CENTER FOR ADVANCING HEALTHY COMMUNITIES | NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS — Promoting Health. Preventing Disease.

National Association of Chronic Disease Directors
CDC Arthritis Advisory Panel
August 8, 2023 @ 10:00 a.m. ET

Notes and Summary Document

- Meeting recording
- Additional information: Please visit the private Advisory Panel web page for a link to the recording, slides, summary documents, and additional information

Participants:

35 Total Participants (including presenters and facilitators)

Project Overview:

The National Association of Chronic Disease Directors (NACDD) Arthritis Portfolio is partnering with The Centers for Disease Control and Prevention (CDC) and other key partners 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.

Session Objectives:

- Review and discuss state and health system criteria.
- Debrief on revenue and incentives.
- Engage in peer-to-peer sharing, learning, and networking.

Presenters:

Lisa Erck, NACDD

- Welcome

Lisa Erck and Shalu Garcha, NACDD

- State criteria
- Health system criteria

Discussion Summary:

State criteria: Consider "must have" list and "most desirable" list.

- Team will need to define terms for implementation guide so that applicant understands practical capacity items needed for each criteria.
- It's important to think about smaller practices and less resourced communities and how the model could apply to these groups too.
- AAEBI capacity = must have
    - Pilot site should focus on a state with sufficient AAEBI capacity (e.g., CDC-funded state, ACL-funded state, or state that has direct contracting with healthcare payors).
    - Consider also working with a state with environmental factors for social interaction (e.g., 1115 Waiver).

    - Model should include state with AAEBIs delivered in multiple formats, including virtual/remote delivery, to reach as many patients as possible.
- Other evidence-based interventions for chronic disease - model should take advantage of linking arthritis with other chronic diseases and think about bundling or coupling interventions.
- Community Hub/centralized community coordinating organization = must have
    - Examples could include state with umbrella hub arrangement, network lead entity, management service organization, ACL CCH model, and others. Arthritis care model should clearly define what we mean by a Hub arrangement so that we are clear on who could carry out this role.
        - Arthritis care model is following this visual for Hub
    - Partnership to Align Social Care – National Learning and Action Network. This group will be releasing function and standard recommendations for community care hubs.
        - Trellis is part of this effort and there are workgroups that are essential to determine how to implement the broader design such as billing contracting. Heather Hodge, Y-USA, is also part of this effort.
        - Autumn Campbell at Partnership to Align Social Care can talk about managed care partners and investing in hub work with CBOs.
- Community health technology enablers
    - It is great to be listed as services on the social health access referral platforms (SHARPs), however, there must also be a payment mechanism for the CBOs.
    - Arthritis care model should consider not customizing EHR as this is a big expense and takes time.

Health system criteria

- Serves diverse populations
- Dedicated physician champion/leader
- Ability to collect and share key data
    - Would be great if the key data needed for arthritis care model was consistent with required quality measures (like HEDIS) that are already being collected.
- Reimbursement pathways
    - It is important to get the interventions like CDSMP and WWE as a covered benefit for health plan beneficiaries. To do this, it is essential to prove the ROI for the plans.
- Bi-directional referral
    - In this specific scenario it might be more important to have a healthcare system and CBO that have a strong working relationship that are willing to enhance a bi-directional referral pathway during the pilot rather than having a robust bi-directional referral platform that has very little engagement/use from the target organizations.

Future considerations:

- Team should consider including payer in pilot site discussion. Dr. Joy might be able to connect team to a contact at Aetna.
    - Bringing payer(s) is a mixed bag. It might lead to financial sustainability for the AAEBIs, but it will add many layers of documentation, administrative overhead and contracting to the CBO as well.
        - Contracting with an insurance company means accepting their rates which they have the right to change; rate can end up being less than it costs CBO to deliver the service.
- Pilot site should document ROI analysis.
    - Doing an ROI analysis will be a long game. It may not be possible to see enough costs savings from any one of these interventions in the 2-year timeframe to balance the expense up front. We're talking reduced costs over

decades which makes this challenging. If there are any areas that have already done an ROI calculation, then there was a suggestion to piggyback on their initial work.

- Trellis/Sarah Blonigan is currently working through proving the ROI based on self-reported data, which is collected via Juniper platform. Once the door opens with the payer/system they can evaluate at an identified participant level.
- Heather Hodge can speak to the ROI analysis done by CMS for the YMCAS's DPP
  - Suggestion to reach out to the AMA (Kate Kirley and Janet Williams) who have worked with the AMA economists to develop the cost savings calculator for the DPP.
  - The ROI analysis done by CMS for DPPs is key, and it is also important to make sure all costs of the administrative supportive services are captured, not just the cost of implementing the program.

- Pilot site selection should consider looking for a delivery organization that can bill insurance for interventions/activities. Note that this doesn't necessarily have to include AAEBIs as this could be added.
- Pilot should consider using data use agreements.
- Arthritis care model should document triple aim, patient experience, and improved clinical experience.
- Arthritis care model should focus on moving upstream with interventions that seek to prevent disease and decrease consequences of disease.

Additional information:

- The EIM Research Learning Collaborative (RLC) is an initiative that aims to bring together peers to learn, share, and apply best practices from the academic research community combined with the wisdom of front-line community service providers. https://www.exerciseismedicine.org/eim-research0/research-learning-collaborative/research-learning-collaborative-webinar-series/