Integration of Public Health and Primary Care

A practical look at using integration to better prevent and treat Sexually Transmitted Diseases

October 2013

Contents

Introduction

As the country begins to thoughtfully prepare for the next stage of implementation of the Affordable Care Act (ACA) in January 2014, it is necessary to reimagine the role of public health and its relationship with primary care. Many Americans will soon have health insurance – some for the first time – and with coverage will come an anticipated increase in health care services utilization. Uninsured and under-insured patients, who have historically looked to public health departments for a range of safety net services, may now have the opportunity to receive comprehensive care at a primary care site. The increase in health insurance coverage will be realized quickly, with the Congressional Budget Office estimating that 14 million Americans will have health coverage because of the ACA by the end of 2014.[1] Because of this improved access, new partnerships between the public and private sectors are needed to consider how and when to utilize a more integrated care model to serve some of the more vulnerable populations.

The Centers for Disease Control and Prevention (CDC), under the direction of Dr. Tom Frieden, has prioritized improved collaboration between public health and primary care. At the National Press Club luncheon in September 2013, he emphasized this point saying "I think that for the next decade the leading challenge for public health is to strengthen the collaboration between healthcare and public health."[2] This focus on integration at the federal level has likewise mobilized the public health and clinical communities to examine their shared missions and resources.

> For the next decade, the leading challenge for public health is to strengthen the collaboration between healthcare and public health.
>
> **Dr. Thomas Frieden**
> **Director of CDC**

CDC/DSTDP National Partners Collaborative

The Centers for Disease Control and Prevention Division of STD Prevention funded this project to examine the issue of integrating prevention and treatment of STD to better serve patients. In addition to the CDC, four national organizations provided counsel and strategic direction for the project. These organizations, through their participation, were vested partners in the outcome of designing a model of integration for public health and primary care, using STDs as the scenario.

Funded by

Association of State and Territorial Health Officers

Centers for Disease Control and Prevention Division of STD Prevention

National Association of County & City Health Officials

National Association of Community Health Centers

National Coalition of STD Directors

[1] Retrieved from www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf on October 2013.
[2] Retrieved from www.cdc.gov/media/releases/2013/t0911-National-Press-Club.html on September 2012.

About the project

The case has been made for why better integration among clinical or medical providers and the local and state public health system is imperative (see Literature Review). Now the question remains, *how do we get there?*

This project examines the current status of integration of services provided for Sexually Transmitted Diseases (STDs) and how transitioning to a more integrated model can be successful. Through a literature review, interviews and an in person day and a half meeting, the sponsors of this effort set out to understand the real challenges and opportunities for better integration.

The goals of the project were to:

1. Understand and document efforts to integrate public health STD and primary care services/functions across the country
2. Identify the challenges, opportunities, successes and lessons learned from these efforts
3. Determine what would help future efforts and develop resources to assist this work

Methods

Identifying multi-disciplinary teams

A team of researchers identified a sample of ten cities/counties and states that represent the range of experiences in public health and primary care across the county. Within each state or county, senior level representatives from public health and primary care were identified to participate in several stages of the process. Teams were selected to reflect a diversity of experience and characteristics, including:

Medicaid expansion With the implementation of the Affordable Care Act, many states will expand Medicaid for their residents, which will greatly increase the percentage of residents who will have health insurance

coverage. As of September 2013, twenty-five (25) states had agreed to expand Medicaid eligibility while approximately an equal number had not.[3] This project includes teams from both expansion and non-expansion states.

Region of the country

The project includes representatives from each of the geographic regions of the country, including Northeast, Southeast, Midwest, Southwest and West.

Size and population density (i.e. rural or urban)

Provision of public health and primary care services vary depending on concentration of the population. Rural and urban areas face different cultural and logistical issues when it comes to health care service delivery. This project incorporates densely populated urban areas, as well as frontier states.

STD rates

State and county specific rates were reviewed to ensure a range of STD concentration across the project sites.

Figure 1. Overview of Areas Examined

		Data Review	Interview	Meeting
		June 2013	July 2013	August 2013
Alabama - Jefferson County	Local (County)	✓		
Arizona - Maricopa County	Local (County)	✓		
California	State	✓	✓	
California - Berkeley County	Local (County)	✓		
Idaho - North Central District	Local (Region)	✓	✓	✓
Illinois	State	✓		
Massachusetts – Boston	Local (City)	✓	✓	✓
Mississippi	State	✓	✓	✓
New York	State	✓	✓	
North Carolina	State	✓	✓	✓
North Dakota	State	✓	✓	✓
Oklahoma – Tulsa	Local (County)	✓	✓	✓
Oregon	State	✓	✓	✓
Tennessee - Shelby County	Local (County)	✓	✓	✓
Texas	State	✓	✓	✓
Washington - Seattle-King County	Local (County)	✓	✓	✓
Total		16	12	10

[3] Retrieved October 2013 from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

Information for the project was gathered through a three-pronged approach:

Figure 2. Summary of Information Gathering Methods

1. Data and Literature Review

- In order to identify 10 final teams, a total of 16 jurisdictions (both local and state) were examined. Extensive data were gathered comparing the jurisdictions on region, Medicaid expansion, population density and STD rates. In addition,
- A literature review was conducted to better understand recent efforts on integration, specifically as it relates to provision of Sexually Transmitted Disease (STD) services.

2. Stakeholder Interviews

- Overall, twenty-one (21) interviews were held with public health and primary care leaders or leadership teams in twelve (12) states.
- Among those interviewed were commissioners of health and directors of infectious disease prevention and control at the state, county and city levels and executive directors of Primary Care Associations and Federally Qualified Health Centers.
- Approximately thirty-four (34) individuals were interviewed.

3. National Meeting

- An in-person meeting was the culmination of process.
- 75 attendees met in Atlanta for 1.5 days.
- Five (5) state-based teams and 5 local teams convened to further explore their current state of integration and ways to improve the provision of services for STDs
- Teams included senior level management from the state and local public health departments (often the commissioners or executive directors) , either the state or local infectious disease director and a leader from a community health center. The five state teams also included , a leader from the state's Primary Care Association (PCA)

The Literature Review is included in this report on page 12; the Stakeholder Interviews and the National Meeting are described in further detail in the following sections.

Identifying Key Issues: Stakeholder Interviews

The second phase of the work included a series of interviews with high-level leaders from a diverse group of public health agencies and from community health providers. The purpose of the interviews was to understand from leaders of those organizations the concrete issues and current state regarding sexually transmitted diseases. Each state and city or county faces its own set of unique challenges when it comes to integrating services within the community. The goal of the interviews was to document the perspective of those closest to the issues, in three general areas:

1. Understand efforts to integrate public health STD and primary care services/functions
2. Identify the challenges, opportunities, successes and lessons
3. Determine what would help future efforts and develop resources to assist this work

The subjects covered in the interviews included:

- How are STD services provided in the jurisdiction, what the division of labor was for public health and primary care
- Are there any changes anticipated in the provision of services?
- What resources would be helpful to promote integration in the jurisdiction?

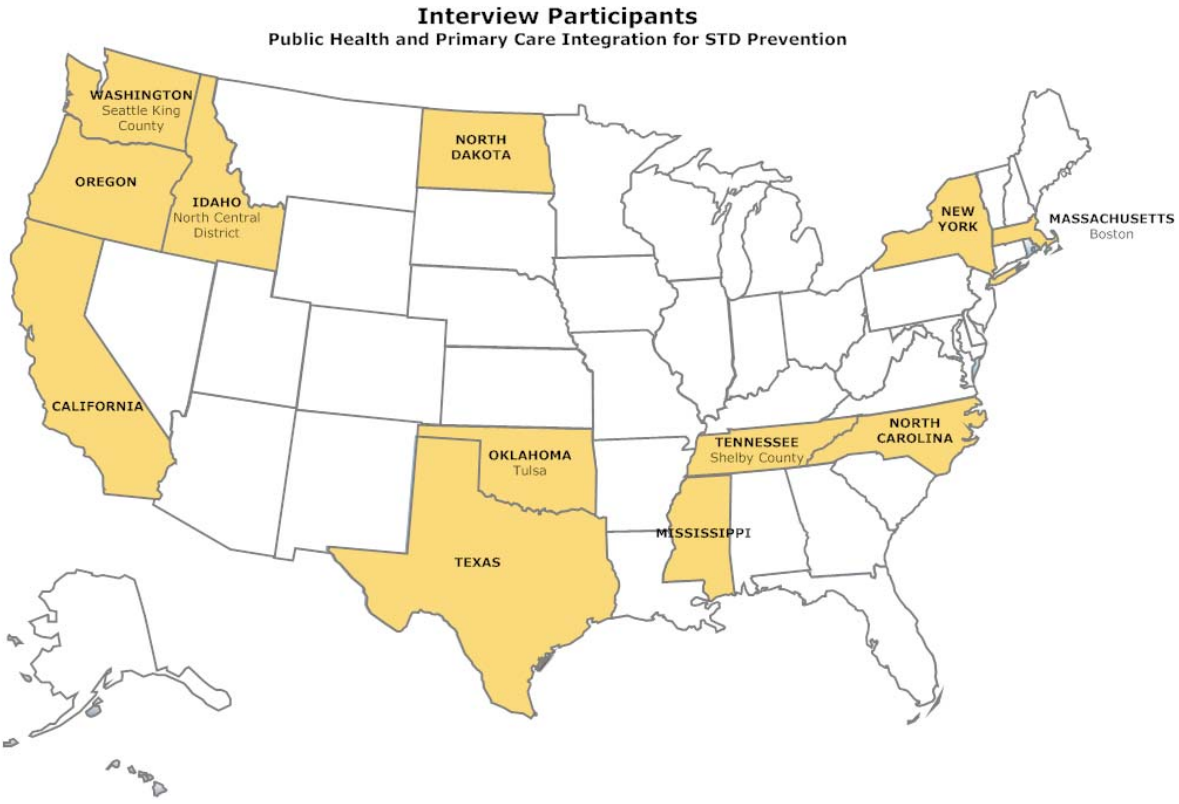
Each interview lasted forty five to sixty minutes. Questions were general in nature and were similar for both public health and primary care participants. (See Appendix 1 and 2 for lists of specific questions.)

