ADVANCING ARTHRITIS PUBLIC HEALTH PRIORITIES THROUGH NATIONAL ORGANIZATIONS (CDC-RFA-DP21-2106)

Arthritis Advisory Panel

Tuesday, August 8, 2023 – 10:00-11:30 A.M. ET

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.

Funding Attribution

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Arthritis Care Model Design Partners

Hospital for Special Surgery/ USBJI	Johns Hopkins Arthritis Center	Intermountain Healthcare	Torrance Memorial Medical Center & Harbor-UCLA Medical Center	Vigeo Orthopedics, LLC.	Orcinus Health Solutions	UT Southwestern Medical Center
Iowa State University	AgeSpan	New Hampshire Department of Health and Human Services	American Physical Therapy Association	Arthritis Foundation	Osteoarthritis Action Alliance	Exercise is Medicine®
Massachusetts Department of Public Health	American College of Rheumatology	National Recreation and Park Association	Administration for Community Living	YMCA of the USA	Freedmen's Health	Humana
	Centers for Disease Control and Prevention	National Association of Chronic Disease Directors	Dartmouth College, Center for Program Design and Evaluation at Dartmouth (CPDE)	Comagine Health	Leavitt Partners	

Design Sessions

1. May 9 **Screening Arthritis Pt's for QoL**
2. May 23 **Brief Advice / Counseling**
3. June 13 **Referral**
4. June 27 **Care Coordination**
5. July 11 **Reimbursement and Beyond**
6. July 25 Design Recap/ **Evaluation**

Expert Panel on 8/9

- Health System Selection Criteria
  - Reimbursement & Incentive Debrief
- State Criteria to host pilot

Expert Panel on 9/12

- Final Evaluation Framework (Dartmouth)
- Elevator Speech Creation
- Implementation Guide/Change Package for Health System Pilot
- Celebrate & Wrap-up

Agenda

- Welcome and Agenda Review
- State Criteria
- Health System Criteria
- Closing/Next Steps

Arthritis Care Model

Aim 1: Evidence-Informed Arthritis Care Model

Develop and implement an evidence-informed arthritis care model to conduct function, pain, and physical activity screenings; patient counseling on the benefits of physical activity; and referrals to arthritis-appropriate physical activity and self-management programs and other evidence based "treatments."

Aim 2: Demonstrate / Pilot

Pilot the arthritis care model in a healthcare system that serves diverse populations; demonstrate clinical outcomes and total cost of care savings; and reimbursement pathways and incentives for provider screening, counseling, and referral.

Aim 3: Scale & Spread

Disseminate learnings on a national level and enhance healthcare provider awareness, knowledge, and skills to promote physical activity as an effective, drug-free way to relieve arthritis pain, improve function, and limit arthritis progression among adults with arthritis.

State Criteria

1. AAEBI capacity
    - Offers at least 2 Physical Activity & 1 Self-Management AAEBI to allow for shared decision making; 1 virtual offering
    - (e.g., grantee has internal capacity to sustain project through September 2025)
2. Other Evidence-Based Interventions for other Chronic Disease (Bonus Item)
3. Community HUB
    - SDOH Screening
    - (CHW/Health Coach) Provide Motivational Interviewing for AAEBI selection
    - Class tracking & other outcomes
    - Seek sustainable reimbursement pathways for AAEBI/health system
4. Community health technology enablers (AAEBI locator, social care plan, billing, classroom management, bi-directional referral)

