CDC/DSTDP National Partners Collaborative on Public Health and Primary Care Integration for STD Prevention

Aug. 15–16, 2013, Meeting Summary
Atlanta, GA

December 2013

Background

Achieving substantial and lasting improvements in the health of individuals and populations will require significant changes to the U.S. healthcare delivery system. Among these changes is the opportunity to better coordinate and, in some cases, integrate primary care and public health activities and health delivery systems. The need for increased coordination, collaboration, and integration is evidenced by the fact that the quality and outcomes of healthcare have not kept pace with the resources invested in the system. Furthermore, services are often fragmented and delivered in isolated systems that do not benefit the patient or support improved outcomes.

Recognizing the need to coordinate efforts better across the public and private sectors, the Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Disease Prevention (DSTDP) funded a group of national organizations to explore the concept of public health and primary care integration, specifically related to STD prevention and service provision. The national organizations are the Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Community Health Centers (NACHC), and National Coalition of STD Directors (NCSD). In collaboration with CDC/DSTDP, these organizations established the National Partners Collaborative on Public Health and Primary Care Integration for STD Prevention in March 2013.

The National Partners Collaborative met Aug. 15–16, 2013, in Atlanta; the meeting brought together local and state public health and primary care representatives to explore integration specific to STD prevention and service provision. This report provides an overview of the activities and planning process that resulted in the meeting and summarizes the dialogue from the meeting.

Five principles guided the efforts of the National Partners Collaborative:

- Common vision and goal;
- Intentional process to include multidisciplinary perspectives;
- Engagement of multiple levels (national, state, and local) of the public health and healthcare system;
- Design of the August 2013 meeting with knowledge about the current state of the field; and
- Support for a face-to-face forum for listening, leveraging, linking, and learning about stakeholders' experiences.

The work of the National Partners Collaborative is informed by recent national-level policies, reports, and efforts to address the quality and outcomes of healthcare, including the following:

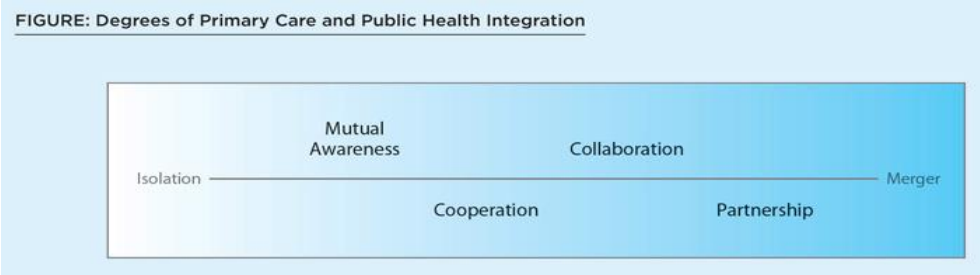
- Patient Protection and Affordable Care Act (ACA), which has far-reaching implications for public health and primary care integration efforts;
- National Strategy for Quality Improvement in Health Care (National Quality Strategy), an important element of the ACA that is intended to align public and private interests to improve the quality of health and healthcare for all Americans and is centered around three aims: Better Care, Healthy People/Healthy Communities, and Affordable Care;

- Institute of Medicine (IOM) report, *The Future of Public Health*,[1] which recommends improvements to a fragmented and underperforming public health system; and

- IOM report, *Primary Care and Public Health: Exploring Integration to Improve Population Health*,[2] which was commissioned at the request of the CDC and Health Resources and Services Administration (HRSA) and outlines four principles essential for the integration of primary care and public health: a shared goal of population health improvement; community engagement; aligned leadership; sustainability; and sharing and collaborative use of data and analysis.

The National Partners Collaborative used the framework of the IOM's integration continuum (see below) to structure the conversation regarding integration and how stakeholders might strategically advance along the continuum, as appropriate and necessary, to improve STD prevention and service provision.

Figure 1. IOM Integration Continuum



Several important events preceded the development of the National Partners Collaborative:

July 2012	ASTHO President's Challenge and Development of the IOM/ASTHO Strategic Map
October 2012	NCSD Annual Meeting: Third Party Billing Guide for STD Services released; keynote session: "The High Court Ruled on ACA; What's Next for Public and Sexual Health?"
December 2012	CDC/ASTHO Meeting: Infectious Disease Integration of Public Health and Primary Care
February 2013	DSTDP/ASTHO Meeting: STD Prevention in a Changing Environment
March 2013	Formation of National Partners Collaborative of Public Health and Primary Care Integration for STD Prevention
April 2013	CDC identifies strengthening of public health and healthcare collaboration as one of three agency priorities; additional priorities include improving health security at home and around the world and reducing the leading causes of death and illness.
	CDC, NACCHO, Duke University, and de Beaumont Foundation Meeting: Advances in Primary Care and Public Health Integration Through Policy, Practice, and Partnership
June 2013	DSTDP releases a new flagship five-year funding opportunity announcement (Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies) that requires

stakeholder engagement and partnership as part of the performance measurement plan.