Interview Participants

We interviewed leaders of the organizations selected, including executive directors, commissioners or senior health officers; directors of STD / infectious disease services and/or chief medical officers. Overall, twenty-one (21) interviews were held with public health and primary care representatives in twelve (12) states.

Approximately thirty-four (34) individuals were interviewed (often, more than one person participated in an interview.) Areas were chosen to reflect diversity of the nation in terms of geography, demographic composition, density of population, and Medicaid expansion policy (see Methods beginning on page 6 for more information). See Appendix 3 for list of participants.

Figure 3. Map of Interview Participants



Facilitating a deeper discussion: National Meeting

With the stakeholder interviews serving as the introduction, the in-person national meeting in Atlanta was intended to further explore those issues identified in the interviews. It lasted one and a half days.

The stated purpose of the meeting was to "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 setting and to learn from health department and primary care leadership how to better support and align prevention, care, and treatment in this changing environment of health care reform."

Meeting Agenda

The meeting was designed to elicit further details and facilitate deeper discussion about what it would take to realize a more fully integrated STD service delivery model. The topics covered included:

- **Integration Definition and Examples:** An explanation of the integration model as described in the Institute of Medicine Report and a panel of state and local representatives discussed examples in their localities

- **Findings from the field**: A detailed summary of the literature review and stakeholder interviews. (This presentation is included as Appendix 5.)

- **Case Studies:** Two case studies provided teams an opportunity to identify solutions and action steps

- **Resources**: Participants were asked to identify resources that would be helpful to them as they work to integrate their work with each other and partners in their home states/counties. While a session was dedicated to this,

questions on this issue were also integrated in the case studies and panel discussions.

(See Appendix 4 for detailed agenda.)

Meeting Participants

Seventy-five people attended the meeting. Ten "teams" attended representing 5 states and 5 cities/counties. Each team consisted of 3-5 members including:

State or local health department	In most cases, the senior health officer or executive director attended, as well as the director of infectious disease / STDs
Community health center	Community health centers were represented by chief medical officers or infectious disease specialists
Primary Care Association (PCA)	For state teams, executive directors or senior leaders from the PCA attended to provide a broader representation of the state's community health centers

In addition to the ten state and local teams, many federal agencies and national associations were represented, including the sponsors of the project: the Centers for Disease Control and Prevention Division of STD Prevention, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), the National Association of Community Health Centers (NACHC), and the National Coalition of STD Directors; as well as the Public Health Service, HRSA, and other divisions within CDC.

Background and Literature Review

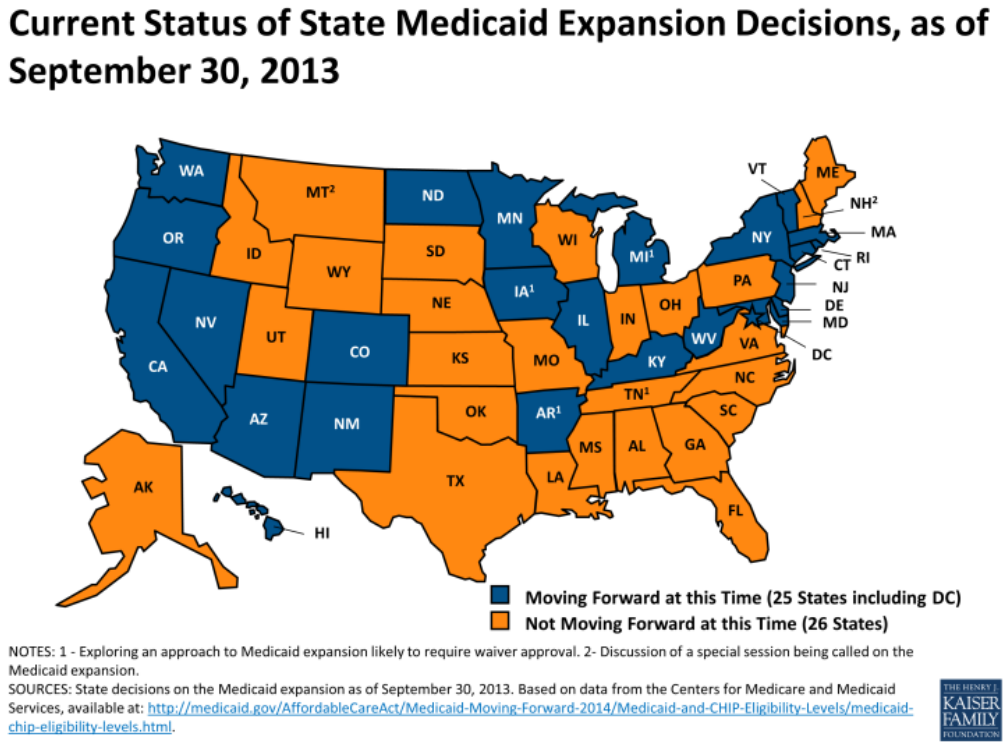
Primary care and public health share the goal of promoting health of all individuals (Fineberg, 2011; Institute of Medicine [IOM], 2012). Yet while there are some overlapping services and activities, these systems have largely functioned as parallel and independent entities. The primary care system has focused on facilitating improved health through the screening, diagnosis and treatment of disease among individuals with public or private insurance while the public health system has directed its efforts to prevention and health promotion at the community and population level through funding from governmental sources, often in the form of grants (Fineberg, 2011; IOM, 2012).

More recently, opportunities have begun to increase for the integration of these two systems. These opportunities are the result of recent developments including the increased emphasis on controlling the costs of health care, the growing recognition of the importance of the social and environmental determinants of health, the availability of health information technology to inform the connection between clinical and community level health issues, and, perhaps most significantly, the passage and implementation of the Affordable Care Act (IOM, 2012).

Affordable Care Act

The passage of the Affordable Care Act will – through a combination of Medicaid expansion, individual mandates and increased employer coverage – greatly increase the number of Americans who have health insurance. Estimates vary on the number of people that will become insured. The Congressional Budget Office estimates that 14 million people will become insured during the first year of the ACA, but that after three years, that number will grow to almost 30 million. States' decisions to expand Medicaid are central to what the increase will be ad will change the experience for many of the states. According to Kaiser Family Health Foundation, twenty-five (25) states have committed to expanding Medicaid (Figure 5).

Figure 4. Map of Medicaid Expansion States, September 2013



Institute of Medicine Report

The release of the IOM report "Primary Care and Public Health: Exploring Integration to Improve Population Health" (2012) reflected and accelerated this emerging phenomenon. The report was prepared by the IOM committee assigned by the Centers for Disease Control and Prevention (CDC) to examine the current status of integration of primary care and public health systems. In this report, integration has been defined as "the linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health" (p.3) that takes place on a continuum ranging from isolation on the one hand and merger on the other, with mutual awareness, cooperation, collaboration, and partnership in between. The continuum represents different degrees of integration which may serve as an informative indicator for the systems to reflect their current level of integration and identify areas that need improvement in order to reach the next level.

> Community-level application of the framework represented by the principles for integration … will require substantial local adaptation and the development of specific structures, relationships, and processes.
>
> **Institute of Medicine *Report, 2012***

The IOM committee reviewed examples of integration in peer-reviewed journals, grey literature, and through discussion with stakeholders and then identified a set of key principles necessary for successful integration of the two systems. These included:

- a shared goal of population health improvement;
- participation of the larger community in defining and addressing health concerns;
- aligned leadership;
- sustainability including shared infrastructure;
- the sharing and collaborative use of data and analysis.

While all of these principles are considered necessary for successful integration, the IOM committee recommended the importance of implementing initial action; if necessary, starting out with just one of these principles.

National efforts and strategic plans

The IOM report as well as other recent works on integration helped jumpstart collaborative efforts between primary care and public health systems. In response to the IOM report, for example, in 2012 the Association of State and Territorial Health Officials (ASTHO, 2012a) convened meetings between leaders of the two systems and developed a two-year strategic map to strengthen integration.

Similarly, collaboration between the National Association of Community Health Centers (NACHC) and the National Association of County and City Officials (NACCHO) resulted in a guide (Feldesman Tucker Leifer Fidell LLP, 2010) designed to introduce a planning process and various models of partnerships between federally qualified health centers (FQHCs) and local health departments in creating a community-based system of care.

A subsequent study published on integration efforts among nine selected FQHCs across the United States (Lebrun et al., 2012) indicated that these FQHCs provided good primary care coordination with a focus on community orientation and

The ASTHO strategic map highlighted five specific foci:

1. identify and create examples of demonstrated success;
2. realign funding to support coordination and sustainability;
3. disseminate effective approaches and systems;
4. implement meaningful measures of population health;
5. creating infrastructure to support collaboration and sustainability

integrated many essential public health activities in their practice. The study also identified specific necessary elements for successful integration including: funding for collaboration and for addressing social determinants of health; solid leadership in guiding collaborations; trusting partnerships with a shared vision and unified responsibilities; and alignment of data collection, analysis and exchange.

Furthermore, NACCHO (2011) published a white paper describing opportunities and challenges for local health departments in the light of ACA implementation and integration efforts. Most recently, a team of partners from CDC, the de Beaumont Foundation, and Duke University began production of a web-based educational learning tool "Public Health and Primary Care Together: A Practical Playbook" that will provide real-life practical information and resources on integration of the two systems for professionals (2013).

Integration and sexually transmitted diseases

In the current changing climate, sexual health is one of the primary examples where the concept of integration is particularly relevant. State and local public health departments have traditionally played a critical and major role in providing sexually transmitted infection/disease (STI or STD) programs and services including prevention, epidemiology, laboratory work, clinical services and disease intervention specialists (DIS). Such public health services have generally been provided without charge to the patients and without health insurance collection in order to reduce the barriers to access.

Many but not all primary care settings also provide clinical STD services such as screening, diagnosis and treatment and bill for them as they do other services. Implementation of the Affordable Care Act (ACA) will increase the health insurance coverage of millions of individuals which will provide them with additional opportunities to receive preventive, screening and treatment services including those for STIs at sites other than the public health clinics.

