Arthritis Council Workgroup: Healthcare Provider Counseling About PA and Referral to AAEBIs Workgroup Call
Thursday, June 2, 2022
2:00 p.m. ET

States in attendance: NY, NC, VA, WA, MN and RI

Additional attendees: Michele Mercier (CDC) and Serena Weisner (OAAA)

Facilitator/Moderator: Dr. Adam Burch, New Hampshire

Workgroup Overview:

This Arthritis Council workgroup is open to states and national partners who want to discuss the screening/counseling/referral of individuals with arthritis and the efforts to increase healthcare providers counseling on physical activity to reduce arthritis pain, and referrals by those providers to evidence-based interventions. Participants are encouraged to share successes, challenges, barriers and invited to discuss opportunities to facilitate success towards strategy 2.

Opportunities for Collaboration and State Sharing

- Participants were asked to share one significant non-COVID related barrier that they have faced related to Strategy 2 (in last two years) and any approach taken to address the barrier.

State Sharing

New Hampshire

- NH partners use Centricity for EMR; discussion on where to record physical activity information.
    - Note - EMR and integration of PAVS looks different for the annual physical and for acute care visits
    - Barrier – found that there were a lot of tabs at the top of the EMR and therefore there was a need for scrolling to see all tabs available; a new tab (e.g., PA) would get lost and most likely never be seen (this was noted by provider/patient care team); EMR programmer never thought about this.
        - Scrolling down would also present problems.
        - A similar problem was occurring with cardiovascular function screening
    - Solution/approach – found that the PHQ depression screen had room for the PAVS without scrolling. This screen is used at EVERY visit.
    - Lesson learned – look at screen shots or go through a sample view/screen for data entry to make sure there isn't a need to search for form; if a search is needed the form will likely not be filled out.

Additionally, work with a team from the health system to ensure that various perspectives are shared.
    - Question – is there anything going out for the after visit summary? After tool is used and physical inactivity is prompted; the primary care patient care plan provides an opportunity to make an electronic referral.

Comagine (Washington)

- Barrier – Need to work with others that use same EHR to present buying power to get changes made. There was an ask for suggestions on the best way to do this.
    - For clinics that don't own the EHR (e.g., FQHCs), the workarounds are hard and when upgrades are made things get lost since the workaround wasn't part of EHR.
    - MN has a user group for Epic which is the power group to help push for change.
- Question – Has anyone been part of conversations about who bears the burden of these EHR costs? Is it always the health system? Should it be the payor?
    - In most cases the health system will have to bear the brunt of the EHR costs. A case can be made if the payor requires certain things added to an EMR that is not required for certification. If a national organization forces a change that alters a component for EMR certification, then the vendor will have to eat the costs to keep their certification status.

Washington

- Barrier - Arthritis falls low on the priority list.
    - Talked about rebranding arthritis as a PA counseling piece which has helped others and created buy in.
- Note – WA did a webinar and slides and recording will be available soon. Overview of June webinar is below.
    - *Arthritis: Screen, Counsel, Refer for Chronic Conditions: A guide to physical activity counseling and arthritis appropriate evidence-based interventions (AAEBIS) in Washington State*. Comagine Health and the Washington State Department of Health held a webinar on June 1, 2022 on physical activity counseling for patients with arthritis and other chronic conditions. This webinar explored the "screen, counsel, refer" process for patients with arthritis, as well as materials and techniques for effective patient counseling and sample workflows for referrals to arthritis appropriate evidence-based interventions. Information was shared on the environmental scan of AAEBIs in Washington state and how to connect patients to local resources.

- It was shared that registered dietitian nutritionists (RDNs) at St Joe's were using work flows like this: https://www.exerciseismedicine.org/wp-content/uploads/2021/08/ExerciseIsMedicine_v8.pdf

Oregon
- Meredith is new to the arthritis program, and she shared that physical activity policy work is a focus of the program.

New York
- Barrier – Strategy 2 was a challenge before pandemic and the challenge continued into pandemic.
    - Health Information Exchange was working to train providers on referral to AAEBIs.
    - Reduction in staffing prior to pandemic caused limited resources; practice facilitator position was eliminated so no one to help people with referrals, which caused referrals to stop.
- Solution - Two targeted campaigns were conducted.
    - A social media campaign for HCPs in particular areas of the state (included LinkedIn and journal websites) provided info on counseling and referral for arthritis.
    - A direct mailer to PTs and OTs, working with YMCAs – still finalizing outcomes.

