**Arthritis Council Workgroup: Healthcare Provider Counseling About PA and Referral to AAEBIs Workgroup Call**
Thursday, November 3, 2022
2:00 p.m. ET

**States in attendance**: Caitlin Gurney, Shea Kelly, and Sherri Rohenaz (NY), Lindsay Nelson (MN), Sarah Blonigan (MN/Trellis-Juniper), Nadia Mazza and Amyia Hardy (NC), Mona Burwell and Karen Day (VA), Jasmine Franco (RI), Renee Allard (IA/CHPcommunity), Theresa Kreiser (WA/Comagine), Lynnzy McIntosh (NM/Workshop Wizard)

**Additional attendees:** Katie Huffman and Serena Weisner (OAAA), Audrey Williams, Margaret Kaniewski, Michele Mercier (CDC), Cheryl Schott (ASTR/CDC Contractor), Lisa Erck, Shalu Garcha and Heather Murphy (NACDD)

**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**

Prior to the call, participants were asked what does an ideal bi-directional referral system look like for your partners? Partners include CBOs and clinicians. What does the referral system look like for the individual that needs services?

**State Sharing**

- New Hampshire
    - Patient goes to primary care with pain, completes health history and discusses physical activity with healthcare provider. Patient is ready to be physically active but worries about pain levels increasing. Ideally, primary care physician would go in through Electronic Medical Record (EMR) and link to bi-directional platform to refer patient to evidence-based program and referral would be received by partner like Granite YMCA (that is part of Welld).
        - The YMCA would receive all the patient information, create a record, call patient, and offer a program that fits the prescription of the physician

        - Patient is scheduled and goes to program and information is digitally shared with physician (no faxes or scans) which allows trend analysis, tracking, etc.
- New York
    - Need to demonstrate the importance of the bi-directional referral system; include incentives for the referrals which might help with buy in; make sure the process is an easy lift for partners; an integrated process within EMR for one sign on; and, ensure there is training for providers/practitioners on how to use the system.
    - Important to have an active and accurate list of workshops and include clear guidance on who can make the referrals (physician, CHW, etc.); self-referral is also important, and referral needs to be open and free for individuals to do on their own.
        - NACDD shared a link to a past TA webinar with Findhelp and Unite Us. Please note that additional tools, notes, and resources have been added to this page. https://actiononarthritis.chronicdisease.org/collaborating-with-community-resource-referral-platforms-and-integrated-health-and-social-care-networks-may-3-2022/
    - NY shared resources that have been helpful
        - https://www.cdc.gov/diabetes/prevention/videos/resources/national-dpp-implementing-bi-directional-referrals-webinar_slides-508.pdf
        - https://365.himss.org/sites/himss365/files/365/handouts/552565546/handout-83.pdf
- WA
    - Don't have a centralized referral system for EBIs in state and referral happens through clinician; currently working with community health workers (CHW) on mechanisms for referral.
    - Accountable Communities of Health (ACH) have taken on role for care connect hubs (like pathways model); clinician refers to a centralized system where CHW reviews and assists the patient in making decisions.
    - Accurate lists of programs/interventions for referral are needed; potential solution would be something like Compass.
- VA
    - Ideally would want to connect CBOs into EHR integration and bring more awareness of the possibilities regarding referral, with EHR integration.
    - Looking to CHWs and the UniteUs work to move forward with referrals for programs.
- NC
    - Ideal model will hinge on NC360 and UniteUs platform and the information on programs that is included in the platform.
    - Programs will need to be available year-round; referrals need to be easy and streamlined in EMR and need bi-directional ability.
    - Self-referrals are also an important element, through patient portals and supported by healthcare provider.

  - Providers and patients need to be aware of referral mechanism, know how it works and see value/importance.
- IA
  - Assessing where HCPs are with their ability to refer is important.
  - Have become an embedded referrer within FQHC system (via e-fax which can be uploaded into the CHPcommunity system/platform).
  - CHPcommunity and partners use the Workshop Wizard platform.
  - Exploring SyncHealth (HIE in IA) and receiving referrals from healthcare partners through them.
  - Also looking at receiving referrals in different ways – direct, through queries, etc.; creating navigator positions (e.g., CHWs) within hub to handle referrals; and addressing social determinants of health, connecting the patient with other resources.
  - Hoping to use patient portal to send resources; want to align processes and help providers.
- RI
  - Referral system is set up; collect referrals via fax and EMR from providers.
  - Feedback regarding referrals is provided via fax currently but working to adapt this to better meet needs of HCP.
  - Working with an external vendor to provide feedback to HCP; also want to share pre/post survey data with HCPs (e.g., fruits and veggies consumed, minutes of PA, confidence in managing pain or condition) so working with vendor on this too.
  - Ideally would like to see more integration in EMR/EHR; would like to see patient navigators connect 6-12 months after programs to continue the conversation with patients.
  - RIPIN does the daily operation for community health network; once pt's attend one session, their information becomes automated (via Salesforce), so surveys can be done electronically. The downside, data collection has gone down b/c they don't have as much control virtually as with in person (that is, fewer individuals fill out the surveys).
- MN
  - In early stages of connecting with UniteUs.
  - Will be focusing on some EIM projects; screening tools and referrals.
  - Trellis is partnering with other AAAs; social determinants of health screening is done through Trellis (AAA); they developed an EHR like referral mechanism, but it is not yet bi-directional.
  - Trellis is looking into developing an AIP so they can talk to EMRs.
  - There is no centralized health integration platform, so they have been using CHWs/health navigators as a solution.
  - Have a wellness engagement center in MN and they do provide feedback on a quarterly basis to health plans, and bi-directional feedback.
  - Know that SHARPs are just a tool; ideal mix of integration of EHR is with CHWs/patient navigators.

- Workshop Wizard/Lynnzy
  - Shared that MD has a bi-directional referral system that has been in development for a long time with slow uptake.
  - A bi-directional referral system needs to be something health systems and HCPs will use; right now, it's seems to be easier for clinics to use paper.
- Katie – OAAA
  - An ideal system has a search function embedded within EMR so HCP can search based on a key word; in this case HCP wouldn't need to know about all the programs that exist, but rather just enter the search word for all programs available.
  - Would be nice to have a printout for the patient or something in patient portal so they have information they can refer to after they leave the medical visit.
  - Flagging the chart in some way to notify the provider that their patient was referred and reminding HCP to check in on patient needs and whether they are being met or not.
  - System needs to have a tracking feature on number of referrals, those that were successful, etc.
  - Having a navigator (sweeper) that is coming behind HCP and keeping up with referrals to make sure that they are not falling through the cracks.
  - OA Care tools – providers want to know what programs are in place and that they are accessible to all pts and in communities where they live; also need access to simple handouts for patients in the system.
- OAAA WWE Portal
  - Ideally would like to have a bi-directional system through Portal.
  - Want to build a health coach layer into Portal so that the coach has access patient/participant progress in the program and can support participant.
  - Comment - another ideal part of the bi-directional referral process is to ensure there is sustainable funding/value-based agreements with entities at risk to help close social needs gaps.
- CDC
  - Comment – Consider the use of patient portals to create demand on patient side

**Key Themes from Discussion**

- Start with the customer profile if you haven't done this before
- Need to also think about the providers perspective and the CBO perspective
- There are many mechanisms for referral (e.g., HIEs) but this varies by state/location

**Homework**

Create a customer profile for a fictional person in your state that would benefit from an AAEBI and think of 3 barriers that you think they could overcome through new partnerships.

**Additional Resources**

- Next call, December 1, 2022 @ 2:00 p.m. ET