

Centers for Disease Control and Prevention
Public Health - Health Care Collaboration Workgroup of the
Advisory Committee to the Director

March 24, 2017
1:00 p.m.
Webinar

Committee Members

LaQuandra Nesbitt, MD, MPH (Co-Chair), District of Columbia Department of Health
Sara Rosenbaum, JD (Co-Chair), George Washington University
Jandel Allen-Davis, MD, Kaiser Permanente Colorado Region
Tony Beltran, MBA, Trinity Health
Benjamin Chu, MD, Memorial Hermann Health System
Brenda Fitzgerald, MD, Georgia Department of Public Health
Sandro Galea, MD, MPH, DrPH, Boston University School of Public Health
William Golden, MD, MACP, Arkansas Medicaid
Ed Hunter, MA, De Beaumont Foundation
Lesley Leiserson, Home Depot
Lewis Sandy, MD, MBA, UnitedHealth Group
Rebecca Owen, FSA MAAA, Society of Actuaries
Ruth Raskas, JD, Anthem
Steve Rosenthal, MBA, Montefiore Health System
Ron Yee, MD, MBA, National Association of Community Health Centers

Absent

Jay Bhatt, MD, American Hospital Association
Rebekah Gee, MD, MPH, Louisiana Department of Health
MaryAnne Lindeblad, Washington Medicaid

Also Attending

Laura Seeff, MD, Designated Federal Officer, Office of Health System Collaboration, CDC
Melanie Duckworth, PhD, Health Disparities Subcommittee, CDC
Tracie Strength, Protocol Specialist, CDC

Welcome – Co-Chairs and CDC Designated Federal Official

Dr. LaQuandra Nesbitt, Co-Chair of the Centers for Disease Control and Prevention (CDC) Public Health - Health Care Collaboration Workgroup of the Advisory Committee to the Director (ACD), welcomed members and thanked them for their attendance. The Workgroup was formed to help support collaboration efforts between public health and health care and so serves an important purpose. Sara Rosenbaum, Co-Chair of the Workgroup, added her thanks and agreed with the importance of the Workgroup. The Workgroup consists of new and returning members of the ACD and is meeting for the first time in this webinar. Dr. Laura Seeff, Designated Federal Official (DFO) for the Workgroup, welcomed members and added her thanks. Dr. Seeff directs CDC's Office of Health System Collaboration (OHSC) and expressed OHSC's advance appreciation of the Workgroup's input on collaboration between public health and health care sectors.

Workgroup Roll Call

Dr. Seeff conducted the roll call. Members were asked to state their names as well as any conflicts of interest. Members should have received a conflict of interest form prior to the meeting. Those that did not asked to have the form emailed to them.

Workgroup Orientation

Co-Chair Rosenbaum gave the presentation, which was divided into four segments.

ACD Roster

Workgroup members can serve a total of two terms, with the opportunity to renew after completion of their first term. Those in a public sector position serve two-year terms while those in a private sector position serve three-year terms.

Charge

The Workgroup's charge is to 1) provide guidance and input to the ACD regarding CDC's efforts to use evidence to inform payment and delivery of preventive services, 2) advise the ACD on the best methods to sustain and scale priority public health and health care collaboration initiatives, and 3) recommend to the ACD the highest impact opportunities to sustain outcome-oriented collaboration between the CDC and public health agencies and the health care sector. The ACD asks that the Workgroup make evidence-based recommendations that are feasible for the CDC to address, promote improvements with a large-scale impact on public health and health care, and have an identifiable outcome beyond additional process steps.

Workgroup Process

Workgroup members should consider two questions for each discussion topic area for future recommendations to the Advisory Committee to the Director. The first question is, where are there gaps in public health collaboration with the health care delivery system that the CDC might be uniquely

positioned to fill? The second question is, what are 2-3 prioritized and time-bound actions that the CDC should consider? Recommendations can include many elements, such as partnerships and processes necessary to move the field forward, potential presenters and ad hoc consultants to the Workgroup to further inform recommendations, and actions that can be taken to address gaps. Workgroup members will discuss the best process to develop recommendations at their in-person meeting in April.

2017 Committee Meeting Schedule

The Workgroup will have an in-person meeting on April 19th in Atlanta, Georgia. On April 20th, the ACD will meet, where the Workgroup Co-Chairs will highlight the Workgroup's deliberations and proposed process to develop recommendations. The Workgroup will have another webinar in September to prepare final recommendations for a future ACD meeting.