In addition to the policies, reports, and meetings listed above, the National Partners Collaborative also employed a strategy of listening, leveraging, linking, and learning from previous work, meetings, and stakeholders to inform its action steps.

To plan for the meeting and to understand the state of the field, the National Partners Collaborative identified the following action steps:

- Ask those in the field about their experience with integration by conducting pre-meeting key informant interviews with local and state public health and primary care representatives;
- Build on and leverage what has already taken place or is currently underway by conducting an environmental scan of the literature on integration and published examples of public health and primary care integration, with a focus on STDs;
- Engage multiple levels of stakeholders by inviting federal, state, and local partners from a variety of agencies and organizations to participate in the August 2013 meeting; and
- Use multiple sources of information including public health and primary care stakeholders, published examples, and recommendations and reports by expert bodies to advance the discussion and exploration of integration for improved STD prevention and service provision.

Meeting Overview

On Aug. 15–16, 2013, the CDC/DSTDP National Partners Collaborative met in Atlanta to (1) bring together partners from public health and primary care to identify, discuss, and examine strategies for the integration of public health and primary care in the STD prevention and service provision setting(s); and (2) learn from health department and primary care leadership about how better to support and align STD prevention, care, and treatment within the changing healthcare and public health landscape. Attendees included 41 local and state public health and primary care representatives and nearly two dozen guests, primarily from divisions across the CDC with an interest in public health and primary care integration. The local and state representatives comprised 10 local/state teams made up of three to five individuals. Five teams represented the local public health-primary care perspective, and five teams represented the state public health-primary care perspective. The local and state public health and primary care representatives included health officers and leaders, community health center executive directors and leaders, STD directors, and state primary care association executive directors and leaders.

The goals of the meeting follow:

- Better understand the impact of environmental factors on the feasibility of public health and primary care integration for STD prevention and overall population health;
- Recognize the role and contributions of an integrated public health and primary care approach to STD prevention and overall population health;
- Identify conditions that lead to increased integration at the various points along the integration continuum outlined in the 2012 IOM report, *Primary Care and Public Health: Exploring Integration to Improve Population Health;*

- Provide recommendations at the local, state, and national levels on potential solutions for addressing existing barriers to public health and primary care integration; and

- Provide a forum for sharing information and experiences and building partnerships among local, state, and national organizations working in support of STD prevention and overall public health.

The meeting was structured to provide the following opportunities for participants:

- To learn about pre-meeting interviews that explored local and state experiences with public health and primary care integration efforts, particularly those related to STD prevention and service provision;

- To work in small groups guided by hypothetical scenarios to explore opportunities for integration and action steps for doing so; and

- To participate in small and large group discussions about where the local and state teams would place themselves along the IOM's integration continuum and actions that could be taken to move forward along the continuum, if desired and appropriate, for improving STD prevention and service provision outcomes.

Overview of Pre-Meeting Interviews

John Auerbach of Northeastern University's Institute on Urban Health Research and Practice, under contract with ASTHO, conducted 21 interviews with public health and primary care providers in June and July 2013. (Auerbach also presented and facilitated during the August 2013 meeting.) The pre-meeting interviews provided critical intelligence about the issues, opportunities, and challenges faced by communities with respect to public health and primary care integration. The interviews had the following goals:

- To understand efforts to integrate public health STD prevention and service provision activities and primary care services/functions;

- To identify the challenges, opportunities, successes, and lessons learned related to public health and primary care integration efforts; and

- To determine what types of tools and resources would support integration efforts.

The interviews revealed that public health and primary care integration was limited and uneven. While some examples of public health and primary care collaboration and communication existed, these relationships and activities were often limited in scope. When a more robust partnership existed, it often involved a clear division of labor (e.g., public health used surveillance and disease intervention specialists (DIS) to assist primary care; primary care treated STDs). In limited instances, public health departments ran community health centers, including federally qualified health centers (FQHCs). In many cases, health departments ran multi-service clinical sites that included STD services. Most interviewees noted an increasing awareness of or discussions about opportunities for integration; however, interviewees expressed the following challenges and barriers:

- Uncertain impact of the ACA and access to insurance;

- Resource and funding issues related to budget cuts and the need to diversify payers through billing and reimbursement;

- Access to primary care and the availability of care varying enormously across the country;
- Stigma and discrimination associated with STDs and high-risk populations;
- STD services linked to other services; a loss in one area of service may impact other areas;
- Need for STD clinical expertise among primary care providers; many primary care providers do not have extensive STD clinical training or expertise.

