National Association of Chronic Disease Directors
CDC Arthritis Advisory Panel Design Session #4 – Care Coordination
June 27, 2023 @ 10:00 a.m. ET

Notes and Summary Document

- Meeting Recording: https://vimeo.com/840561987
- Additional information: Please visit the private Advisory web page for a link to the recording from today, summary documents and additional information

Participants:

43 Total Participants (including presenters and facilitators)

Project Overview:

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

Design Session #4 Objectives:

- Explore potential referral mechanisms
- Refine care pathway for the arthritis care model referral component
- Engage in peer-to-peer sharing, learning, and networking

Presenters:

Lisa Erck, NACDD
- Welcome

Lesha Spencer-Brown, Administration for Community Living (ACL)
- Overview of Community Care Hubs

Sue Lachenmayr and Leigh Ann Eagle, Maryland Living Well Center of Excellence
- Community Care Hub linking AAAs and community-based programs with primary care providers for referrals to evidence-based interventions

Mark Cullen, Trellis
- Juniper network and Trellis community care hub providing health promotion programming and SDoH screening

Grisel Rodríguez-Morales and Padraic Stanley, Rush University Medical Center
- Connecting patients with chronic pain to social worker and care team to screen, intervene, and refer to evidence-based program

Heather Hodge, Y-USA
- Bidirectional services eReferral (BSeR)

Shalu Garcha, NACDD and Theresa Kreiser, Comagine Health
- Strategic Discussion and Workflow

Discussion Summary:

Role of community care hubs in screening, counseling, and referral process

- Community Care Hubs provide a centralized location to find local evidence-based programs
- Network incorporates SDoH screening (e.g., CMS Accountable Health Communities tool or screener through SHARP tool (e.g., UniteUs)) and can identify a wide range of social needs/connections that might be barriers to arthritis program/physical activity participation. Network can also address barriers to participation such as transportation, timing, childcare needs, and language. Some SDoH screeners also track physical activity.
- Community Care Hubs can help to share outcome data with community-based programs and providers. Additionally, they facilitate communication between partners (e.g., health system and health plan) and can act as the billing mechanism to get funds for evidence-based initiatives to appropriate partners (e.g., community-based organization).
- Using technology to deliver programs to those with access challenges helps to increase reach of referrals. This works best when participants also receive warm hand-offs to local community-based programs who help navigate other needed community resources. Additionally, Community Care Hubs ensure that programs and services are delivered in the appropriate language.
- Community Care Hubs often tap into other benefits offered through health plan (e.g., transportation benefits) and Older Americans Act funded resources (e.g., transportation and meals) to close the gap.
- Training care team members and care coordinators in motivational interviewing helps to ensure appropriate advice and referral.
- Key is for health care provider to identify patient who is having issues with arthritis and make a referral. CBO can ask additional questions and determine eligibility for broad range of services
    - It's not fair to shift the risk to provider or patient. Services need to be covered and not denied.

Key elements of screening, counseling, and referral pathway in the Community Care Hub model

- Use of HIE (or similar tool) for screening and bi-directional referral https://www.healthit.gov/sites/default/files/state-hie-contacts-april-2013.xlsx
- Use care coordinator (or member of care team) to match patient with the right evidence-based intervention
- Collect return on investment data to document ROI and VOI
- Utilize two-way communication with provider and care team
- Invest in training and skill development (e.g., motivational interviewing)
- Engage CBOs as partners to address social need and additional lifestyle modifications
- Establish funding mechanisms and reimbursement protocols to cover screening, counseling, and referral and care coordination (e.g., contract with health plan for AAEBI reimbursement)

Strategic Discussion and Workflow

What data do healthcare providers want/need? What data do AAEBI deliverers need to know from the referring provider?

- Too much data back to the referring provider is likely to remain completely unread. Not because they don't care about the data, they just don't have the time.

Key take-aways

- Care team (e.g., community health workers and social workers) are key to effective and efficient screening, counseling, and referral efforts. These individuals provide

the necessary care coordination to ensure that patients unique needs are met and understood.

- There is a need to clearly document needs of providers and needs of community-based organizations. Additionally, we need to document what information each partner needs and what they are going to do with the data. Lastly, there is an opportunity to translate outcomes into dollars and cents.
    - Over time, CBOs should look to document improved health and quality of care.
    - NRPA developed a few short resources regarding EHR referral pathways specifically to AAEBIs in the Park and Recreation/CBO setting. "Level of Readiness Scale" to consider when engaging stakeholders/partners to develop a successful EHR referral pathway to AAEBIs. https://www.nrpa.org/contentassets/ce61ea9b63934de6bed170b04fbdbccd/ehr_referral_pathway_case_study_2023.pdf
- Perhaps primary care should make a referral for assessment rather than referral to specific AABEI. Instead of trying to navigate which services are needed and in which order, it would be a much lower barrier to adoption to ask healthcare provider to navigate the need for comprehensive assessment.
- Arthritis care model should include technology tools and front line workforce to assist with care coordination process and referral to appropriate care to address social needs https://www.healthaffairs.org/content/forefront/moving-incremental-transformational-strategies-address-health-related-social-needs
    - https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804105
- Physician champion is key to successful arthritis care model
    - The important next step is to translate the results of the integrations and experiences of provider champions into the core curriculum for future healthcare providers and integrate it into the United State Medical Licensing Examination (USMLE).
- Bidirectional pathway is needed
    - The Bidirectional Services eReferral (BSeR) FHIR implementation guide provides guidance for using the HL7 Fast Healthcare Interoperability Resources (FHIR) standards as an exchange format for clinical and non-clinical requests. http://build.fhir.org/ig/HL7/bser/
    - The goal of the BSeR project is to streamline and enhance the efficacy of the exchange of health information between health care systems and community services organizations involved in addressing chronic health conditions by establishing information exchange standards for electronic referrals and referral outcome reporting.

Future considerations:

- Consider understanding if there are differences regarding how certain care team members engage with patients? (e.g., are there any differences between MDs vs. NPs vs. DNPs?)
- Continue to address risk stratification framework to ensure patients are referred to appropriate care
- Consider partnering with hospitals with community social work or community health departments as health promotion, self-management efforts, and chronic disease prevention programs are a good fit for these departments. These programs can help these types of hospitals fulfill nonprofit hospitals' requirements for community benefits and community health improvement, which is mandated by the ACA for all nonprofit hospitals.
- Investigate reimbursement codes (e.g., CCM codes - chronic care management) for services provided by LCSWs and others for recruitment and coordination.

Evaluation:

- **Poll Question**: In this design session, I had an opportunity to contribute my own knowledge and expertise to influence the arthritis care model referral methodology
    - 90% Strongly agree or agree
- **Poll Question**: In this design sessions, I had an opportunity to influence tools and resources to assist healthcare providers in providing referrals to AAEBIs
    - 100% Strongly agree or agree