Additionally, increasing budgetary and workforce constraints for the public health system may lead health departments to reconsider STD programs and services and make decisions about their priorities, roles and services, while at the same time, continuing to assure access to services for individuals who are in need (ASTHO, 2012b). In the light of the ACA implementation, ASTHO's Infectious Disease Policy Committee, for example, has worked with its members and partners to examine how the changing health care system will affect the role of state and territorial health departments and potentially promote the integration of infectious disease programs and services. Their effort resulted in the report "Infectious Disease Integration of Public Health and Primary Care: Findings from the December 2012 Integration Meeting" (2012b). The report identified key components for moving towards integration including: developing partnerships; ensuring a safety net; and promoting efficient and meaningful data management systems. The report also identified possible sites for integration such as workplaces and schools and provided examples from some states.

Stigma and Discrimination

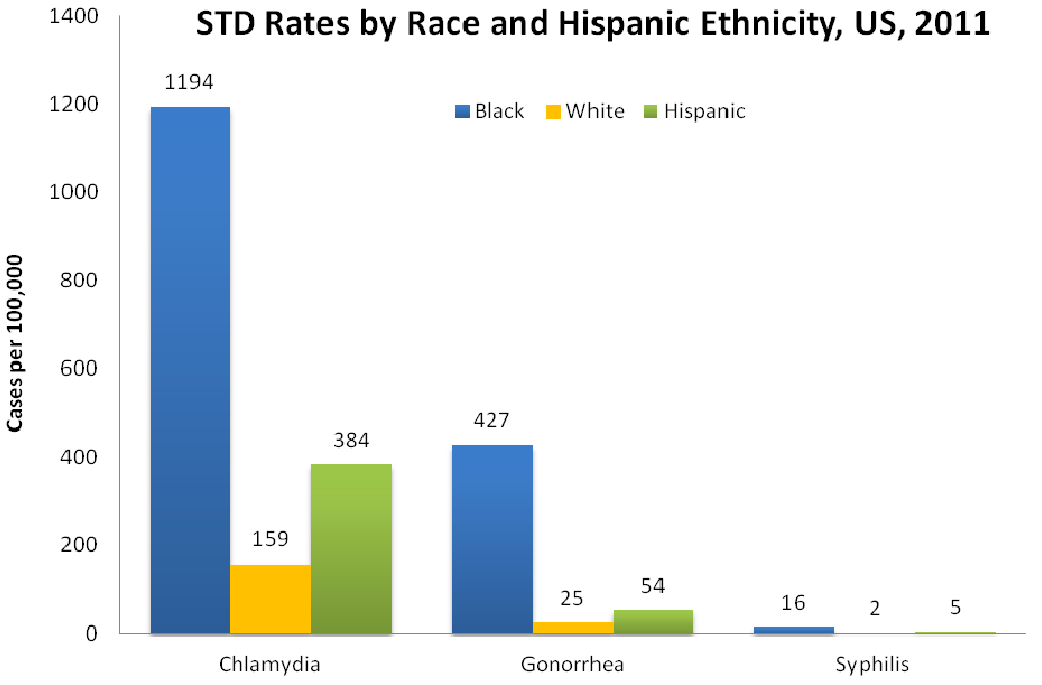
But while integration is on the horizon for STDs and other public health areas, there are disparities and stigma associated with STDs that present unique challenges.

The general public and those at risk for STDs hold similar attitudes that STDs are a result of poor choices, promiscuity or that the STD could be prevented. In a review of the literature, Hood and Friedman (2011) found that stigma leads to a delay in testing and treatment seeking. Studies found that patients were hesitant to have an honest conversation with their health care provider because they anticipated judgment and blame. Stand-alone STD clinics provided their own challenges with many of them in run down sections of town, or requiring patients to wait a long time before seeing a provider. Among the recommendations for decreasing stigma, researchers recommended (but did not provide evidence for) increasing sensitivity training for health care

providers and redesigning the way STD services are provided. Suggestions included enhancing the physical characteristics of STD clinics to incorporating STD services into broader clinics in an effort to normalize testing and treatment and facilitate referrals for other health care needs.

In terms of disparities, African Americans have the highest prevalence of selected reportable STDs, and both African Americans and Hispanics are significantly more likely to be diagnosed with Chlamydia, Gonorrhea or Syphilis than Whites (Figure 6). Discrimination is cited as one of many social determinants of health that cause this disparity (Reed 2013).

Figure 5. National STD Rates 2011



Source: Centers for Disease Control and Prevention. (2012). Sexually transmitted disease surveillance 2011. Retrieved from http://www.cdc.gov/std/stats/

Implementation of integration efforts

In contrast to the growing body of integration literature with conceptual frameworks and key components, documented examples of successful integration of primary care and public

health services remain scarce and are limited to health areas such as maternal and child health and immunization with few if any publications that highlight concrete examples of the process of moving towards the integration STD services.

Thus, the present work aims to consider the current status of STD programs and services, and the real world challenges and barriers experienced in the process of integration. It examines the insights, observations and attempted efforts at integration of stakeholders from seven states and five local jurisdictions across the United States. Insights shared by the stakeholders will be used as a rich source of information to inform future planning and policy considerations and to inform the development of useful resources such as a guiding document, pilot programs or training protocols.

Summary of Findings

The following pages summarize information learned from both the interviews and the in-person meeting. Themes and content for both were similar. The national meeting was designed to follow up on issues raised during the interviews, allowing for a fuller discussion of issues.

The findings in this report represent the views and opinions of the interview and meeting participants.

Profile of current services provided

During the interviews, we gathered baseline information from public health and primary care on what services were provided for sexually transmitted infections. One objective was to determine if there was existing collaboration between the two sectors.

There a wide range of public health services provided to address and prevent sexually transmitted diseases. These include:

- Education and outreach
- Epidemiology
- Disease intervention and partner notification
- Laboratory testing
- Screening
- Clinical services (including medication)

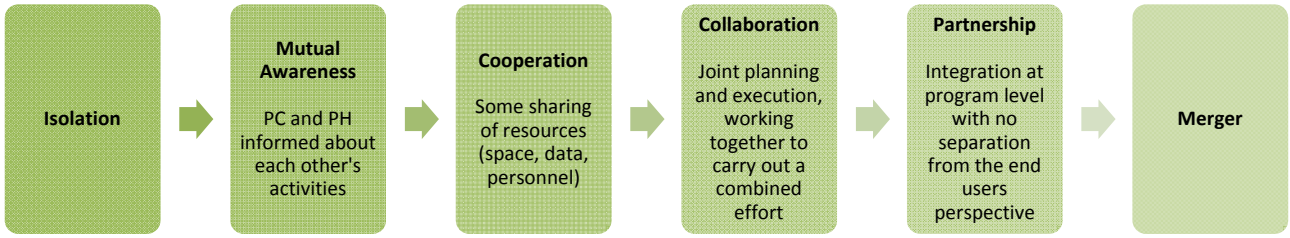
All health departments provide some level of education and outreach, epidemiology and disease intervention and partner notification. All but two of the health departments provided some form of direct clinical services for STDs (see Figure 8). Public health agencies noted their ability to provide care that was free or low cost, confidential and targeted to vulnerable and hard to reach populations.

Community health center and primary care associations outlined the broad level of clinical services they provided to patients,

which included screening, testing, medication and follow up care. Many health centers discussed their desire to provide a complete array of services to their patients in order to fulfill their mission of being a patient-centered medical home. Both public health and primary care interviewees talked about their shared mission to treat the most vulnerable populations, including the uninsured, immigrants, non-English speaking and the poor.

With regard to "integration", there were examples across the spectrum.

Figure 6. Model of Integration, adapted from the IOM Report



From the interviews it was determined that the integration of sexually transmitted infection services into primary care settings is limited and uneven across the nation. There were some instances of a collaborative approach to clinical services with a shared understanding and support of the current system including the following:

There were several examples of a partnership with a clear division of labor:

- Public health uses epidemiology and disease intervention services (DIS) to assist primary care providers
- Primary care (community health centers specifically) screen and treat patients for STIs
- In limited instances public health departments operate their own federally-qualified health centers that provide services

- In some states or counties, there were discussions about opportunities to develop pilots.
- In many instances, public health departments operate multi-service clinical sites with STD services.

Based on the interviews, the provision of clinical services by public health departments is outlined below.

Figure 7. Clinical Services Provided by Health Departments

Location	Public Health-run STD clinics?
California	Yes
Idaho – North Central District	Yes
Massachusetts - Boston	No
Mississippi	Yes
New York	Yes
North Carolina	Yes
North Dakota	No
Oklahoma – Tulsa	Yes
Oregon	Yes
Tennessee – Shelby County	Yes
Texas	Yes
Washington – Seattle & King County	Yes

Funding, Reimbursement, Budgets

"It would be really helpful to learn about billing and potential opportunities for generating revenue, and learn from experiences of other states."
Mary Currier
Mississippi State health officer

Why this matters:
In anticipation of health care reform, local and state governments have considered whether existing public health department-funded direct clinical care could be scaled back or defunded. The thinking has been: if most residents are going to have insurance, we don't need to provide free STD (or other) clinical services anymore. In addition, previous recession-related local, state and federal cuts have caused public health programs to reduce services and re-examine what services they can continue to provide. In addition to cutting services, many public health departments are beginning to look at another alternative: billing insurance for services that have been traditionally funded with governmental resources.

The possiblity of billing insurers for STD services was raised regularly by public health departments as an issue of sustainability, a means to diversify and solidify the funding structure. However, public health departments pointed to the complications in establishing billing systems and their lack of familiarity with the specifics involved. We heard concern with regard to the resources needed to develop an infrastructure for billing insurers and credentialing providers.

Furthermore, federal, state or health insurer rules can limit public health's ability to get reimbursement in various ways. For example, one participant noted that screening an insured patient for STDs could only be reimbursed if it was approved by the primary care provider. Another participant noted that in her state, it is against the law for public health to bill for STDs.

What could help:

- Health centers can be natural partners for technical assistance. In areas where the health center and health department are co-located or have a good working relationship, the health centers could provide the billing service for public health.
- Many health departments have begun billing one payer – often Medicaid – to build a billing infrastructure within their organizations.
- Because of the complicated nature of billing, it would be helpful for well-planned and thorough training sessions to be developed for public health, with different options for learning (in-person, web-based, etc.)