Local and State Experiences with Integration Efforts

Several pre-meeting interviewees shared in greater detail their experiences with integration. Three representatives presented on their experience with integration, and open discussion followed. This format allowed for a deeper learning process and raised issues that were further explored throughout the meeting.

Oregon: Benton Health Services
Sherlyn Dahl, Executive Director of Benton Health Services, an FQHC embedded within the Benton County Health Department, described how the health center implemented a process to meaningfully change the design and delivery of services, including the organizational culture and management structure, to support integration. The process called for a shift in thinking from "services of the organization" to "services for the patient." The system employed health navigators to bridge public health and primary care. Using existing public health staff enhanced the services/reach of the primary care component.

Idaho: North Central District
Carol Moehrle, District Director of the North Central District in Idaho, described a process that took place several years ago when local health departments began reaching out to health centers to collaborate. In one instance, the health department turned over the provision of family planning services to a health center. After approximately one year, the health center returned the responsibilities for this work back to the health department, stating that paperwork and lack of billable funds were too burdensome. At present, health departments are reluctant to give clinical services over to health centers because the nurses assigned to these areas are part of the core public health infrastructure; if they go away, services in multiple areas could go away. The North Central District currently has no direct plans for integration.

Mississippi: Southeast Mississippi Rural Health Initiative
Tonya Green, Director of Social Services, Southeast Mississippi Rural Health Initiative, shared the health center's experience integrating HIV rapid testing across six sites through a contract with the Mississippi State Department of Health. In the future, the health center intends to use this experience to maintain and build its partnership with the health department, expand HIV testing in schools, and pursue integration in other areas.

Small Group Case Studies/Hypothetical Scenario Exercise

Meeting participants were separated into five smaller groups (two "teams" per group) to consider two hypothetical case studies/scenarios related to public health and primary care integration and STD prevention and service provision. Participants were asked to propose next steps for addressing real-life challenges. This approach generated new and creative ideas that were unencumbered by participants' realities in the field. The following list of ideas and potential next steps was generated during this exercise:

- Promote health departments as accessible experts about STDs for primary care providers. Health departments could provide clinical training and guidance in STD clinical settings or by phone or telemedicine;

- Build on health centers' expertise about billing and train health departments on billing systems and practices;

- Leverage the joint resources of public health and primary care (e.g., staff, technology, clinical expertise, billing) to achieve patient-centered goals. This approach extends the reach of public health and primary care in geographic areas where there is less access to services. A "circuit rider" approach could be established, in which public health or primary care services are delivered to the patient. Patients could also be empowered to perform some STD related-services themselves, such as using home-testing kits;

- Create models that delineate core public health and primary care roles and responsibilities and provide examples of collaborative/joint responsibilities that local and state jurisdictions can adapt to meet their needs;

- Authorize nursing staff to work at their highest level of competency (i.e., at the top of their license), thus expanding the reach of services and creating more time for providers to see additional patients;

- Design patient navigators into the healthcare system and explore expanding the role of DIS to carry out this function. Additionally, explore opportunities for these staff to bill for services (i.e., expanded case management responsibilities);

- Consider "fast lane" eligibility processes that allow clients access to multiple systems/services in one visit;

- Create a centralized repository and process for identifying and capturing best practices and intellectual capital;

- Demonstrate integration efforts at the national level to support and be a model for state and local level integration efforts;

- Create a shared vision with respect to integration between public health and primary care;

- Incorporate social determinants of health into models of public health and primary care collaboration and integration;

- Contextualize STDs within a larger framework of systematic and ecological models for improved health outcomes and overall population health;

The preceding ideas were generated in response to case studies/hypothetical scenarios and are not intended to be a formal list of next steps to advance integration efforts.

Placement along the IOM's Integration Continuum and Actions/Resources to Support Advancement

Building on the national-level efforts regarding the IOM's integration continuum, participants considered where their states or local areas were on the continuum. Responses ranged from isolation to collaboration, with the vast majority of participants indicating they were at the point of cooperation (Figure 1, page 4). Participants, and the meeting conveners, suggested that there is no ideal or "right" place to be on the continuum, although being in absolute isolation is not conducive to meeting public health or personal health goals. Participants also recognized that, even within a given state or local jurisdiction, there will be variation along the continuum for different services, activities, programs, etc.