Overview of CDC's Public Health-Health Care Collaboration Initiatives

Dr. Seeff presented the overview. Two broad contexts have informed the CDC's work on public health and health care collaboration, including dynamic changes to the health care system and the public health sector. The CDC has supported initiatives to align complementary skills among public health and health care entities in order to reach shared goals. The CDC has several examples of public health and health care collaboration at the federal, state, and local level. At the state and local level, the CDC works with state Medicaid agencies and State Innovation Model awardees, among others. The CDC also has strengthened partnerships with federal agencies such as the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of Personnel Management (OPM). A fundamental part of these partnerships is the use of evidence to develop and support interventions to prevent and control health conditions. The CDC also has a growing number of public-private partnerships and has established a unit to help coordinate relationships between the CDC and private sector.

The CDC's 6|18 Initiative is a cross-agency partnership between public health and health care purchasers, payers, and providers to translate effective evidence-based public health interventions into public services accessible to all insured Americans. 6|18 has two primary goals: to establish sustainable cross-sector relationships between public health and health care sectors and to use evidence-based interventions to improve health and control costs. Establishing these cross-sector relationships will help entities develop effective interventions. The 6 in 6|18's title refers to six health conditions that 6|18 is working to address: health care-associated infections, high blood pressure, diabetes, asthma, tobacco use, and unintended pregnancies. These conditions were chosen because they are common, expensive, preventable or controllable, have interventions that can be scaled up quickly, and have specific evidence-based actions that payers can ensure are covered benefits and are accessible to all insured Americans. The 18 in 6|18 represents a set of 18 evidence-based interventions associated with each of the 6 conditions that health care purchasers, payers, or providers can implement.

6|18 was launched roughly a year ago, and in that time nine state public health agency and Medicaid agency teams have been implementing a set of 6|18's interventions. The nine states prioritized tobacco

use, asthma, and unintended pregnancies as health conditions to address and were interested in testing the associated evidence-based interventions. Leadership in these states supported partnerships between Medicaid and public health agencies. States that did not have this joint support did not participate. The nine states also have a high penetration of Medicaid managed care in most of their Medicaid programs, and so the Medicaid managed care programs act as an important partner.

The CDC is interested in the series of events that allows a state payer and public health partners to move from considering health conditions to using the Initiative's interventions to improve health and decrease costs. One of these steps is a payment change for services related to the Initiative's six conditions. What are the levers that states are using to make these payment changes? Once the interventions become available, CDC will assist health care system-public health teams in exploring how to best use evidence so providers and consumers can utilize the services. Use of the interventions will hopefully improve health outcomes and decrease costs. The CDC is working with states to ensure that they understand this process.

The CDC has been able to set up a technical assistance infrastructure around the nine states that have been implementing 6|18. They have been able to do with funding from the Robert Wood Johnson Foundation to the Center for Health Care Strategies. This has given states protected time to work together across sectors with subject matter expertise support from CDC to implement interventions from 6|18, which in turn has allowed entities to learn from each other and develop best practices. The nine states had already prioritized which health conditions to address, and so 6|18 acted as a catalyst for priority efforts already underway in the states. Medicaid agencies should have a baseline understanding of what services are covered by the Medicaid managed care program. In order to ensure that interventions become readily available to Medicaid recipients, states are taking actions such as amending state plans with CMS and changing billing features. In some cases, state Medicaid agencies are making changes in their contracts with managed care organizations (MCOs).

In parallel to the work being done with Medicaid and public health, the CDC is working with several large commercial payers at the federal level. The CDC is asking the payers to prioritize the six health conditions in 6|18. So far, the top priorities have generally been diabetes prevention, hypertension control, and asthma control. The CDC has met with payers to understand gaps in their ability to improve access and control the above health conditions. Payers discussed how to use behavioral economics to get providers to engage and deliver new services and how to do better targeted member engagement.

Discussion Topics

Co-Chairs Nesbitt and Rosenbaum led the discussion. Members were asked to give their thoughts in the context of Dr. Seeff's presentation as well as share their experiences in their own settings. The discussion was broken into three topic areas, and for each topic area members were asked to consider where there are specific gaps, which activities are likely to have the greatest impact, and how action can be catalyzed.