Stability of public health

Cutting STD services would destabilize the counties. For example, some of the nurses whose jobs would be lost also provide non-STD services. Those services would suffer.
State Health Officer

Why this matters:
There was real concern that transitioning services from public health to primary care would destabilize the current public health system. A few departments thought that reducing or eliminating clinical STD services could mean that other services – such as family planning or emergency response – would be eliminated without the staff and resources dedicated to STDs.

What could help:

- Greater awareness of the inter-dependency of these services only some of which have the potential to be integrated into primary care.
- There needs to be thoughtful discussion about how roles can be transformed recognizing that it "can't happen overnight."

Confidentiality and Stigma

Stigma is still a huge issue for STDs - there's a lot of small town living - so patients might go outside of their local area because they can keep anonymity. They don't want their health care provider to know.
Community health center

Why this matters:

Participants spoke eloquently about patients' demand for complete confidentiality. Patients who do not want friends or family to know they have an STD may go to great lengths to avoid being seen by someone they know. In some areas, this means they travel to free clinics far away from their home town. Examples were given of how this plays out in the health care system, namely:

- **Financially**: Some patients would rather pay the out of pocket expenses rather than present an insurance card
- **Explanation of Benefits**: Providers in public health and primary care expressed concern about the "Explanation of Benefits" which could breach a person's confidentiality within their family. For example, teenagers might not want a parent to know they have been treated for a STD.
- **Stigma**: Public health departments pride themselves on providing services free from judgment and targeted to populations who might not otherwise seek care such as migrant workers, immigrants or LGBT populations. These specialized and tailored efforts could be lost if public health clinics were phased out.

In those areas where public health provides the majority of clinical STD services, we heard concerns that it would be a difficult transition to change things drastically. For reasons that are cultural and historical the system as it stands today works for many of the residents of those locations.

What could help:

- Specialized training in cultural and clinical competency for vulnerable populations could be provided.
- The federal government and major insurers could come together to identify ways to improve confidentiality in EOBs.

Clinical Expertise

Why this matters:

There were two areas of concern raised during the interviews regarding clinical expertise and training:

1. Many primary care providers generally are not comfortable with routinely taking a sexual health history, or with identifying complex cases of STDs. Both primary care and health department staff pointed to lack of medical school training in STD screening and treatment as a barrier to integration.
2. It is important to maintain specialized expertise at the state or local level to contain concentrated epidemics, treat unusual cases and sustain research. Two participants proposed that STD services should be provided within Centers of Excellence or other highly specialized clinics. Their viewpoint: this would allow for sophisticated care for complicated or co-occurring conditions and be the best place for disseminating current research and education to the primary care community.

What could help:

- Opportunities for cross-training with public health and primary care, where members of both teams can attend each other's trainings.
- Public health can provide nurses to health center monthly meetings to discuss current trends, emerging concerns.
- Support of STD clinics – private or public – where high risk and stigmatized sub-populations can go for high quality care.

Our clinicians wanted more education about leading questions – they realized they were missing opportunities how to identify cases and how to get the patient navigator to work with those patients.
Primary Care Association

STIs are extremely concentrated epidemics when you talk about syphilis, gonorrhea. (I.e. syphilis is 80% in MSM) you need a unique infrastructure for that.
County Health Department

Impact of the Affordable Care Act (ACA) and Access to Insurance

It is too early to know what to expect as the ACA is rolled out. We need openness that health departments will need to continue to provide STD services.
State health department

Why this matters:

With perhaps the exception of Boston which expanded health coverage in 2006, health centers and primary care associations are universally preparing for the implementation of the Affordable Care Act. At the time the interviews were conducted (July 2013), six of the twelve states with interviewees were planning to expand Medicaid eligiblity (California, Massachusetts, New York, North Dakota, Oregon, Washington) and six were not (Idaho, Mississippi, North Carolina, Oklahoma, Tennessee, and Texas).

In addition to enrolling individuals into health insurance, many health centers were focused on positioning themselves as the first choice of care for their patients. In some instances, health center personnel were concerned that previously uninsured patients would move to private health providers. In other health centers, they felt confident they would maintain their client base.

For public health departments, a few interview participants – regardless of whether they were in a Medicaid expansion state or not – expressed concern that there would be no safety net system for STD services once health care reform was fully implemented. Furthermore, public health departments regularly expressed uncertainty about their roles in the ACA and Accountable Care Organizations (ACOs).

Lastly, the implementation of health care reform – and the increase in number of insurance packages available – will be an administrative problem for some. In health centers or clinics that used to see almost all Medicaid clients, the ACA will mean many more health payers to deal with.

Health Informatics and Technology

Why this matters:

Many jurisdictions, both on the public health and primary care sides, discussed how good use of health information technology strengthens integration and how the lack of a good electronic medical record can hinder that collaboration. Good electronic health records are necessary for implementing improvements in all care, including STDs. Many health centers regularly use data from their EMRs for quality assurance, to check screening rates and to implement reminder systems for providers – all areas that would benefit the delivery of care for STD patients.

But the issue of whether or not public health will have access to a Health Information Exchanges (HIE) is generally unknown across providers and states. Several participants noted that communication of health information would be greatly improved if both public health and primary care could share information via EMR / HIE.

What could help:

- Greater understanding of how to utilize new data systems and data warehouses would help to improve surveillance information for public health.
- Addressing issues of confidentiality and ownership of data would help alleviate some of the barriers to information sharing that currently exist.

Our CHCs struggle to get data back into the health record. If patients go somewhere else, that information doesn't make its way back into the medical record, yet CHCs are responsible to be a medical home.
Primary Care Association

Expedited partner therapy (EPT)

Why this matters:
Expedited partner therapy (EPT) was described by several as an essential tool for better STD care and prevention. While many states have successfully championed legislative and regulatory changes to allow EPT in their areas, other participants described great struggles and resources needed to implement EPT in their own states.

While some recognized the benefits of a policy change on EPT, they feared that such change would be difficult and time-consuming to implement.

What could help:

- Learning from other states who have successfully advocated for EPT;
- Well written documents explaining the benefits of EPT, including cost savings and health outcomes
- Toolkits containing sample language, fact sheets and speaking points

Access to primary care

Why this matters:
In small and rural states (and even in some urban areas), availability of primary care is harder to come by. As a result, public health clinics tend to provide critical STD services in addition to services such as TB, family planning or WIC. These clinics supplement the work of limited primary care providers. With so few options for care, there is less duplication of services; providers are scarce and the division of labor is well understood.

We are worried about the clinical providers getting burned out. We are working with our academic partners to beef up primary care training programs.
State health officer

What could help:

- In areas where there are limited primary care resources, it is important to consider new models of care such as visiting nurses, mobile clinics and using paramedics in new ways

Best Practices and Examples of Integration

Most participants recognized that with budget cuts and the implementation of health care reform, changes were in store for the provision of both public health and primary care services. Many had begun planning for more coordinated services. Examples include:

- Public health departments are looking to integrate their services such as STD, TB and HIV by partnering with a federally-qualified community health center, hospital or ACO
- In rural areas with severe primary care workforce shortages, North Dakota is looking at the expanded use of paramedics – how they can bill for services and possibly work under the license of a doctor on EPT and other STD-related services
- In Mississippi, public health and primary care are working together on a conference to train providers on STDs and how to take a sexual health history
- One health center has begun an internal assessment of why certain patients may not be using the health center for screening – "What barriers are we putting up that we don't even know we are putting up?"
- In order to be a true patient-centered medical home (PCMH) most health center representatives felt they need to "treat the whole person" and be one-stop shopping for their patients.
- Co-location has been successful for a few public health / primary care systems. Close proximity to one another allows for better partnership, regular meetings, and regular opportunities for integration.
- Using a variety of funding sources, a state health department developed a new CME for physicians, APRNs and RNs. By partnering with a statewide medical association, they were able to meet more people than they could before.

Spotlight: An example for a County Health Department

Benton health services: transforming care delivery

Two services under one roof

In Benton County, Oregon, the health center and the health department share a building. But even with close proximity, services were not always coordinated. "Even though we were in the same building, we had big barriers," said the director of Benton Health Services. "We wanted to change, so we focused a lot on organizational culture."

The agency involved all levels of staff and spent a lot of time looking at all areas of service delivery, not just STDs, and began on a process that allowed them to really focus on this issue of organizational culture.

They had 5 basic principles they stuck to:

1. Embrace full continuum of person-centered and population based services
2. Serve target populations
3. Actively implement integration strategies
4. Focus on organizational culture and redesign to support integration
5. Focus on quality improvement and use data to measure and improve

Building the bridge

An important piece of the puzzle for Benton was focusing on how to connect the public health side to the delivery of health care services. The key for them eventually turned out to be Navigators – staff who serve as connectors to social services and supports, and who also help the primary care team engage the patient in self management. Navigators work side by side clinically and in health promotion, fulfilling the public health mission.

Applying it to STDs

As integration spread throughout the agency, it began to have an effect in the delivery of STD care. They admit they tested a few models before "we landed on something that worked for us." The first approach they tried: eliminate the STD clinic and send patients straight to a Primary Care Provider (PCP). It seemed like an integrated model, but it wasn't a perfect fit. "We were implementing medical homes. If someone was coming in for an STD and were put on a panel, they weren't going to embrace the model."

They shifted gears, keeping the STD clinic, but added two PCPs who were available at the same time. Staff could easily send the person to the PCP if they had another medical need. And that's where the navigators come back into the picture. "The goal was to get them connected to a medical home. We needed to make the connection with navigation – to bring them into services most appropriate for them."

Tuning into patients

With the organizational change, staff became more aware of the unique needs of each patient. "We don't expect that every PCP is going to be an expert in STDs. We do expect they are thinking about it and can make the connection."

Realizing the benefits

It took years to implement a wide-reaching change like this, but the benefits are real. "We have had to remind ourselves a lot of where we were compared to where we are today."