Participants shared ideas for action steps with respect to moving forward along the integration continuum and the types of tools, resources, and technical assistance that would support these action steps. The results of this conversation and brainstorming activity are detailed below. The ideas generated during this discussion were determined by the national partners to fall under eight domains.

Partnerships

- Identify stakeholders critical to integration efforts;
- Create directories of community resources;
- Work jointly to conduct community assessments, gap analyses, improvement efforts, or strategic planning;
- Leverage one another's services (e.g., communication platforms/strategies);
- Place representatives on each other's boards;
- Co-locate staff;
- Hold joint staff meetings;
- Conduct provider education in new ways and through new platforms;
- Engage with payers; and
- Link similar professionals across systems (e.g., CFOs, nursing).

Service Models

- Pilot integration within one service or one location;
- Cross train staff across public health and primary care;
- Engage DIS in work across systems; and
- Use patient navigators.

Payment Reform and Health Insurance

- Understand the impact of the ACA in states;
- Explore STD-specific reimbursement options (e.g., opportunities for billing);
- Assess training and operational needs with respect to managing insured/uninsured clients; and
- Look at alternate mechanisms to fund staff/services (e.g., Accountable Care Organizations, funding of DIS).

Community/Provider Knowledge

- Collaborate on an STD prevention campaign, other community education efforts, and the development of best practices;
- Have health departments lead STD education and training for primary care providers;
- Use telemedicine and telephone consultation models;
- Build discussion of sexual health into communities;
- Consider the possibility of different approaches for easy-to-treat STDs versus more complex STDs;
- Provide cultural and linguistic diversity training for providers;

- Conduct workforce development activities;
- Create patient-centric care settings; and
- Transition to models of nurse-directed services for STDs.

Financing
- Aggregate funding for public health services; and
- Build billing systems for STD clinics.

Data and Measurement
- Create universal metrics; and
- Share data.

Tools and Resources Needed to Support Integration
- Develop guidance on data, assessments, and planning;
- Create sample partnership agreements and policy briefs;
- Gather and share information on pilot projects, case studies, and clinical care and other integration-related trainings;
- Develop a clearinghouse for successful models, policies, and technical assistance; and
- Package and circulate provider trainings.

Policy and Society
- Tackle stigma and discrimination;
- Address criminalization issues; and
- Address confidentiality issues and concerns.

Additionally, participants raised federal-level considerations including exploring the use of 340b drugs for expedited partner therapy, building flexibility into categorical funding, and exploring policy changes to improve confidentiality and reduce barriers to access. Participants emphasized the importance of similar messaging by federal agencies and clarity around expectations of public health versus primary care core functions and responsibilities.

Tools, Resources, Technical Assistance, and Other Support

In exploring ways to support and advance the work of integration, participants provided recommendations regarding resources. Participants identified the following types of resources as useful:
- Best practices;
- Case studies;
- Guidance on relevant data for planning and decision-making;
- Templates for assessment and planning meetings with multiple partners and stakeholders;
- Sample partnership agreements;
- Assistance establishing pilot projects, including funding to support pilot projects;
- Clinical care training for diagnosing and treating STDs;
- Billing and reimbursement training; and
- Guidance on the implications of and changes resulting from ACA implementation and Medicaid expansion.

Conclusion

The National Partners Collaborative meeting resulted in a rich infusion of ideas about integration of public health and primary care, particularly as they relate to the STD prevention setting. Dr. Gail Bolan,

Director, CDC/DSTDP, closed the meeting by reminding participants that STD prevention and service provision can be a "dot connector" in efforts toward public health and primary care integration and elevate the discussion around STDs in the changing healthcare landscape. Activities at the national level among CDC, HRSA, and national partners are currently underway in support of public health and primary care integration. To support the ongoing national efforts, the National Partners Collaborative will continue to build on the findings of the August 2013 stakeholder meeting and the other national-level policies, reports, and efforts in support of better care, healthy people/healthy communities, and affordable care.

References

[1] Institute of Medicine. 2002. The Future of Public Health. Washington, DC: The National Academies Press.

[2] Institute of Medicine. 2012. Primary Care and Public Health: Exploring Integration to Improve Population Health. Washington, DC: The National Academies Press.

Acknowledgments

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