Capacity to Implement AAEBIs and Other Evidence-Based Interventions

12 CDC Funded States

CDC-RFA-DP-23-0001 Cooperative Agreement

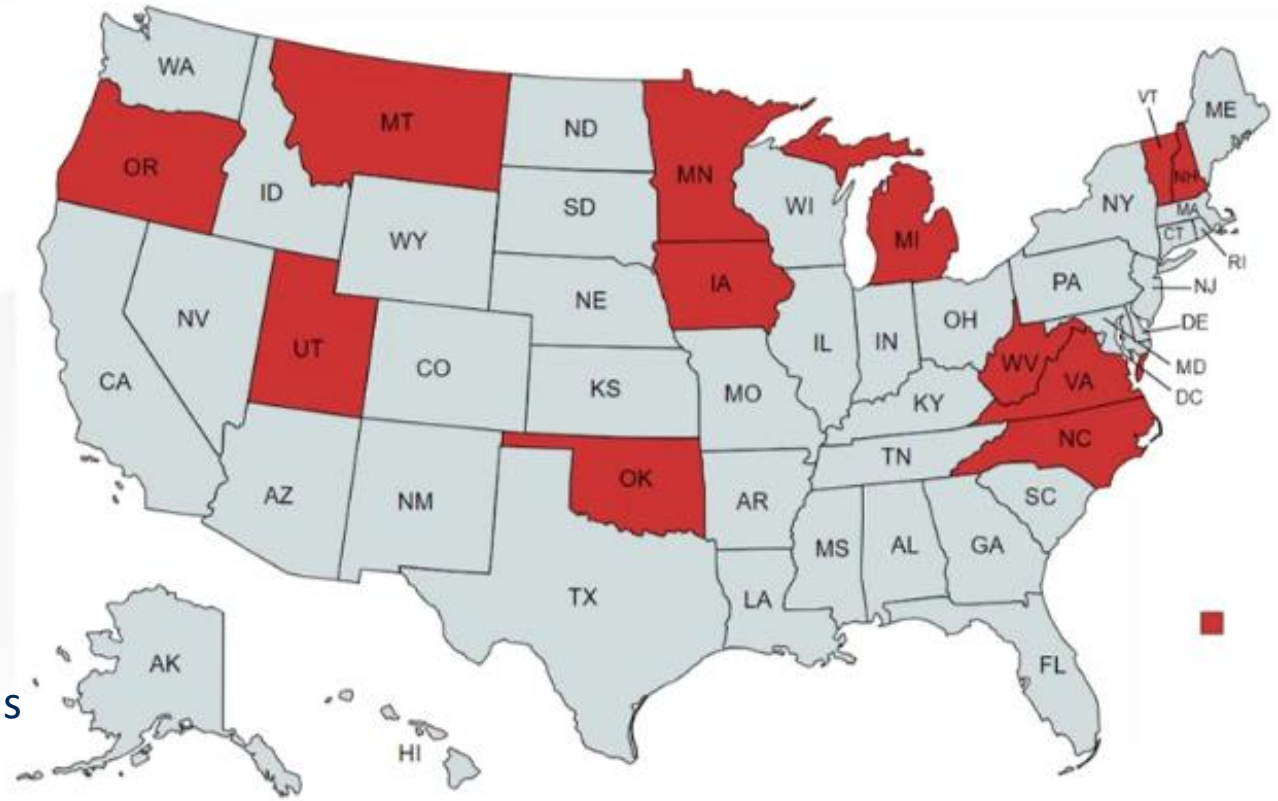
- Funding Period: July 1, 2023-June 30, 2028

Component A (6 funded recipients= $225,000 Annually per Recipient)

- Establish capacity and infrastructure to sustainably and equitably disseminate AAEBIs
- Raise awareness about arthritis management strategies among healthcare providers (HCPs)

Component B (6 funded recipients= $410,000 Annually per Recipient)

- Expand on sustainably and equitably disseminating AAEBIs
- Expand on strategies to increase physical activity (PA) assessments and PA counseling and referral pathways to AAEBIs among HCPs and other organizations



Current Capacity of DP-23-0001 Recipients

- Recipients are State Health Departments, Universities, and ACL's Area Agency on Aging (AAA)
- Recipients have established network of organizations to help implement AAEBIs
  - 3-4 of the 12 have established community care Hubs that organize and support networks of CBOs to meaningfully and efficiently integrate CBOs and the health-related services they provide into the health care continuum.
  - Focus is on osteoarthritis and other chronic diseases (e.g., diabetes, hypertension)
  - Some activities related to social drivers of health
  - Partnerships with CDC funded Diabetes and Heart Disease programs.
- Recipients have established or building partnerships with healthcare providers to assess, counsel and refer patients to AAEBIs