Next steps and moving forward

Survey of Meeting Participants

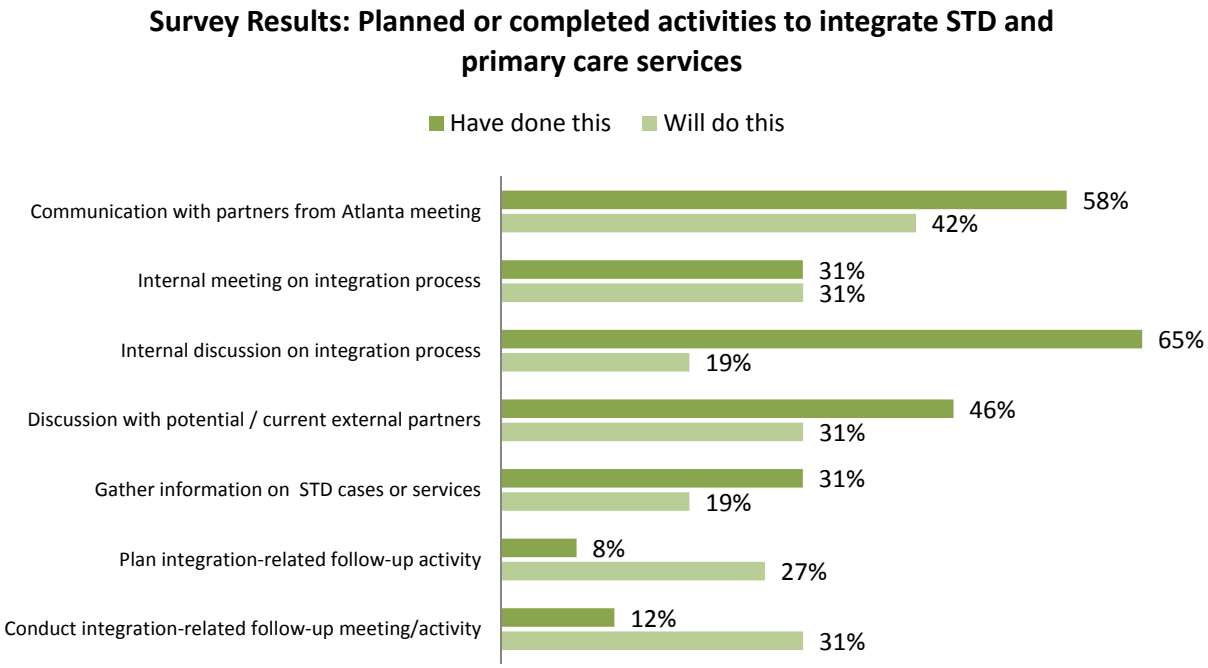
A total of 43 individuals from ten jurisdictions who attended the national meeting were invited to participate in an online post-meeting follow-up survey. The survey was sent approximately six weeks following the meeting in order to evaluate whether the meeting had an initial impact on integration efforts. Over the course of two weeks, a total of 28 individuals participated in the survey with a response rate of 65%. Of 28 participants, almost all responded to closed ended questions while responses to open ended questions varied from 13-20 participants per item. At least one individual from each of the ten jurisdictions participated.

The survey consisted of seven questions that were designed to address the post-meeting integration efforts among the ten jurisdictions that attended the August meeting.

The survey was intended to measure:

- extent of integration activities after the meeting and those planned in the near future
- obstacles preventing participants from taking steps related to integration
- ways that national partners can assist in the short-term
- views on pilot programs

Figure 8. Overview of current and planned activities



In the weeks following the meeting, most participants engaged in some kind of follow up activity. More than half of the participants reported engaging in specific activities such as, having informal initial internal discussions in organizations about possible ways to begin or continue the integration process (65%), and having follow-up communication with local/state partners who were present at the national meeting (58%). Slightly less than half (46%) of the participants also reported that they had spoken to potential or current external partners about ways to begin or continue the integration process (Figure 8).

When asked about anticipation for future plans to engage in the integration-related activities, less than half of the participants reported their anticipation to engage in activities such as, follow-up communication with local/state partners who were at the national meeting (42%), hold informal initial internal discussions in organization focused on ways to begin or continue the integration process (31%), speak to potential or current external partners about possible ways to begin or continue the integration process (31%), and conduct an integration-related follow-up meeting/activity (31%) (Figure 8).

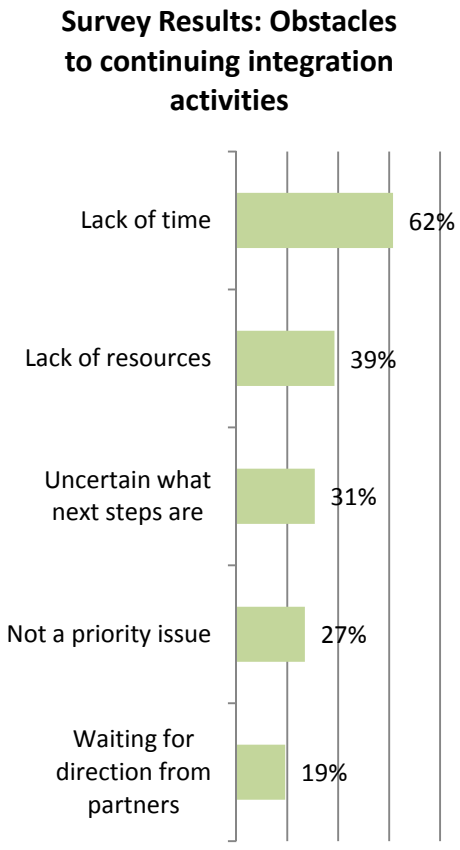
As shown in Figure 9, meeting participants experience various obstacles to working on this issue. More than half of participants (62%) reported the lack of time, followed by a lack of resources (39%).

Participants also rated the potentially helpful ways in which the national partners could support integration efforts in their respective jurisdictions. Rating average ranged from 3.07 to 3.70, suggesting that helpfulness of each means of support fell under "somewhat important" range.

The three most helpful means of support (see Figure 10) included:

1. training and educational sessions on public health and primary care integration for improved STD prevention and service provision, in conjunction with national meetings;

Figure 9. Obstacles to integration



2. compilation of a "How to" material on best practices, models, and policies on integration and;
3. a small grant ($5,000) to help plan and convene a meeting.

Figure 10. Resources that would be helpful

	Not at all important	Slightly important	Somewhat important	Very important	Extremely important	Rating Average
Offer training and educational sessions on public health and primary care integration for improved STD prevention and service provision, in conjunction with national meetings	2	2	3	15	5	**3.70**
Compile a "How to" with regard to integration: best practices, models, and policies	1	2	8	11	5	**3.63**
Offer a small grant ($5,000) to help plan and convene a meeting	3	4	4	8	8	**3.52**
Hold webinars on key topics related to public health and primary care integration	4	1	6	11	5	**3.44**
Prepare slides presentations and fact sheets on policy issues, such as expedited partner therapy and insurers' explanation of benefits mailings	1	3	9	11	3	**3.44**
Prepare a packet of materials that would be useful to plan and facilitate a local/state meeting about public health and primary care integration for improved STD prevention and service provision (combination of power points, case studies, draft agenda, etc)	1	6	5	13	2	**3.33**
Convene a meeting of regional, multi-state partners for collective planning	4	3	9	7	4	**3.15**
Provide customized technical assistance to local/state public health and primary care	2	5	10	9	1	**3.07**

Finally, survey participants were given the opportunity to answer open ended questions aimed at capturing their original and specific ideas on pilot programs, funding and worthwhile activities for the federal partners.

Possible pilot projects

Twenty (20) participants provided meaningful responses to the question "If resources were available to support a pilot integration effort, what might that look like in your local/state area?" While few specific proposals were offered, respondents provided general direction for pilots. Most of the respondents (12) thought a **pilot testing an integration effort between a specific primary care provider and the health department** would be helpful. The next most common suggestion **was meeting facilitation** (5 respondents). A pilot concerning **Accountable Care Organizations, Workforce Development and Messaging to Policymakers** were each suggested once.

Necessary Funding

Participants were asked how much funding they would need for the pilots suggested above. The most common response (8 out of 14) was that a small or moderate amount of funding ($5,000-$100,000) would allow the pilot to move forward. Participants provided examples of $5,000 incentive grants to funding for a full time disease intervention specialist.

Federal partners

When asked for specifics on what the federal partners could do to improve the state and local ability to integrate, respondents overwhelmingly said to provide best practices and materials that were specific and appropriate for their community (8 out of 13). Other responses included meeting facilitation (2), continued or increased communication from federal agencies (2), and funding (1).

Proposed Pilot

We should embed 1-2 senior/experienced Disease Intervention Specialists (DIS) in a Community Health Center, particularly in an area where STD rates are elevated. The DIS could train the CHC staff, including the physician or other health care provider, on discussing and evaluating sexual health concerns with all clients. The DIS could perform the intensive counseling and contact investigation, leaving the clinic staff's time open for more patients. The CHC, which already has the means for billing, could charge for the medical evaluation services.

Appendix 1: Interview Questions - State and Local Health Departments

1. **How are STD services provided in your (state or local)?**
    a. What are the different components of STD services that you provide (laboratory testing, nursing or other clinical visits, risk reduction counseling, primary prevention, and outreach)?
    b. Do you pay for them all?
    c. Are there others who provide such services in your state without your funding?
    d. Do you provide direct services (by your staff)? If so, which services?
    e. Do you contract them out? If so, which services?

2. **Have certain conditions led you to change or think about changes the way services are provided?**
    a. If so, what are those conditions?
    b. If you have made changes in the last few years, what were they?
    c. If you are planning to make changes in the near future, what is planned?
    d. If yes to b. or c. what process did you use to decide on the actions to take?

3. **Are there specific resources that would have helped you or would help you review the pros and cons of various approaches regarding STD services?**
    a. What are they?
    b. How helpful is it to know about the experiences of other locals and states?
    c. Would you find case studies of value?
    d. Would you find it helpful to review a set of questions that would help you gather useful information; review your options; consider the pros and cons?
    e. In consideration of the pros and cons, how important is:
        i. Cost
        ii. Quality of services
        iii. Access

Appendix 2: Interview Questions - Primary Care Associations and Community Health Centers

1. **Can you give us an overview on how STD services are generally provided in your state? Are certain functions handled by primary care and others by the public health system?**
   a. What are the different components of STD services that your health centers provide (laboratory testing, nursing or other clinical visits, risk reduction counseling, primary prevention, and outreach)?
   b. Are there others who provide such services in your area, such as local or state public health clinics? What services do they provide?

2. **Have certain conditions (i.e. Health Care Reform, Patient Centered Medical Home) led you to change or think about changes the way primary care services (or STD services) are provided at your health center/ your state's health centers?**
   a. If so, what are those conditions?
   b. If you have made changes in the last few years, what were they?
   c. If you are planning to make changes in the near future, what is planned?

