able to do or have available.
- It all boils down to easy communication pathways, provider trust in external resources, and financial support for staff (either on the health care side or the community organization side) to follow up on referrals.

ACTIVE COUNSELING

This topic was addressed during discussion of other topics.

Comments Provided via Form:

- This is labor intensive
- Using other care team members (not PCPs) to do the counseling. Use chronic disease management model where a nurse provides coaching to patients outside the appointment
- Depends on healthcare personnel/staffing
-
- Funding and/or ROI
- Trained persons to engage and possibly funding.
- Assessing patient's ability to engage with a plan, and barriers.
- Training peer - educators instead of clinicians to deliver coaching (for example)
- Training of health coaches, CHWs, exercise physiologists, mental health providers.
- Physicians are trusted by patients to inform them of conditions and care; however, they (especially PCPs) are INCREDIBLY strapped for time. Ideally, a physician could refer to a health coach who would use MI approaches to understand the patient preferences and goals, and help them create an action plan and f/u with them to ascertain if it is working for them.
- Impact of counseling could be improved by ensuring that there is broadly available interventions to counsel on with sustainable payment mechanisms in place.
- Again, this is already happening, and data supports that counseling works; the challenge is in building counseling opportunities to help those clinical care settings and communities that have fewer resources.
- Not sure. PCPs don't have time to provide active counseling. Maybe using health coaches could fill the gap.
- Wrap physical activity into the ever-expanding focus on lifestyle medicine and a wholistic, preventive approach to care. PCPs often don't have the time nor knowledge to do extensive PA counseling, but rather offer brief advice. Medical school curriculum and continuing education related to arthritis should incorporate PA as an evidence-based treatment approach.

SCREENING BEFORE A VISIT

This topic was addressed during discussion of other topics.

Comments Provided via Form:

- digitization and integration into EMRs

- Dependent on the healthcare system and if this already exists. If it does not already exist, very difficult to integrate new measures/systems into EHR or into office process
- This is the most feasible to pre-visit and collect information for treating physicians allows the ability to leverage the limited time into brief counseling and ensuring referrals.
- "Financial incentives to patients and providers for screenings completed.
- Share the % health system pre-screeners (positive peer pressure)"
- May be challenging to implement…
- A standard form with more than one way to access form.
- Keep it very simple
- Building it into a patient-reported information request that would be included. Patients can indicate if they want the physician to discuss it with them so that they have autonomy over the conversation
- Provider communication with patient. Use of different digital tools- email, text, phone, etc.
- uncover new information and address additional health issues, barriers and challenges
- Increasingly, this will be a way to collect patient reported information and outcomes. Given the prevalence of arthritis, it makes sense to lobby for the inclusion of questions that help providers and care teams to better understand arthritis and its impact on health, function and QoL.
- Picking screening tools that cover all of the areas that need screening by defining very clear outcomes and adjusting language to convey that. Standardize screening of arthritis severity for adults already diagnosed with arthritis or standardize the screening of physical activity levels for everyone.
- many clinical care settings are already doing this so the models are there for others. The challenge, really, if for those settings that have fewer resources to support the technology needed to make this broadly available. Or even the patients who are capable of pre-visit screening (i.e. poor broadband, discomfort with technology, distrust, etc.)
- If it can be done easily by the patient and does not take much time.
- Very important.

Appendix C: Impact and Feasibility Scores

After the discussion, Advisory Panel members were asked to fill out a survey to further explore how to operationalize the ideas. Members ranked the impact and feasibility of each idea (with 1 being low impact/feasibility and 5 being high impact/feasibility). The following table contains the average ranking across 18 responses for each idea.