Recipient Capacity

AAEBIs being implemented	Healthcare Providers Engaged	Community Partnerships/Collaborations
• CDSMP (English and Spanish) • CPSMP • WWE- SD and Group (English and Spanish) • Program to Encourage Active, Rewarding Lives (PEARLS) • Enhance Fitness • Tai Chi Programs • Stay Active and Independent for Life (SAIL) • Arthritis Foundation Exercise Program (AFEP)	• Hospitals/Group Practice/Clinics • Community Health Centers • FQHCs • Medicare/Medicaid providers • Primary Health Home care • Area Health Education Centers (AHECs) • Health coaches • Community Health Workers • Physical Therapists • Pharmacists • Physicians/PAs • Nurses	• Local and state level Health Coalitions • Foundations • Professional state chapters • Healthcare Associations • Chronic Disease focused Advocacy groups • State and local health departments • Quality Improvement Organizations • Other CBOs

Recipient Partnerships

CBOs implementing AAEBIs under this grant:

- ACL's Area Agency on Aging (AAA)
- YMCAs and other fitness organizations
- Local Recreation and Park Centers
- University Extension Offices
- Senior Centers
- Libraries
- Faith based organizations
- Other organizations that engage Community Health Workers.
- Large Worksites including state agencies
- Local/County health departments

Systems used to support patient referrals/electronic supports

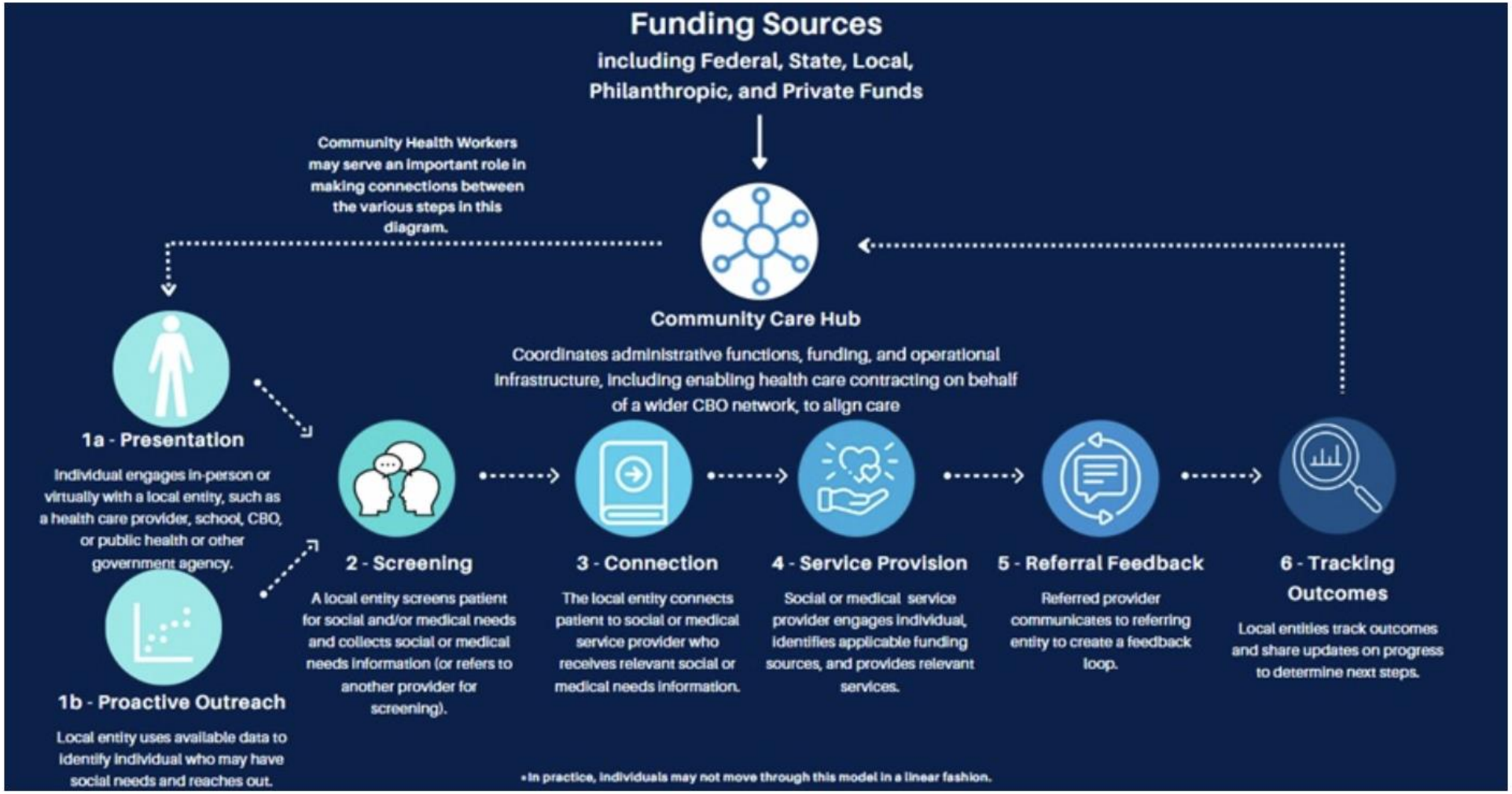
- UniteUs
- Findhelp
- RedCap
- Mon Ami
- Workshop Wizard
- Reliance eHealth Collaborative
- 211

