

# INFECTIOUS DISEASE STRATEGIC THINKING SUMMIT REPORT

STRATEGIES TO ADDRESS  
HIV/AIDS, VIRAL HEPATITIS, STDs, AND TB



## EXECUTIVE SUMMARY

The current economic climate and changing healthcare landscape are challenging state health officials (SHOs) to make difficult decisions about how to maximize limited program resources and articulate the unique role of public health in addressing HIV/AIDS, viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB). ASTHO is committed to fostering innovative program integration and financing strategies to maintain state governmental capacity to protect the public against these infectious diseases. ASTHO can convene national-level discussions with its affiliates around program integration, and coordinate discussions among CDC, HRSA, and SHOs about federal funding and requirements for these programs. Ideally, ASTHO will be able to develop a repository of best practices on integrating services and funding while maintaining effective programs.

Several contextual factors should be taken into account while developing program integration and funding strategies:

- Historically, health agencies have approached these four disease areas as discrete silos, largely as a result of specific funding requirements. As a result, integrated tools, policies, and clinical and population-based interventions are relatively new concepts.
- As funding continues to dwindle, SHOs need to understand how best to prioritize investments in the four disease areas, and many states would benefit from a more thorough understanding of how to leverage Medicaid waivers to enhance billing practices.
- SHOs need to be strategic about their unique role with respect to the four disease areas. Maintaining sufficient state health agency capacity to effectively address the disease areas may entail regionalization, use of telemedicine, and expanding the scopes of practice for mid-level providers.
- Disease identification and treatment need to keep pace with biomedical advances.
- A number of systems outside of governmental public health are responsible for reporting these diseases.

A comprehensive approach to advancing program integration and funding strategies for the four disease areas includes exploring the overall issue of integration, ensuring adequate funding, developing and disseminating model practices, educating new SHOs and other providers, identifying the most appropriate role for public health and designing an ideal system of care, and developing uniform reporting requirements. ASTHO and SHOs have complementary roles in these efforts, and specific strategies fall under the following categories:

1. Integration of services, funding, and advocacy efforts.
2. Sufficient funding and reimbursement.
3. Contemporary model policies and practices.
4. New SHO education.
5. Education for all providers.
6. System of care.
7. Clear role of public health.

## 8. Uniform reporting requirements.

The range of activities explored in this report includes: integrating programs at the health agency level, working with Medicaid to obtain waivers, collecting best practices and model policies, enhancing peer-to-peer mentoring of new SHOs, and brokering the development of integrated systems of care.

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## MEETING SUMMARY

ASTHO convened state health agency leadership to discuss policy issues related to HIV/AIDS, viral hepatitis, STDs, and TB. The goal of the meeting was to identify strategies for ASTHO and SHOs to effectively address these infectious diseases. Defining these strategies comprised four steps:

**Conducting an Environmental Scan:** The meeting began with the participants discussing national and state initiatives to address the four program areas, including ASTHO's activities. This was followed by a brainstorming session regarding factors in the current environment that affect health departments' ability to integrate efforts. (See Appendix A for the full environmental scan.)

**Envisioning an Ideal System:** Participants were asked to envision a system that effectively addresses the four infectious disease areas. They concluded that the ideal system is based on integrated services, funding and advocacy efforts that are supported by stable funding, and model policies. New health officials and all public health and clinical providers would be fully educated and trained with respect to their roles and responsibilities, and there would be a clear and deliberate role for public health. A comprehensive system of care would be in place, with a uniform system of reporting adhered to by all. (See Appendix B for the affinity diagrams that were generated through the visioning exercise.)

**Identifying Strategies:** Participants then identified strategies for ASTHO and SHOs to achieve each component. Staff categorized strategies as follows:

- The strategy is already underway.
- The strategy could be addressed with current resources.
- The strategy may be underway by ASTHO affiliates and will be discussed with them.
- The strategy would require new resources.

**Identifying Measures of Success:** The final step was for participants to determine how to measure progress toward the strategies: specifically, what success would look like after one year.

The result of meeting's efforts is a draft work plan for ASTHO and SHOs. The next step will be to share the draft plan with ASTHO's Infectious Disease Policy Committee for their review and comment. The final version will be used to prioritize ASTHO staff activities in the four infectious disease areas over the coming year. (See Appendix C for the draft work plan.)

