National Association of Chronic Disease Directors
Arthritis Expert Panel II
March 21, 2024 @ 4:00 p.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:

32 Total Participants

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 and pilot 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:

- Establish a collaborative environment by facilitating introductions and highlighting the specific areas of expertise relevant to the Public Health Framework for Collaborative Arthritis Management and Wellbeing present in our meetings.
- Understand the roles of the partners and collaborators engaged in the implementation of the pilot project.
- Analyze the pilot project's implementation progress to date, identifying strengths, weaknesses, and any encountered challenges. Collectively brainstorm solutions and refine the implementation strategy based on these reflections.

Pre-meeting materials:

- Public Health Framework for Collaborative Arthritis Management and Wellbeing
- Description of the pilot/HUB/PHC
- Expert panel bios

Presenters:

Ali Jaglowski, NACDD Center for Advancing Healthy Communities
- Welcome

Lisa Erck, NACDD Center for Advancing Healthy Communities
- Introductions and roles

Julia Chevan, NACDD Center for Advancing Healthy Communities
- Overview of the pilot project and the "Framework"

Trina Radske-Suchan, Iowa Community HUB
- Description of Iowa Community HUB

Bery Engebretsen, Primary Health Care

- Description of Primary Health Care

Kathy Carluzzo, The Dartmouth Institute for Health Policy and Clinical Practice

- Role of Dartmouth Center for Program Design and Evaluation

Discussion summary:

- Prevalence of doctor diagnosed arthritis and link to co-morbidities
    - Arthritis is a leading cause of activity limitations, disability, and chronic pain, and is associated with dispensed opioid prescriptions, substantially contributing to health care costs.
    - During 2019–2021, 21.2% of U.S. adults (53.2 million) reported diagnosed arthritis. Approximately one half (52.2%–62.4%) of adults aged ≥65 years with self-reported diagnosed dementia, chronic obstructive pulmonary disease, stroke, heart disease, diabetes, or cancer also had a reported diagnosis of arthritis. Can we look into arthritis patients with doctor diagnosed depression?
    - All adults should take steps to prevent or manage arthritis - including maintaining a healthy weight, exercising regularly, and avoiding joint injury - to prevent long-term chronic pain and activity limitations.
    - McGrath R, Al Snih S, Markides K, Hall O, Peterson M. The burden of health conditions for middle-aged and older adults in the United States: disability-adjusted life years. *BMC Geriatr*. 2019 Apr 8;19(1):100. doi: 10.1186/s12877-019-1110-6. PMID: 30961524; PMCID: PMC6454610 link
- What should our final criteria be to define the target population in Iowa for this pilot? What criteria should we use to exclude patients?
    - Exclusion criteria should be limited as not all AAEBIs have a physical activity requirement.
    - What threshold will be used to gauge participation? Referrals to AAEBIs or physical therapy should have reasonably high fidelity assuming they are entered in the EHR or other system. A minimum attendance level in physical activity likely will be influenced by insurance benefit and co-pay or co-insurance burden - depending on the target/criteria set that could cause an interpretation problem.
    - Should we consider patient activation measures for the pilot? Can AAEBIs and evidence-based interventions be proven to better 'activate' patients in the management of arthritis and care?
- Reflecting on the pilot project activities to date, what questions do you still have? What additional information do you want?
    - What evidence-based programs are being offered in Iowa via Iowa Community HUB?
        - Here is a link to the Iowa Community HUB program library. Current evidence-based interventions include falls prevention programs such as Tai Chi for Arthritis and Falls Prevention, physical activity programs such as Walk With Ease, and self-management programs including Chronic Disease Self-Management Program/Better Choices Better Health.
    - What is payer mix and how will this be valuable when the pilot ends?
        - From PHC: Regarding the payor insurance mix in 2022, 46% of patients were on Medicaid, 28% were uninsured, 17% had private insurance, 7% were on Medicare, and 1% on public. Finally, 23% of PHC patients in 2022 were 45-64 years of age and 8% were over the age of 64.
    - What is the experience of Iowa providers in referring to evidence-based programs. How will conversations happen? Who will be generating referrals and follow through?

- How will clinicians be trained on the framework? How will healthcare providers be educated about AAEBIs?
  - NACDD will train healthcare providers using a learning management system with access to on-demand trainings about the framework and the model. Additionally, Iowa clinicians will take the Medscape Clinical Practice Assessment titled "Lifestyle Management Programs for Arthritis: Expand Your Knowledge on Evidence-Based Interventions."
- How will underinsured or uninsured be addressed?
  - Primary Health Care is an FQHC and FQHCs are intended to increase the provision of primary care services in underserved communities. Individuals receiving care from FQHCs are mostly low-income and uninsured or covered by Medicaid. Uninsured patients will be treated the same as insured patients for this pilot.

Follow up tools/resources:

- Link to complete list of arthritis-appropriate, evidence-based interventions (physical activity and self-management education programs that have been shown to improve arthritis symptoms including pain or limitations of function).
- The Public Health Case for Arthritis Presentation
- Hubs as HIPAA entities
  - Are Hubs HIPAA entities? Does that mean the Hub is essentially clinical care but delivered in community? Or is the Hub focused on non-clinical care in the community but in partnership with clinical care?
    - "HUB meets all minimum healthcare sector compliance requirements. The HUB maintains a formal compliance program consistent with the requirements of the HHS Office of the Inspector General. The HUB implements written policies, procedures, and standards of conduct; designates a compliance officer and committee; conducts compliance training; develops effective lines of compliance-related communications; audits activities involving confidential health information; enforces standards through guidelines; and corrects violations. The HUB has a written manual for policies, procedures, and standards of conduct focused on HIPAA compliance, service documentation, and non-duplication of services." Link to additional information.

Next steps and future considerations:

- How are we handling non-English speaking patients?
  - Will PROMIS be delivered in language that is native to each patient?
  - Is PAVS available in additional languages?
- Comorbidity and participation in physical activity b/c of impaired physical function
  - Patient may not have improvement in arthritis b/c of their physical function. Will this be taken into account?
  - Can some general comorbidities be collected in a standardized way? Like a Charlson Comorbidity Index, or extraction from EPIC problem lists?