Minnesota
- Barriers - FQHCs in MN, prior to pandemic, had changes in staff which caused problems. Health systems merged as they were being engaged.
- Lesson learned - don't reach out to health systems that are in the process of merging.
- Solution - Sage+/WISEWOMAN has added in WWE as one of the programs that can be offered to patients; weaving in AAEBIs as PA programs to benefit other chronic conditions.
- MN shared that their WISEWOMAN program has been open about working together but they are just beginning the partnership.
    - Patients are offered a menu of programs that they can be a part of; working to figure out how to best meet the needs of patients and promote PA and AAEBIs.

Virginia
- Barrier - FQHCs were going to embed prompt into eClinical Works for PA/AAEBI referral but due to staffing changes it didn't happen. However, referrals for WWE were conducted.
- Lesson learned – If partnership with an organization is made, ensure all know about this agreement and follow up on agreement on a regular basis.
- Approach/Solutions
    - Currently working with local health districts to embed AAEBIs into UniteUs and pilot in two health districts.

- Discussion with Weight Watchers re including WWE in marketing materials for state employees.
- WWE and CDSMP integration into EWL/WISEWOMAN program options.
- Work with a team of individuals to try to ensure that multiple decision makers are part of the discussion.
- Dialog with Medical Society of VA re including AAEBI information as a component of marketing efforts (FB page, monthly newsletter, etc.)

North Carolina

- Barrier - measuring impact in Strategy 2; can measure number of physicians reached, health coaches, etc., but not impact. For EHRs (e.g., NCCare360) it is hard to measure impact since there aren't a lot of referrals being made yet, but a significant amount of work is being done both with NCCare360 and health coach training.
- Question re health coaching program and who is leading.
  - NC arthritis program is working with UNC Greenville (part of the UNC family) since they have a health coaching program that can certify individuals. Using the Iowa model to use students and health coaches to further engage participants in the OAAA WWE Portal

Rhode Island

- Toolkit for providers was created and included a three-step process (assess, counsel and referral/connection to community health network).
- Barrier/challenge is getting HCPs to utilize the Toolkit and use the patient resources.
  - Conducted an evaluation/assessment of 8 practices (FQHCs) with only had three responses; two indicated that they were engaging in PA counseling/referral; the third wasn't aware of the CHN and programming.
- Approach - Taking a look at how better to get information out; thinking about engaging HCPs outside of FQHCs with Toolkit.

Group Discussion/Takeaways:

- EMRs
  - Epic and Cerner are the 2 largest EMR systems in the nation and both offer developer APIs so most hospital networks could add 3rd party elements if needed without going direct to EPIC. If a hospital network wants to treat PA screening as a vital sign EPIC already created, it so there is no reason to pay for the development again. It helps to know this going into any talks with a partner that uses Kaiser already.
  - NH is working to set up a partnership with an organization that uses Epic.
  - Developer API – can hire a third party to do programming changes you need rather than going to Epic; this could be a good intermediate step.
  - FHIR and data transmission should be considered.

  - Kaiser did integration of PAVS into Epic; Epic should be able to turn this back on at any time.
- Discussed working together as a group to make changes in EMRs.
  - More funding might be available for a hospital system that crosses state lines into more than 1 funded state. Bigger total impact lower total cost for each program. Neighboring states should take a look at joint projects if possible.
- AAFP - https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf
- Look for program in your state that has good physical activity component or robust network. Find out who is in charge of this programming and befriend them. They already have a system, network and relationships in place. Use this to your advantage.
  - Example. Adam has a relationship with Diabetes and WISEWOMAN programs. WISEWOMAN already has PA built into their screening so working with them makes sense. Pick partners based on who you already have relationships with.

- How do we know if we are doing things right, talking to the right people, etc. when it comes to working with HCPs?
  - We are talking about changing the way patients are cared for so it takes time – there are no quick wins.
  - Consider this - for providers, 80% of the day is what was taught in school and 20% is what they learn from CMEs. The CE information is received well but may not be retained by providers. Work with University (medical school – pediatric, geriatric, endocrinology, etc. and anywhere that PA fits in) to integrate physical activity counseling into the curriculum for a more sustainable approach.
- Opportunity for HRSA to enforce/mandate reporting of PA measures; if something like this happens then EMR vendors will need to incorporate which would benefit us.
  - AMA has ability to push HRSA to incorporate PA measures.

Additional Resource/Discussion Items:

- Next call is August 4 at 2pm ET
- For the next call participants should come prepared to share one missed opportunity from their current five-year grant. For example, what had to be restructured or done differently, what original ideas fizzled and what was done to refocus efforts. Please be ready to share your learning so participants can learn from your work.