Recurring challenges

- Bi-directional referral processes
- Reimbursement/Billing
- EHR use/modification
- Sustaining availability of AAEBIs
- Sufficient staff to operationalize and sustain activities, especially as it relates to managing referrals

Community HUB

Community HUB



Community Health Technology Enabler

Community Health Technology Enabler

Competencies of States / CBO Per Design Sessions

A. Referral

1. Referral from Healthcare Provider communicates with HUB/CBO (e.g. FindHelp?; UniteUs; HIE)
2. Patient may self-refer

B. HUBs

1. Complete Coaching & Social Care Plan
2. AAEBI Locator, Class Availability and Pt Progress
3. Ability to Collect Data:
   - Coaching/ Patient Touches
   - PA minutes?
   - PROMs post?

C. Bidirectional Data

1. Enrolled in AAEBI
2. Completed Series
3. PA Mins ?
4. PROMs post?

D. Revenue Pathway

Reflections

Recap on State Criteria

1. AAEBI capacity
2. Other Evidence-Based Interventions for other Chronic Disease (Bonus Item)
3. Community HUB
4. Community health technology enablers (AAEBI locator, social care plan, billing, classroom management, bi-directional referral)

Health System Criteria

Health System Criteria

1. Serves Diverse, Medicare/Medicaid Populations
2. Program Leadership/Infrastructure
   - Physician Champion to lead efforts
   - Project Lead (Project Manager/QI Coach/Practice Manager) to lead QI huddles to test PDSAs & gather monthly data
3. Ability to collect and share key data
   - Ability to collect Screening, Counseling, Referral Data
   - Site has ability to collect and utilize PROMs data
   - Ability to share data on a monthly basis (screening, counseling, referral)/ run report
4. Reimbursement Pathways -Fee for Service vs Value Based
5. Incentive Alignment
6. Bidirectional Referral (proof concept)

Program Leadership/Infrastructure

Roles and Responsibilities Accountable Clinical Executive/Physician Champion

Responsibility

- Ultimately accountable for successful implementation of Arthritis Care Model
- Provides guidance on prioritization of interventions
- Align & Integrate with QI & PCMH Initiatives

Characteristics

- Respected leader with leadership and direct care givers
- Effective communicator / collaborator/ change leader
- Well-informed of local clinical quality and safety priorities
- Supports local Ambulatory quality team(s)/care redesign team in removing barriers and monitors progress
- Member of Senior Management Team (SMT) or direct report to SMT member
- Works in the ambulatory setting/ health networks

Roles and Responsibilities of Project Lead

Responsibility

- Serves as the Network's primary point of contact and local project manager for day-to-day management of Ambulatory Redesign / Arthritis Care Model activities :

Characteristics

- *Leads Arthritis Care Model QI Huddles to ensure progression of work
- Supports Data collection & QI activities
- *Works with local practice leadership to manage implementation of collaborative activities and tasks (e.g. communication/training) at the practices
- * Ensures Accountable Clinical Executive /Physician Champions updated on project status and risks