3. **Could you talk a little bit about the work you are currently doing with the health department at the state/local level in this or other areas.**

4. **What do you think needs to happen for Public Health, primary care associations and health centers to improve the health and well-being in your state/community and to provide more coordinated STD services? Are there any resources that would be helpful to you?**

Appendix 3: Interview Participants

	Public health representatives	Primary care representatives
	Twelve interviews were held with public health jurisdictions from across the country. Many interviews included both the state health officer and the director of infectious disease. Twenty-two (22) people in total participated. See detail below	Nine interviews were held with primary care representatives. There was a wide range of job titles of those interviewed with the most common being director of the agency or director of clinical services. Twelve (12) people in total participated.
California	**California Department of Health** RON CHAPMAN, Director	
Idaho – North Central District	**Idaho North Central District** CAROL MOEHRLE, District Director, Public Health	**Terry Reilly Health Services (Idaho)** HEIDI HART, Executive Director
Massachusetts – Boston	**Boston Public Health Commission** ANITA BARRY, Director, Infectious Disease Bureau	**East Boston Neighborhood Community Health Center** MARI BENTLEY, Clinical Compliance Officer
Mississippi	**Mississippi State Department of Health** MARY CURRIER, State Health Officer JOY SENNETT, Director, Office of Communicable Diseases MARY JANE COLEMAN, Retired Director, Office of Communicable Diseases	**Mississippi Primary Health Care Association** ROBERT PUGH, Executive Director JOYCE SMITH, Director of Clinical Quality
New York	**New York State Department of Health** DAN O'CONNELL, Acting Director, AIDS Institute	
North Carolina	**North Carolina Department of Health & Human Services** EVELYN FOUST, Director, Communicable Disease Branch LAURA GERALD, State Health Director	**Piedmont Health Center (North Carolina)** EVETTE PATTERSON, Director of Clinical Services **North Carolina Primary Care Association** MARTI WOLF, Clinical Programs Director
North Dakota	**North Dakota Department of Health** TERRY DWELLE, State Health Officer KIRBY KRUGER, Director of Disease Control	**Community HealthCare Association of the Dakotas** MARY HOFFMAN, Clinical Services Specialist LINDA ROSSI, Chief Executive Director CHERYL UNDERHILL, Director of Training and Technical Assistance
Oklahoma – Tulsa	**Tulsa Health Department**	**Morton Comprehensive Health**

	BRUCE DART, Director PRISCILLA HAYNES, Division Chief, Community Health	**Services** CASSIE CLAYTON, Chief Nursing Officer
Oregon	**Oregon Health Authority** THOMAS EVERSOLE, Administrator, Center for Public Health Practice MELVIN KOHN, Director, Public Health Division VEDA LATIN, HIV, STD and TB Section Manager	**Oregon Primary Care Association** JENNIFER PRATT, Director of Systems Innovation
Tennessee – Shelby County	**Shelby County Department of Health** YVONNE MADLOCK, Director	
Texas	**Texas Department of State Health Services** TAMMY FOSKEY, Manager, HIV/STD Public Health Follow Up Team ANN ROBBINS, Manager, HIV/STD Epidemiology and Surveillance Branch JANNA ZUMBRUN, Acting Assistant Commissioner, Disease Control and Prevention Services	**Texas Association of Community Health Centers** DAVELYN HOOD, Director of Clinical Affairs
Washington - Seattle & King County	**Seattle & King County Department of Health** DAVID FLEMING, Director and Health Officer MATTHEW GOLDEN, Director, HIV/STD Program	

Appendix 4: National Meeting Agenda

CDC/DSTDP National Partners Collaborative on the Integration of Public Health and Primary Care to Improve STD Prevention

August 15-16, 2013
Atlanta, GA

Meeting Purpose and Goals

Purpose: To 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 setting and to learn from health department and primary care leadership how to better support and align prevention, care, and treatment in this changing environment of health care reform.

Goals: At the end of the meeting, participants will be able to:

1. Better understand the impact of environmental factors on the feasibility of public health and primary care integration for STD prevention and overall population health.
2. Recognize the role and contributions of an integrated public health and primary care approach to STD prevention and overall population health.
3. Identify conditions that lead to increased integration at the various points along the integration continuum outlined in the 2012 Institute of Medicine Report on Primary Care and Public Health: Exploring Integration to Improve Population Health.
4. Provide recommendations at the local, state, and national levels on potential solutions for addressing existing barriers to public health and primary care integration.
5. Provide a forum for sharing and building of partnerships among and between local, state and national organizations working in support of STD prevention and overall public health.

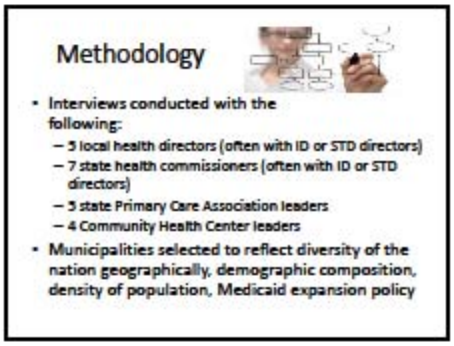
Agenda: August 15th

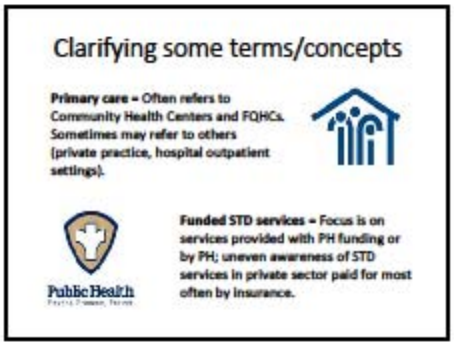
8:30 – 9:00 am	**Registration** *Breakfast, Great Room II*
9:00 – 9:20 am	**Introductions** *Cheryl Modica, Facilitator*
9:20 – 9:35 am	**Welcome Remarks** *Gail Bolan, CDC, NCHHSTP, DSTDP*
9:35 – 10:15 am	**Informing the Integration Model** *John Auerbach, Northeastern University*
10:15 – 10:35 am	**Participant Reaction** *Local/State Participants*
10:35 – 10:50 am	**Break**
10:50 – 11:50 am	**State of the Field** *John Auerbach, Northeastern University*
11:50 – 12:45 pm	**Lunch** *Great Room II*
12:45 – 1:00 pm	**Case Study Overview** *John Auerbach, Northeastern University*
1:00 – 2:00 pm	**Breakout Session** *Local/State Participants: Assigned Breakout Rooms* *Federal Attendees & Guests: Great Room*
2:00 – 3:00 pm	**Sharing** *CDC & National Partners*
3:00 – 3:15 pm	**Integration Continuum** *John Auerbach, Northeastern University*
3:15 – 4:20 pm	**Translating Work into Action** *Local/State Participants: Assigned Breakout Rooms* *Federal Attendees & Guests: Great Room*
4:20 – 4:55 pm	**Sharing** *CDC & National Partners*
4:55 – 5:00 pm	**Closing** *Cheryl Modica, Facilitator*

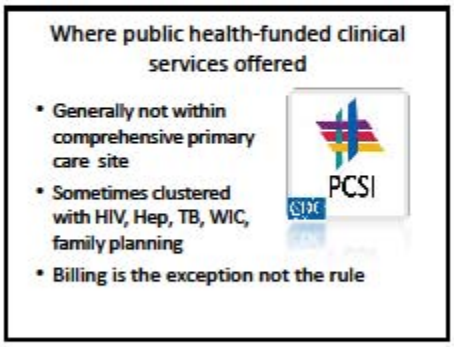
Agenda: August 16th

8:30 – 9:00 am	**Breakfast** *Great Room II*
9:00 – 9:10 am	**Welcome Remarks** *Cheryl Modica, Facilitator*
9:10 – 10:10 am	**Resources to Support Integration** *John Auerbach, Northeastern University*
10:10 – 10:25 am	**Break**
10:25 – 10:45 am	**Action Steps for Moving Forward** *John Auerbach, Northeastern University*
10:45 – 11:45 am	**Participant Reaction** *Local/State Participants* *CDC &National Partners*
11:45 – 11:50 am	**Closing Logistics** *Cheryl Modica, Facilitator*
11:50 – 12:00 pm	**Closing Remarks** *Gail Bolan, CDC, NCHHSTP, DSTDP*

Appendix 5: National Meeting Presentation: *Findings from the Field*







Pride in offering services that are:

- Free – low barriers
- Non-judgmental & welcoming
- Confidential
- Less risk of stigma
- Targeted to high risk population

[redacted]

FREE STD TESTING & Treatment

Community Health Centers Are Partners

- Many CHCs provide STD services to their patients
- CHCs share the mission of treating vulnerable populations; uninsured
- CHCs are mindful of being Primary Care Medical Home (PCMH) and want to treat the 'whole person'
- Many are grappling with logistical issues of ACA – enrolling patients, preparing for transition and new billing requirements

Findings – Primary Care Integration Limited and Uneven

- Some but limited PH-PC collaboration and communication
- Periodic partnership with division of labor
  - PH uses epidemiology & DIS to assist PC
  - PC (especially CHCs) treat STDs
- In limited instances PH runs CHC or FQHCs
- In many instances PH runs multi-service clinical sites with STD services
- Increasing discussions about opportunities and pilots

Challenges and Opportunities

1. The ACA will bring change

For some, there will be big changes and many newly insured….but change is coming everywhere

Current Status of State Medicaid Expansion Decisions, as o July 1, 2013

For some the change is big

- For expansion states, large segments of the uninsured will be insured in a short time period (2014)
- Lot of attention to those likely changes
- Possible significant impact on STD services

For non-Medicaid expansion states

- The impact is less clear
- Some will gain insurance through non-Medicaid provisions – numbers uncertain
- Those who gain insurance may not be current PH STD clients

Differences Are Striking

North Carolina (NO)
- 83% with insurance
- No Medicaid expansion

Texas (NO)
- 75% with insurance coverage
- No Medicaid expansion

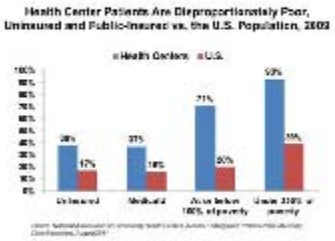
Washington State
- 86% with insurance coverage
- Will expand Medicaid
- 800,000 may be newly insured

Oregon
- 85% with insurance
- Will expand Medicaid by 240,000

North Dakota
- 89% have insurance
- Will expand Medicaid by 20,000 (1/3 of uninsured)

Oklahoma (NO)
- 78% have insurance
- No Medicaid expansion

CHCs already care for many uninsured: limited ability to handle more



Challenges even with insurance expansion

- Public health not always aware/involved in changes
- Insurance coverage may not lead to changes in care site
- Assumptions about impact may be incorrect – cut first & understand later

2. Budget cuts and other resource obstacles

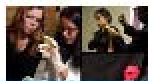
Effect of cutbacks – states and local still feeling impact

STD Programs Facing Severe Cutbacks, Affecting Public Health Infrastructure

Economic Crisis Impacting Health Department Capacity to Address Rising STD Rates

WASHINGTON, Nov. 16 /PRNewswire-USNewswire/ -- Amid the mounting toll of budget cuts across the country, a new study from the National Coalition of STD Directors (NCSD) shows just how much an impact the economic crisis is having on sexually transmitted disease (STD) programs and in turn, having more broadly on public health infrastructure.