A. Investing in Prevention

Three specific questions posed to members for this topic were:

1. How can the CDC continue to support effective public health and health system collaboration at the state, local, and health system level?
2. How can the CDC continue to encourage delivery systems and payers to invest in patient-centered prevention?
3. How can the CDC most effectively sustain and scale early successes among federal, state, and local public health as well as state Medicaid agencies and commercial insurers?
 - Member Allen-Davis asked to what extent states are aware of evidence-based prevention data and measures that exist at the state level. Is this information readily available and is there a way to share gaps at the state and local level?
 - Member Golden commented that there is often an underappreciation of actions that payers and Medicaid programs are already taking, and that the CDC and health departments are becoming collaborators alongside these entities. Another issue is model development.
 - Member Golden's organization, Arkansas Medicaid, has partnerships with health departments to develop health information exchanges (HIE), registries, and scorecards. They are being careful not to create silos in their new prevention models. They are empowering local medical homes to lead the development of public health prevention population self-measurement.
 - Co-Chair Rosenbaum said that the challenge and opportunity of 6|18, which is especially true with Medicaid agencies, comes as more and more agencies are looking at a form of global payment. The question is not if a specific procedure is covered, but rather what the underlying assumptions are for the global payment and if a robust prevention performance expectation is built into the payment system.
 - Member Golden added that, in his example, all local medical homes need to achieve certain benchmarks for shared payments. Arkansas Medicaid is developing mechanisms to help these entities understand quality gaps in real-time so that they can achieve these benchmarks.
 - Co-Chair Rosenbaum commented that the CDC might find thinking about the relationship between the delivery system and financing useful, such as whether a delivery system and its intermediary have been incentivized to focus on prevention and what this focus would look like.
 - Member Golden agreed but added that he wouldn't want to necessarily prescribe how to obtain this focus, because the effectiveness of certain methods could change depending on the system.
 - Co-Chair Nesbitt said that she also understood Member Golden to say that the CDC should be mindful to establish infrastructure in the public health system that can be better achieved in the health care setting where they'd be most effective. Not doing so could unintentionally create silos. Member Golden agreed and added that public

health and health care structures should complement each other rather than stand alone.

- Member Raskas commented on the importance of the broader health community in thinking about effective ways to engage consumers in uptake of services.
- Member Allen-Davis added that there is an opportunity for the CDC and public health entities to campaign at a community level to get more people enrolled in services.
- Co-Chair Nesbitt commented that this could be changed depending on which organization is closest to the community.
- Member Chu suggested the idea of expanding to other community resources, including churches, etc.
- Member Yee commented that primary care providers (PCPs) often don't have the information they need about a patient to recommend preventive health services. This could be addressed by having payers exchange information with PCPs about members so that PCPs could then proactively contact patients with information about preventive health services.
- Member Golden said that this is what they are doing in Arkansas. The payer community has concluded that it will largely be the one to finance a robust data infrastructure and is working with the Arkansas Department of Health to put this infrastructure in place.
- Member Golden believes that the CDC and the Workgroup should track this project. Co-Chair Rosenbaum agreed that it is very important for the CDC to be involved in discussions about information systems.
- Member Allen-Davis agreed and added that these systems should take into account that people move from coverage to coverage.

B. Hospital Community Benefits

Hospital community benefits have garnered a lot of attention in recent years. There has been a fundamental rethinking in communities about the best way to design community benefit spending. Members were asked to consider the following questions:

1. How can the CDC best leverage the process of assessing community-wide health needs?
2. Which community benefits activities can extend the 6|18 goals?
3. What other clinical and community supports can community benefits resources offer?
4. How do community supports benefit from the community benefits process?
5. Are there examples of community benefits activities that are designed to complement a prevention agenda that consists of prevention in the community as well as access to clinical prevention?
6. Are there examples of relationships between entities that are shaping community benefits strategies and entities that are shaping clinical prevention strategies, and how likely are these to be the same entity?
7. Can the CDC learn anything from these relationships?