Quality Improvement Infrastructure

QI Team:

1) Physician champion;
2) Project Lead
3) Practice manager;
4) Care Team Lead
5) billing/coding lead;
6) EHR customization lead
7) Data lead
8) Hub lead

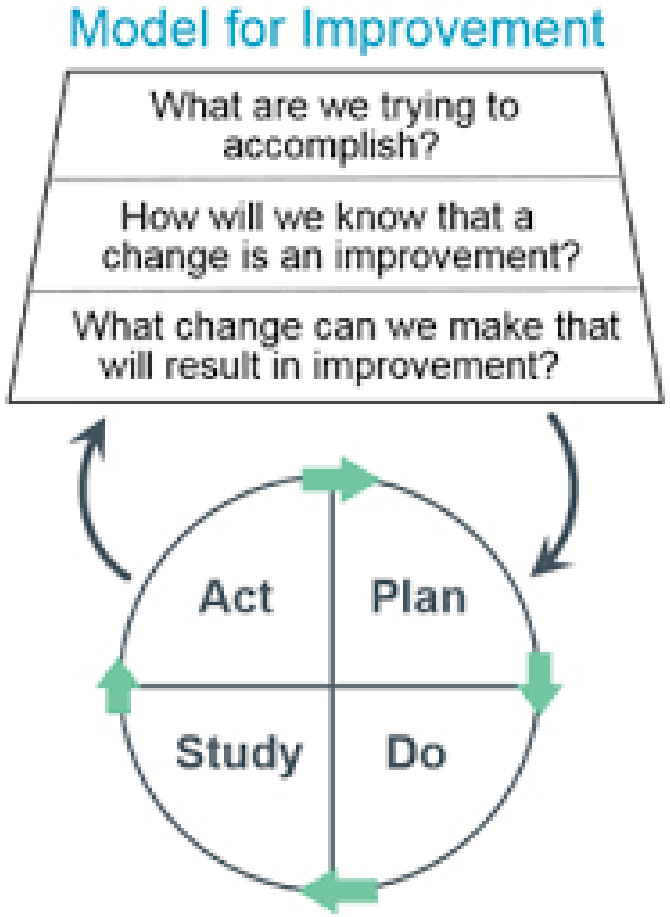
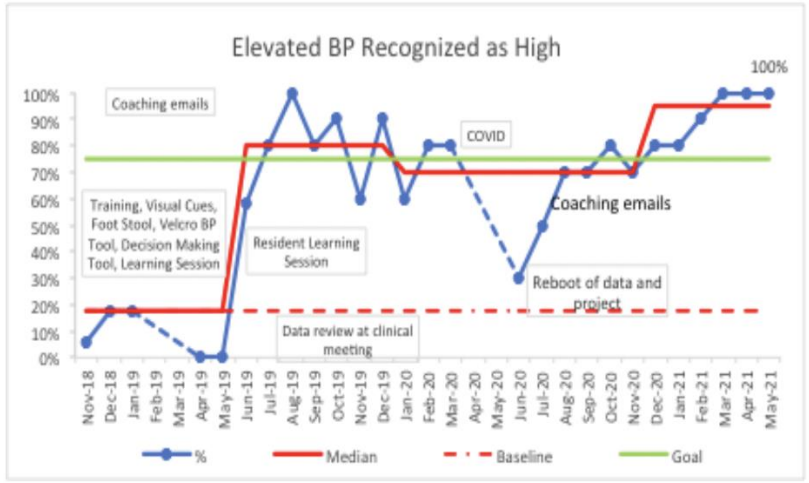
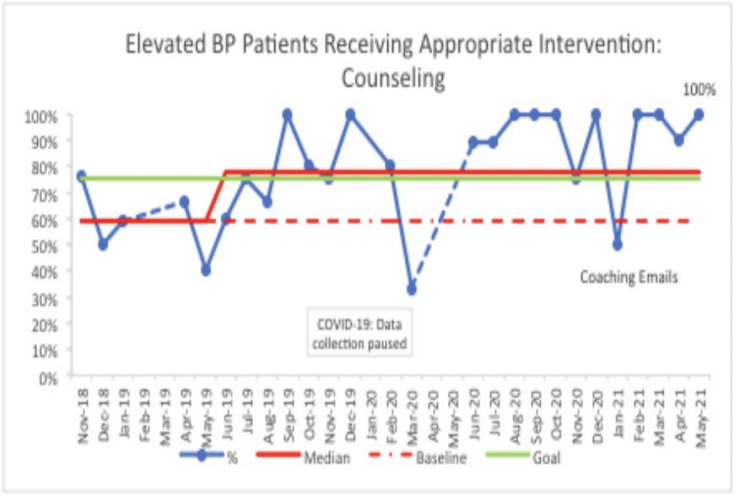