"These cuts threaten our national ability to control both STDs and our entire public health infrastructure," said Dr. William Wong, lead author of the study, NCSD Board member, and STD Program Director for the Chicago Department of Public Health.



Editorial: Cuts to public health come back to hurt county

Cuts to Family Planning

Title X Programs

Screening for sexually transmitted infections.

More than 2.5 million clients (2,287,270 women and 245,326 men) were tested for chlamydia; 2.7 million for gonorrhea (2,470,645 women and 258,933 men). Nearly 750,000 clients were tested for syphilis (608,224 women and 135,557 men)

Family Planning Cuts

Texas family planning clinics slowly rebuilding after deep state budget cuts

Other circumstances matter

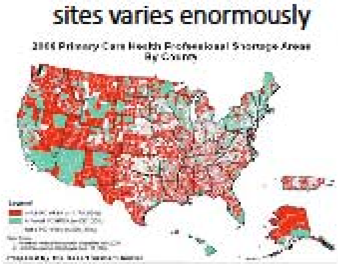
The Washington Post

How Mississippi could end up killing Medicaid

Why Does it Matter?

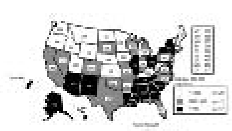
- Budget cuts may reduce services and flexibility
- Other issues may absorb limited resources for planning and change
- Seemingly unrelated issues may lead to reduced funding for STDs

3. Availability of primary care sites varies enormously



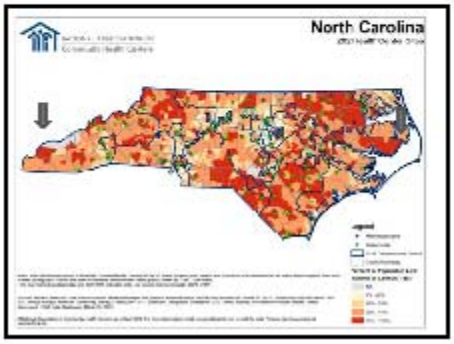
CHCs and STDs

STD Distribution



FQHC Distribution

Example: North Dakota



Why Does It Matter?

- Decisions may be made with the assumption that primary care options exist for STD patients
- Uneven access to PC could leave segments of population without options
- Not all PC providers offer comprehensive care (as do CHCs)

4. Stigma and Discrimination

Stigma of STDs:

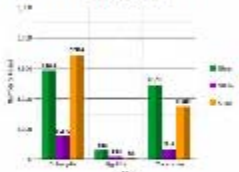
In some areas STDs are still stigmatized to the extent that patients might avoid a primary care setting or a setting where they have to provide insurance card -

*Teenagers

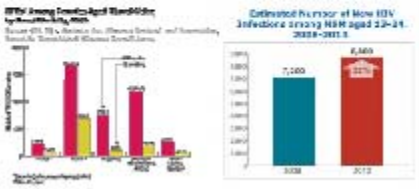
*Small towns/rural areas

Discrimination against certain people/populations

STD clinics may be the only clinical providers for some who have experienced or fear they will experience discrimination.



Elevated Risk Among Those Who Face Discrimination



Why Does It Matter?

- Those who fear/experience stigma & discrimination may avoid care
- Some of those who face discrimination may be:
  - At greater risk
  - Less likely to be insured even after reform

5. STD services are linked to other services

STD services are linked to other services

States and locals often run clinics that house a cluster of services – STD care, immunizations, Family Planning and WIC, for example.

Why Does It Matter?

- Loss of STD services could have impact on ability to provide other services
- STD services sometimes embedded within other service units (such as FP)
- Unintended consequence could be impact on other non-PC services

6. Clinical expertise is needed

STD Sexually Transmitted Diseases Treatment Guidelines, 2010

Clinical expertise

Concern primary care practices don't always have the expertise to treat STDs in part because of lack of experience in taking a sexual history

Levels to Address

- Initial skill-building needed for clinicians in training
- Clinical skills needed for those already in practice
- Retention of public health STD expertise needed for referral

Alabama – North Carolina
STD HIV
Prevention Training Center

Summary of Opportunities and Challenges

1. Insurance expansion for some
2. Budget cuts & other complicating issues
3. Access to primary care
4. Stigma and discrimination
5. Multiple services at STD sites
6. Clinical expertise

Questions and Comments

Appendix 6: National Meeting Handout Case Study 1

Case Study #1
Integrating Care without a New Source of Funding

Outcome:

To recommend practical action steps that might be taken in the public health – primary care arena with regard to integration under even the most challenging of situations. Recommended action steps may have application to a wider audience including the work of the national partners as part of this integration initiative.

Introduction:

Case Study #1 presents a series of scenarios related to the integration of STD services and prevention activities in the context of funding constraints and issues related to implementation of the Affordable Care Act. The situations highlighted within the case study do not come from a specific local or state situation. However, they reflect the types of circumstances mentioned by a number of participants interviewed as part of this project.

Instructions:

Groups will have 55 minutes for this segment. Please use the below as a general guide to timing for the work.

1. **Transition to assigned breakout room** (5 min.)
    - Industry 1: North Dakota & Seattle
    - Industry 2: Mississippi & North Central District
    - Industry 3: Texas & Shelby County

2. **Read case study** (5 min.)
   Each participant reads the case study in preparation for discussion.

3. **Discuss case study** (35 min.)
   The group discusses each of the questions. For the discussion, group members should assume they are not only analyzing what is happening within the state or local community but also advising the health director about what he/she could do.

4. **Summarize discussion points to share with larger group** (5 mins)
   The groups should identify, and be prepared to share with the larger group, two (2) overall responses/positions.

5. **Transition back to main room** (5 min.)

Division of labor:

a. *Facilitator* – This person should be a volunteer from one of the local/state participants. He/she will also be responsible for facilitating the discussion of the group and presenting the summary of the discussion with the larger group.
b. *Note taker* - Someone from one of the national partner organizations will be taking minutes that capture the key higher level observations or conclusions – he/she will not be taking detailed notes or attributing the comments to any particular person.
c. *Timer* – A local/state participant responsible for ensuring the group moves through all the questions and does not get 'stuck' on any one topic. The timer will provide the group with cues near the end of the discussion to allow for adequate wrap up and summary.

Case study scenario:
Dr. Mara Lavitt, the county public health director, said what a lot of people were thinking when she said – "The biggest obstacle is how to pay for the services for the uninsured or underinsured. There are other issues but that's the most challenging".

She was participating in a rapidly called meeting that was being held at Kummer County's health and human services offices. The gathering was composed of about 20 people including the public health director and her senior staff, the director of the state primary care association, the directors and medical directors of three community health centers, the state public health STD director and leaders of a couple of community-based agencies from low income sections of the county. The meeting was called in anticipation of some major changes in the coming year. The county budget had just passed and the public health department was in for the third year of budget cuts. In addition, the group was considering if there would be any noticeable changes in the number of insured in the state since the governor and legislature had decided not to alter the Medicaid eligibility criteria but several provisions of the Affordable Care Act would go into effect.

Dr. Lavitt asked for the group's advice in how best to reduce the budget this year. There were a number of options on the table but one that was of particular interest to the attendees related to STD services. She proposed cutting back the hours of operation of the county-funded STD services in the county's two cities, Kummer City and Springfield. Kummer City's clinic had seen decreasing utilization. That might have been a result of more patients shifting their care to primary care providers in the area (including a small community health center in a building it had outgrown) or it might have been due to a reduction of STDs. Springfield's clinic on the other hand had seen a slight rise in its visits and had grappled with two syphilis outbreaks in the last 5 years. But it was located near a newly rebuilt FQHC which had room to expand the number of patients it served.

The Springfield Community Health Center was eager to help the county PH department and provide care for the STD patients as part of its efforts to be a patient-centered medical home. But its Executive Director, Brian O'Connor was concerned about his ability to absorb lots of patients without insurance, some of whom had not had a physical in years. He encouraged the county to consider ways it could identify grants or safety net funding to help.

There were other questions that arose at the meeting, too, including whether the county-run Family Planning Services - which operated in the same buildings as the STD clinics - should also be shifted to the community health centers. They offered STD services to numerous women in the area as part of the provision of reproductive care. More of these patients were insured. However, the director of the Family Planning services relayed that a sizable percentage of their patients preferred not to use their insurance out of fear of a loss of confidentiality. The director of a local community-based organization in Springfield said, "Like it or not there is still stigma associated with having an STD. We better think twice before closing a clinic folks trust".

Some of the senior staff members from the county health department proposed trying to seek reimbursement for the public health services from those that had insurance as an interim step. This would be challenging since the health department had no experience in the complicated matter of third party billing. Perhaps the health center could lend some expertise in getting the system going and they could keep the public clinic going – in the short term at least.

During a break in the meeting, Dr. Lavitt and Mr. O'Connor withdrew to a corner of the hallway to talk in confidence. "There has to be a way we can figure out what to do. Let's come up with a proposal to bring back to the group."

