**National Association of Chronic Disease Directors**
**Arthritis Expert Panel II**
December 5, 2024 @ 9:00 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
- These notes are derived from the Expert Panel meeting on December 5, 2024, and follow-up one-on-one meetings with panel members.

**Participants:**

26 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:**

- Foster a collaborative and open-sharing environment that highlights panel members specific areas of expertise enabling members to identify strategies and potential challenges in implementing the Public Health Framework for Collaborative Arthritis Management and Wellbeing.
- Analyze the pilot project's implementation process to date, identify strengths, weaknesses, and any encountered challenges.
- Consider the implications of the foundations of the pilot project toward growing the business case for AAEBI referral.

**Pre-meeting materials:**

- Background information on the work towards making the business case for arthritis-appropriate, evidence-based interventions

**Audience engagement activity:**

Share a creative way you've successfully opened the door to get decision-makers interested in your ideas OR What's the most memorable 'hook' you've used or seen someone use to capture attention for a new initiative?

- **Appealing to expertise and knowledge**: Acknowledge the individual's expertise to establish credibility.
- **Using intentional terminology**: Framing preventive care as "life care" to emphasize value.

- **Addressing pain points**: Focus on challenges such as scarce workforce solutions. Start by building relationships and listening to understand the decision-makers needs. Then, align solution with data and compelling stories.
- **Crafting a narrative:** Develop messaging that resonates emotionally, connecting with personal experiences.
- **Making the case for significance and impact:** Tailor the message to highlight the significance, impact, and innovation in a way that speaks to directly to the targeted audience.
- **Offering a competitive advantage:** Position solution as one that provides a clear competitive advantage or competitive edge over alternatives or competition.
- **Engaging stakeholders**: Involve key stakeholders in crafting the message to ensure it resonates across diverse perspectives.
- **Asking strategic question:** Frame questions in a way that guides the conversation toward your desired outcome.
- **Presenting solutions**: Offer solutions in a way that emphasizes partnership, collaboration, and mutual benefit.

**Iowa pilot discussion summary:**

- **Billing codes**: In response to information about the use of E&M codes for activity one panelist suggested that we should consider where and how the G codes for Chronic Care Management or increased visit complexity apply to billing. (e.g., G2211 or G0511)
- **Capture insights from patients:** Team should capture input from patients on acceptance of the intervention(s) to help tell the patient story and narrative for this work.
- **Pilot programs:** Propose additional pilot program(s) with measurable success metrics to demonstrate feasibility, ROI, and VOI before scaling.
- **Holistic approach:** Align efforts with other chronic conditions to address whole person care.

**Business case discussion:**

**Healthcare providers**

- **Chart burden and document time**: Healthcare providers need to understand the time commitment involved in charting and documenting, especially face-time requirements. They want clarity on whether they must personally perform every step of the framework/workflow and how long it will take to complete the documentation. Additionally, providers are interested in getting resources to their patients but are interested in learning how to add to workflow without adding burden.
- **Time as a barrier:** The issue of time is a very real barrier for healthcare providers and must be addressed when considering workflows and expectations.
- **Make it easy for providers:** They key to provider buy-in is to show that referral to AAEBIs is easy and doesn't impact productivity. To gain provider buy-in, ensure that the process of referring patients to AAEBIs is streamlined and simple with a clear value proposition.
- **Provider believes in something:** Highlight the importance of collaboration with community members and community-based organizations to strengthen trust and credibility. Encourage providers to connect directly with CBOs, emphasizing shared goals of improving health outcomes through accessible, culturally sensitive interventions. Demonstrate impact though evidence. Use clear, data-backed evidence to show how lifestyle change programs lead to measurable benefits such as reduced chronic disease rates, improved mental health, and better quality of life. Emphasize trust and importance of building relationships with community members and community-based organizations. The key will be to get providers to a point that they believe that lifestyle change programs make a difference.
- **Readmissions or complications:** Healthcare providers often feel helpless when it comes to addressing readmissions or complications, especially in patients with complex chronic

conditions. To help shift this mindset, it's important to empower providers with the right tools, support systems, and evidence-based interventions that can make a meaningful impact on their patients and help give providers tools to benefit patient well-being.

**Health system leaders**

- **Document ROI and VOI clearly and impact on bottom line:** Clearly outline both the upfront costs of implementation and the potential through reimbursement through value-based care models, grants, or other funding opportunities. Include both short-term and long-term financial projections to ensure decision-makers can evaluate both immediate and strategic impacts.
- **Marketing value of initiatives:** Frame the work as part of a holistic, patient-centered approach that aligns with the system's strategic goals. Emphasize long-term benefits such as improved patient outcomes, operational efficiencies, and enhanced reputation in the community. Utilize data storytelling to demonstrate how the initiative supports broader goals (e.g., improving access, addressing equity gaps).
- **Impact on patient readmissions:** Track and document reductions in readmissions associated with the AAEBIs, as these can directly affect reimbursement rates and financial penalties. Use comparative metrics (e.g., pre- and post-implementation rates) to show improvement trends. Highlight these data points in discussions to show measurable, financial outcomes.
- **Resource-optimizing:** The business case should focus on better use of resources and relieve burden for hospital system leaders and administrators. Frame solutions as a strategic tool to help leaders optimize operational efficiencies and relieve administrative strain. Illustrate how reallocating resources through innovative programs, preventive care models, or streamlined workflows, will reduce system strain and improve provider capacity.
- **Focus on clinical measures and workflow:** When promoting AAEBIs and lifestyle change programs, emphasize their direct impact on clinical measures that align with value-based care goals and quality performance metrics including chronic care management (e.g., HbA1c, blood pressure, weight reduction), heightened rates of preventive screenings, and patient engagement metrics.