Figure 4. Elevated Blood Pressure Identifcation





Ability to Collect and Share Key Data

Ability to collect and share key data

1. Ability to collect Screening, Counseling, Referral Data
    - Screen HL7
    - Counsel - (custom build; smart notes/dot phrases; prescription)
    - Referral Module - "community interventions" (dummy code); referral to Hub (APIs)
2. Site has ability to collect and utilize PROMs data
    - Portal in advance
    - In waiting room via tablet
    - During intake
    - QR Code
3. Ability to share data on a monthly basis (screening, counseling, referral) / Report Generation

Reimbursement Pathways

Payment Models

*May include value-based payment

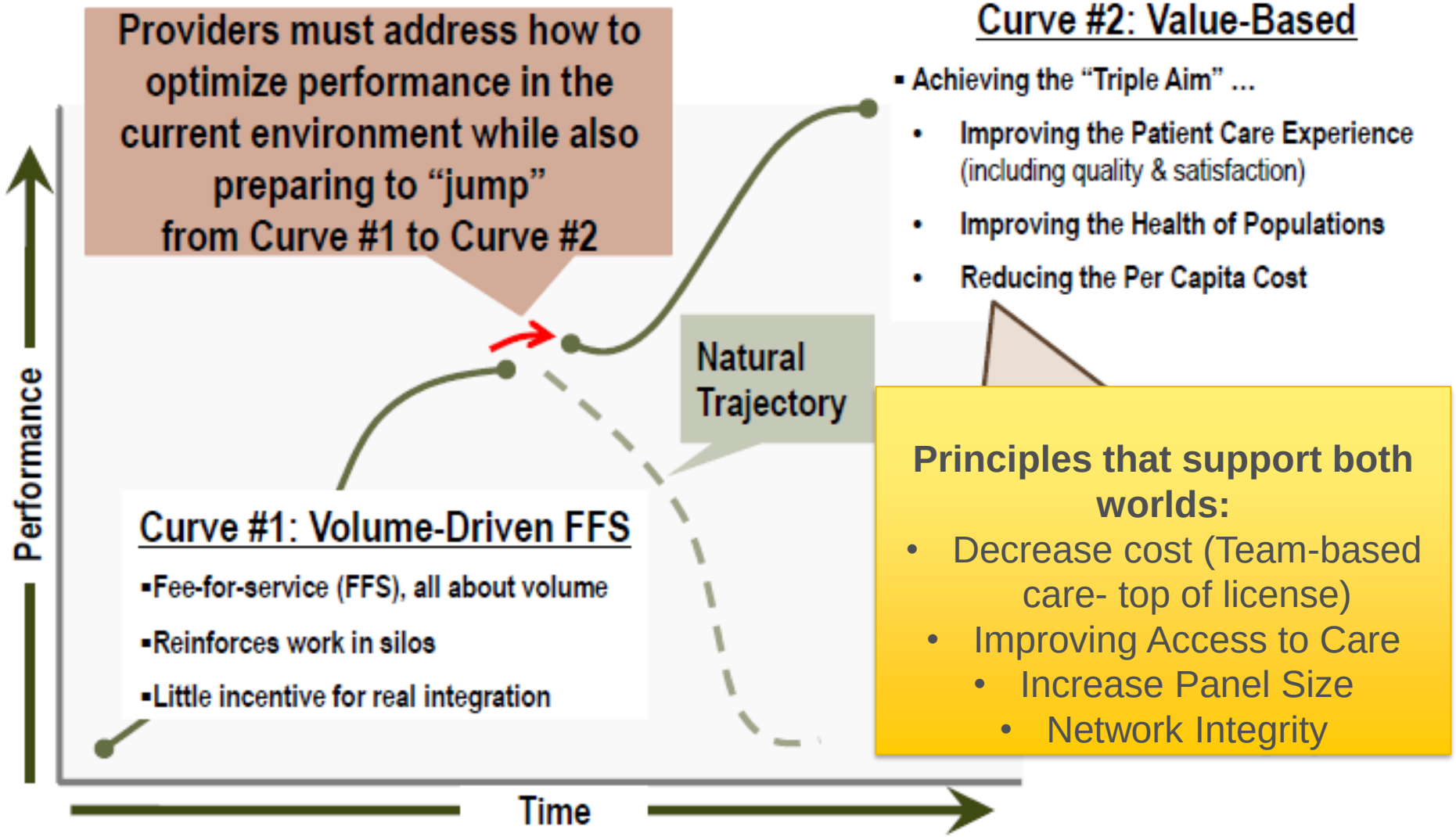
PAYMENT MODEL	FEE-FOR-SERVICE	PAY-FOR-PERFORMANCE	SHARED SAVINGS	BUNDLED PAYMENT	CAPITATION/ MANAGED CARE
Description	Providers paid for the services they administer[23]	Providers earn financial rewards or penalties based on performance[24]	Providers form networks and coordinate patient care[25]	Providers receive one payment for an entire episode of care[26]	Providers receive fixed payments to cover patients' health needs over a period of time[27]
Provider Incentives	Provide large volume of services[28]	Provide large volume of services, and meet specific quality and cost metrics[29]	Reduce total cost of care and coordinate care with other providers[30]	Reduce the cost of a specific episode of care[31]	Reduce total cost of care[32]
Potential Benefits[33]	Emphasis on productivity and maximizing patient visits	Emphasis on health outcomes, collaboration, and efficiency	Emphasis on coordinated and timely access to care	Emphasis on reducing unnecessary treatments and simpler billing	Emphasis on population health and innovation in care delivery
Potential Risks[34]	Little incentive to prevent unnecessary care	Administrative burden, providers could avoid high-risk patients	Care could be withheld from patients	Difficult to define episode of care, providers could avoid high-risk patients	Care could be with-held from patients, could have fewer choices in primary care
Potential Cost Savings to System	None[35]	Low[36]	Moderate[37]	Strong[38]	Strong[39]