Questions

1. What are the pros and cons of the different proposals on the table – transitioning services or instituting a reimbursement system?
2. Are there any critical pieces of information that would be helpful to have in order to proceed?
3. Does this situation lend itself to a limited solution (perhaps a pilot) or is it better to try to address the larger systemic issues?
4. What would you propose as the immediate steps the group should focus on within the next 30-60 days?

Appendix 7: National Meeting Handout Case Study 2

Case Study #2
Living in a Diverse State

Outcome:

To recommend practical action steps that might be taken in the public health – primary care arena with regard to integration under even the most challenging of situations. Recommended action steps may have application to a wider audience including the work of the national partners as part of this integration initiative.

Introduction:

Case Study #2 presents a series of scenarios related to the integration of STD services and prevention activities in the context of diverse health care resources and diverse populations and needs in different parts of a state. The situations highlighted within the case study do not come from a specific local or state situation. However, they reflect the types of circumstances mentioned by a number of participants interviewed as part of this project.

Instructions:

Groups will have 55 minutes for this segment. Please use the below as a general guide to timing for the work.

1. **Transition to assigned breakout room** (5 min.)
   - Industry 4: Oregon & Boston
   - Studio 2: North Carolina & Tulsa

2. **Read case study** (5 min.)
   Each participant reads the case study in preparation for discussion.

3. **Discuss case study** (35 min.)
   The group discusses each of the questions. For the discussion, group members should assume they are not only analyzing what is happening within the state or local community but also advising the health director about what he/she could do.

4. **Summarize discussion points to share with larger group** (5 mins)
   The groups should identify, and be prepared to share with the larger group, two (2) overall responses/positions.

5. **Transition back to main room** (5 min.)

Division of labor:

d. *Facilitator* – This person should be a volunteer from one of the local/state participants. He/she will also be responsible for facilitating the discussion of

the group and presenting the summary of the discussion with the larger group.

e. *Note taker* - Someone from one of the national partner organizations will be taking minutes that capture the key higher level observations or conclusions – he/she will not be taking detailed notes or attributing the comments to any particular person.

f. *Timer* – A local/state participant responsible for ensuring the group moves through all the questions and does not get 'stuck' on any one topic. The timer will provide the group with cues near the end of the discussion to allow for adequate wrap up and summary.

Case study scenario:

The board of the Fields Corner Health Center voted unanimously that they increase their outreach to beyond their traditional catchment area in order to serve more patients. They were understandably proud of the new wing of their main facility. It doubled the number of exam rooms, replaced their old laboratory and housed a new pharmacy. The timing of the opening of the new wing came at a good time because the state was anticipating that a million more residents of the state would soon gain insurance as a result of the Affordable Care Act and its Medicaid expansion.

In addition to its other outreach efforts, the health center Medical Director called the state public health commissioner's office to see if there were any needs that the center might help out with. The commissioner was very appreciative of the call and suggested that there might be an opportunity to discuss transitioning some of the state-run services over to the center. "We serve a very high risk population at our STD clinics" said the commissioner, "and most of them are uninsured. But soon a good number of them will become insured and they may no longer need our services".

When he got off the telephone, the commissioner sighed. He thought how lucky it was for the patients in the northern, more urban section of the state that there were health centers like Fields Corner. "I wish the same options existed for the people in the south", he thought. He wondered if it was fair and defensible to have two different approaches to STD services in different parts of the state. "I may have a hard time explaining this to the press."

The state covered 5,000 square miles. Its population was 1,500,000 but that size was unevenly distributed across the state. Within the northern more urban region – where two-thirds of the state's population lived -- services were relatively easy to find. It had a sizable capital city with a population of 700,000 and three other smaller cities with populations of about 100,000 each. There were several acute care hospitals, 1 dozen community health centers (half of which were

FQHCs) and numerous group private practices. The large rural southern region was compromised of small towns and large rural areas and it accounted for half the geographic area of the state. It had only two health centers and two medium-sized community hospitals. At the hospital and health centers, the volume of patients was relatively low. The logistics of providing services in the many isolated parts of the region were challenging. Large areas of southern section had no health services within 100 miles.

The state provided grants to the 6 county health departments with the requirement that they operate STD clinics. The northern section, which was a single county, had three such STD clinics. The five remaining counties in the south each had at least one STD clinic. Two of them also operated part-time rural satellite clinics run by county staff who worked at these mini-service sites on different days of the week.

The STD clinic in one of the three smaller northern cities was located in the heart of the Black community. Known as the Davis Square clinic, it was run by a director who was a longtime resident of the area with strong ties to the neighborhood. She had worked for two decades to create an environment in the clinic where the community members would feel comfortable seeking services. She had carefully picked and trained her staff with the goal of guaranteeing that any patients – young or old – knew they'd get high quality and confidential care. Davis Square's reputation was so strong that it was not unusual for residents from other cities to travel past a closer clinic in order to get their services there.

There was a growing Latino population in two of the rural southern counties, some of whom were migrant farmworkers. Many of the Latinos in these counties had been in the U.S. for less than 5 years and were likely to be ineligible for Medicaid or other subsidized insurance.

One of the biggest challenges the public health department faced was not knowing the true state of affairs when it came to STD prevalence. Half of the state's STDs were treated in the public health clinics, but the other half were handled by the primary care providers. STDs were notoriously under-reported; the health centers and primary care practices had many competing demands and case reporting often fell off the list.

But most important issue was trying to share resources in the areas of the state where there were few. The STD clinics in the rural areas provided a much need service – but what they did was often in isolation from the patients' larger health needs which were often chronic disease related. It seemed like there had to be a way to let each side continue to do what they did best, but share information so that patients were referred for appropriate care.

The state health commissioner called the director of the state's primary care association to ask if it made sense to talk through the possibilities for integrating STD services after the insurance expansion kicked in. They agreed to convene a meeting. But they both acknowledged that the issues would be quite different in the north and the south and what worked for one region might not work for another. They both agreed to convene a meeting to discuss this further but they also acknowledged that first each organization had some planning to do.

Questions

1. What are the issues in the North? Are there particular considerations related to the reputation of the Davis Square Clinic?
2. What are the issues for the rural part of the state?
3. What are the pros and cons of developing a single approach to linking STD services to primary care? Is it okay to have different approaches?
4. What are the barriers to better information sharing and case reporting? How could they be overcome?

Appendix 8: Post-meeting survey

CDC/DSTDP National Partners Collaborative on the Integration of Public Health and Primary Care to Improve STD Prevention

Thank you very much for your participation in the CDC/DSTDP National Partners Collaborative Meeting held in Atlanta last month. Your insights and feedback were extremely valuable and helpful.

The national partners are finalizing a meeting summary and a report on the pre-meeting key informant interviews and information gathering process. These documents will be distributed to all meeting attendees in the coming weeks.

Since meeting in August, the national partners have used the information we gathered during the meeting and from the evaluation results to inform our next steps to advance integration efforts already underway. To help us further develop and refine our plans, we would like to gather additional feedback from you now that you have had time to reflect on the August meeting and return to work.

This brief seven question survey should take approximately ten minutes to complete.

Your Name _____

Organization _____

1. Since the meeting in August, are there activities that you have been involved in related to the integration of public health and primary care to improve STD prevention and service provision? Please check as many answers as apply.

    a. Had follow-up communication with my local/state partners who were at the Atlanta meeting
    b. Held an internal meeting in my organization focused on ways to begin or continue the integration process
    c. Had informal initial internal discussions in my organization about possible ways to begin or continue the integration process
    d. Spoke to potential or current external partners about possible ways to begin or continue the integration process
    e. Gathered additional information about STD cases or services to better understand the potential for integration
    f. Planned an integration-related follow-up activity
    g. Conducted an integration-related follow-up meeting/activity
    h. Other (please explain below)

Please explain any follow-up work on the STD-primary care integration effort that has occurred since the August meeting.

2. Do you anticipate that you will be taking any additional steps in the **next 90 days**? If so, please indicate which ones are most likely. Please check as many answers as apply.

    a. Have follow-up communication with my local/state partners who were at the Atlanta meeting
    b. Hold an internal meeting in my organization focused on ways to begin or continue the integration process
    c. Have informal initial internal discussions in my organization about possible ways to begin or continue the integration process
    d. Speak to potential or current external partners about possible ways to begin or continue the integration process
    e. Gather additional information about STD cases or services to better understand the potential for integration
    f. Plan an integration-related follow-up activity
    g. Conduct an integration-related follow-up meeting/activity
    h. Other (please explain below)

Please explain any additional steps you anticipate to take in the next 90 days.

3. Are there any obstacles or challenges that are preventing you from taking steps related to integration efforts? Please check as many answers as apply.

    a. Lack of time
    b. Lack of resources
    c. Uncertain about what the next steps are
    d. Not a priority issue for my organization
    e. Waiting for direction from the CDC, other federal partners/funders, and/or the national partner organizations.
    f. Other (please explain below)

Please explain any obstacles or challenges that may prevent you from taking steps related to integration efforts.

4. What would be the most helpful ways for the national partners to support integration efforts in your state/local jurisdiction in the short-term? Please rate the importance of each item listed below using 1 “not at all unimportant” to “5” (extremely important). Please share additional assistance options that you would find helpful under “Other.”
    ___ Prepare slides presentations and fact sheets on policy issues, such as expedited partner therapy and insurers’ explanation of benefits mailings.

___ Prepare a packet of materials that would be useful to plan and facilitate a local/state meeting about public health and primary care integration for improved STD prevention and service provision (combination of power points, case studies, draft agenda, etc).
___ Compile a “How to” with regard to integration: best practices, models, and policies
___ Convene a meeting of regional, multi-state partners for collective planning
___ Provide customized technical assistance to local/state public health and primary care
___ Offer a small grant ($5,000) to help plan and convene a meeting
___ Hold webinars on key topics related to public health and primary care integration
___ Offer trainings and educational sessions on public health and primary care integration for improved STD prevention and service provision, in conjunction with national meetings
___ Other (please explain below)
Please list any additional information about the type of assistance that would be helpful.

5. If resources were available to support a pilot integration effort, what might that look like in your local/state area? (Please describe).

6. What is the estimated amount of external/additional resources this would require? (Please describe).

7. What would be the most helpful follow-up work that would be helpful? (Please describe).

THANK YOU FOR YOUR PARTICIPATION!

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