**CMS and commercial payers**

- **Align strategies with payer priorities:** Highlight how lifestyle interventions improve quality of care and patient experience, which directly impacts satisfaction scores tied to payment incentives. Map out projected cost savings over time, including the reduction of unnecessary care or hospitalizations. Frame lifestyle change programs as proactive solutions that help move payers toward preventive care spending rather than reactive treatment costs.
- **ROI and VOI:** Money talks as does patient satisfaction. Make the business case to emphasize ROI and VOI as well. This is especially true with value-based payment models. By aligning lifestyle change interventions with CMS and commercial payer priorities—demonstrating measurable ROI and VOI, addressing sustainability with proven models like CHWs, and leveraging navigation services—you make a clear, compelling case. The goal is to show that these investments not only improve patient health outcomes but also align with the financial and operational goals of value-based payment models.
- **Interested in what competitors do and what regulators say:** When engaging stakeholders, especially payers or health system leaders, it's crucial to understand their interest in competitors and regulatory guidelines. Payers are keen on how their competitors are adopting and implementing lifestyle change interventions, particularly those that improve clinical outcomes and cost-efficiency. Highlight how similar organizations are integrating AAEBIs or other lifestyle programs into their care models, noting any success stories that demonstrate tangible benefits (e.g., reduced hospitalizations, improved patient satisfaction). Additionally, Emphasize how adopting these interventions can help stay ahead in a competitive marketplace,

especially in value-based care settings where early adoption can lead to superior performance on quality metrics and financial outcomes.

- **Center value and focus on money and profit:** When discussing initiatives like AAEBIs or lifestyle change programs with health system leaders, payers, or other stakeholders, it's essential to frame the conversation around value while emphasizing financial benefits and profitability.
- **Organizational capacity:** Instead of offering standalone programs like "falls prevention" or "arthritis programming," consider creating a comprehensive "service package" of services and programs. The HUB can play a key role in this approach, helping to address quality measures and enhance overall impact.

**Next steps and future considerations:**

- **Conduct qualitative assessments**: The team should conduct qualitative research with participants from the clinician training modules to evaluate effectiveness and identify opportunities for quality improvement.
- **Document insights and recommendations**: NACDD and Dartmouth should continue to formally document insights, lessons learned, and recommendations. This documentation will support replication, scaling, and future training and technical assistance beyond the pilot project. Additionally, a marketing and dissemination plan should be developed to share findings, promote adoption by other chronic conditions, and facilitate coordination for future efforts by NACDD, CDC, ACL, and other partners.
- **Holistic framework**: The framework should aim to improve both efficiency and effectiveness in care delivery. The team should explore how it can be applied not only to chronic disease self-management but also to other chronic conditions and health topics (e.g., healthy aging). Given that healthcare and primary care systems prefer non-disease-specific frameworks, this approach should be adaptable and broad and focus on aligning chronic diseases.
- **Impact on individuals with chronic mental health conditions**: The team should continue to assess the impact of the Community Care HUB and the arthritis framework on patients with chronic mental health conditions.
- **PHC Billing Codes**: The NACDD team should continue to explore specific billing codes for PHC and FQHCs to gather relevant data in the future. NACDD will meet with Julie Raasch, PHC Chief Operating Officer, and others to understand how billing will impact pilot and future scale and spread.
- **GLP-1s and landscape**: The ROI and VOI work should focus on the impact of self-management and physical activity, considering how the landscape is evolving due to the introduction of the GLP-1s and their impact on chronic disease management.
- **Core data sets**: The team should continue to focus on HEDIS measures, quality of life measures, and other core data sets that can be used for pilot projects, scaling, and spreading initiatives, as well as for building the business case. Additionally, the team should pay attention to the idea of a common data set across AAEBIs and evidence-based programs.
- **How do we handle those who want to bring SDoH screening and evidence-based programs in-house?** Some large non-profit health systems and insurers might want to bring community health workers (CHWs), SDoH screenings, and evidence-based programs in-house due to the perceived benefits of greater control over these services. The framework should continue to explore this idea.
- **Incoming administration:** The NACDD team should closely monitor Medicare Advantage plans, ongoing chronic disease initiatives, and stay informed about key priorities and the evolving political landscape.