E&M Codes
Pain Codes
Chronic Care
Management Codes
Health Coaching Codes
Medicaid Codes

Conditional Based Bundles
(UT Austin)
Bundled Arrangement
Knees/Hips

Figure source: Center for Health Progress' Payment Reform and Alternative Payment Models Primer, Nov'17.

Navigant's Point of View: Healthcare Industry Leaders are Facing a Classic Two-Curve Problem



Principles that support both worlds:

- Decrease cost (Team-based care- top of license)
- Improving Access to Care
- Increase Panel Size
- Network Integrity

Most markets transition to "Curve 2" will not be linear, requiring multi-year "bridge strategies"

Seek to Align Incentives

1) Quality Measures
   - **A) HEDIS (NCQA)**
     - A1) Physical Activity in Older Adults (PAO)
       - This survey measure assesses Medicare beneficiaries 65 years and older who had a doctor's visit in the past 12 months and who report that they:
       - Spoke with a doctor or other health provider about their level of exercise or physical activity.
       - Received advice to start, increase or maintain their level of exercise or physical activity.
   - **B) ACO Measures**
     - Quality ID: 318 Falls: Screening for Future Fall Risk
   - **C) MIPS**
     - C1) Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
2) Align any Provider Quality Incentives - (Health System or Health Plan)
3) MOC Credit
4) Align Residency Program – QI Projects

Recap Health System Criteria

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5. Reimbursement Pathways - Value-based vs Fee for Service
6. Bidirectional Referral (proof concept)

Wrap Up and Closing

Design Session Evaluation

https://nacdd.sjc1.qualtrics.com/jfe/form/SV_cZTUE94NALq7MPA

Thank you!

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