- Member Allen-Davis discussed the work being done in Colorado around food insecurity. Food insecurity directly impacts some of the health conditions addressed by 6|18. Some of this work revolves around using 211 centers as a go-between for payers and social agencies. She also suggested addressing unintended pregnancies by understanding how to more intentionally partner with the Nurse Family Partnership.
- Member Rosenthal believes that large health systems should be a focus, many of whom have community partnerships in states, particularly in those that are focused on the Section 1115 Medicaid waivers. A state must have outcome measures demonstrating community involvement in order to receive funding from this waiver.
- Co-Chair Rosenbaum said these state initiatives share several features, the core feature being an emphasis on trying to achieve and measure gains in health and greater value for Medicaid investments.
- Member Beltran added that the amount of collaboration varies between those working on community benefits and those providing direct clinical services. Creating a strategic initiative across health systems would be helpful. Work between 6|18 and community benefits can present some challenges, because there is often pushback from local hospitals about the importance of their local health needs assessments. It is important to make sure that 6|18 actions don't stifle what is important at a local level to communities. It is also important to ensure that vulnerable populations within communities are identified and helped.

C. Sustainability

Members were asked to consider the following questions:

1. How can the CDC support prevention-oriented payment and health care delivery, use of evidence to inform coverage decisions, and cross-sector partnerships?
2. What systems-level changes can the CDC and external stakeholders consider to sustain effective public health-health care partnerships and payment and practice changes via education and training, sustainable practice and payment shared learning platforms, local foundation support, and others?
 - Co-Chair Nesbitt said that initiatives with an emphasis on paying for value rather than volume lend themselves to sustainability. However, she does not want to limit the discussion to payment reform as the only way to sustainability. Sustainability is defined from several perspectives. One is institutionalizing pilot programs and initiatives that effectively close the gap between public health and health care. Another is understanding what kinds of policies and programs can be put in place to make this type of work sustainable. There is often a workforce and training component to consider.
 - Member Hunter discussed sustainability from the viewpoint of normalizing intersections between health care and public health and obtaining consensus.

- Member Chu discussed the key components of Kaiser Permanente's success in hospital-acquired infections prevention work. It was measurement, reporting, and comparison of performance across sites that drove improvement more than the incentives and disincentives related to value based purchasing.
- Member Golden said that it is important for health departments to consider what their niche is in this environment. New enterprises should come to the table with specific skills rather than global programmatic ideas because a lot of thought has already been put into program design. At this point, new enterprises will be coming in as contributors rather than architects.
- Member Allen-Davis commented that there is important evaluation pre-work to be done to show why investing in prevention is beneficial and what methods are effective.
- Member Yee asked what is required for a payer to decide to cover a service or test. Once providers understand this, they can gather the necessary data and complete the necessary tests. Once payers begin to cover a service or test, PCPs will begin to use them.
- Member Golden said that return on investment and accountability are very important in these situations. Accountability is especially important when gathering evidence for an evidence-based measure.
- Member Allen-Davis commented that public health entities and the CDC might be uniquely positioned to bring stronger evaluative components when addressing social care needs. These entities could also bring an understanding of the larger ecosystem and its trends.
- Member Raskas commented that another dimension could be creating effective and innovate publicity for preventive measures in a unified way in order to engage the public. Co-Chair Rosenbaum commented that because of the nature of insurance coverage, it can be difficult to find evidence on the effectiveness of a measure within a particular timeframe and maintain effectiveness across systems and timeframes.
- Member Beltran added that the CDC can help payers by showing prevention's long term effectiveness and cost efficiency.
- Member Allen-Davis argued that public health entities and the CDC should also challenge the notion that it takes a long time to see the effectiveness of a prevention measure.
- Co-Chair Nesbitt thanked members for their discussion and summed up recurring themes. These themes included focused evaluation and measurement efforts, using lessons learned in other CDC-supported initiatives, using comparison reports to drive results, and shifting payers' thinking about the need to finance areas that have traditionally been thought of as in the realm of public health, such as prevention and social support services.

- Co-Chair Rosenbaum added that the Workgroup's challenge is to figure out where the CDC brings added value to the public health and health care collaboration arena.

Close and Next Steps

The Workgroup will have an in-person meeting on April 19th at which they will continue today's discussion. Themes from this discussion will be presented to the ACD on April 20th. Questions about travel and logistics can be directed to Dr. Seeff. Dr. Seeff thanked members and the co-chairs for their work and participation.

There being no questions, the webinar adjourned at 2:30pm.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the March 24, 2017 meeting of the Public Health-Health Care Collaboration Workgroup of the Advisory Committee to the Director, CDC are accurate and complete.

Date

LaQuandra Nesbitt, MD, MPH
Co-Chair, Public Health-Health Care Collaboration
Collaboration Workgroup, CDC

Date

Sara Rosenbaum, JD
Co-Chair, Public Health-Health Care
Collaboration Workgroup, CDC