## ENVIRONMENTAL SCAN

The day began with the SHOs on the workgroup sharing a best practice or challenge to addressing one or more of the four infectious disease areas. This included North Dakota's anticipated increase of STDs in its westernmost regions (due to the emerging natural gas industry) and tracking TB among university students after the semester ended; New Hampshire's merger of its TB and HIV/STDs clinical operations in the low-prevalence state; and New Mexico's success in enhancing access to clean syringes, as well as its border issues related to STDs and TB. The stories have been captured by ASTHO's "Have You Shared?" initiative.

Following these brief presentations, ASTHO staff provided a high-level review of national programs to address the four disease areas. These topics prompted a rich discussion about various issues related to the four diseases, providing a natural segue into the environmental scan.

Several prominent themes emerged through the morning's discussions. In addition to particular issues of concern regarding individual diseases, participants emphasized the need to focus on program integration and the barriers associated with program integration. For example, the idea of integrated tools, policies, and clinical and population-based interventions for these four diseases is relatively new.

Although some integration may be occurring on a small scale, these types of practices are not widespread. Advocates and constituencies may not know how to effectively collaborate around these issues. Moreover, there is a longstanding belief—which has proven to be true in many instances—that aggregated funding will result in an overall funding decrease.

Other funding issues were raised as well. There is a clear need for a mechanism to prioritize investments in these disease areas, particularly as funding cuts continue to occur. Many states would benefit from a more thorough understanding of how to leverage Medicaid waivers to enhance billing practices. Medication pricing, including the federal government’s role as a major purchaser, is also a pertinent issue.

Another issue was access to treatment in rural areas. The need to maintain capacity, perhaps through regionalization, was noted, as were the use of telemedicine strategies and the expansion of scopes of practice for midlevel providers. Despite the presence of various communication technologies that provide venues for linking to resources, participants noted that technological difficulties pose barriers to access, e.g., lack of internet or mobile connections, or the high cost of obtaining reliable technology in rural areas.

Disease reporting proved to be an important consideration in moving integration forward. One issue is the number of systems other than governmental public health that are involved in disease reporting, including sovereign nations, the Veterans Health Administration system, workplaces, military hospitals, and institutes of higher education. Other reporting issues had to do with country of origin—a data point not captured in reporting systems, but one with many implications with respect to surveillance. Associated issues included an increasing number of immigrants, drug-resistant strains, migration patterns, active cases, and cultural beliefs.

Several biomedical advances were mentioned, as well as various policies that come into play: laws, regulations, enforcement, state health policy, and healthcare reform. Finally, the role of public health was discussed, particularly the need for public health to be strategic about its unique role with respect to the four disease areas.

## **STRATEGIES**

The morning’s discussion and the environmental scan set the stage for the meeting participants to envision what an ideal system would look like to effectively address the four infectious disease areas. They were asked first to brainstorm the various parts of an ideal system, and then, through an affinity diagram, to group these parts in several succinct components. The group then discussed the major points captured in each component.

The system envisioned by the group was progressive, comprehensive, and intentionally inclusive. Therefore, all public health system partners would need to meet their respective responsibilities in order for such a system to come to fruition. To achieve the meeting’s goal, however, the participants were then asked to focus solely on identifying strategies unique to ASTHO and SHOs to advance an ideal system.

The following is a summary of the very broad system components, in addition to specific strategies that reflect the roles and responsibilities of ASTHO and its members.

## **Integration of Services, Funding, and Education Efforts**

At the heart of the day's discussion was the nature of current categorical funding streams. As with all programs funded in this manner, there is a long history of approaching these four disease areas as discrete silos, which is largely driven by specific funding requirements. The current structure does not promote, and at times can prohibit, efforts to identify programmatic synergies and use pooled funds to address common issues in a more efficient and collaborative manner. Hepatitis C virus (HCV) services and policies are still in their infancy; the approach could be built on the framework of HIV services, and requires sufficient funding and comprehensive policies and programs.

An ideal structure would be characterized by integration of services, funding and advocacy efforts. Population-based efforts would include integrated prevention messages and expanded screening, particularly for HCV and HIV. At the client level, addressing the health of the individual as a whole would be reflected in screenings for the four diseases that are integrated into patient care and paid for as part of all routine screening.

SHOs are beginning to make difficult decisions about how to trim program activities due to declines in funding. This situation presents an opportunity to carefully evaluate areas of duplication among the four infectious disease programs, and to identify aspects of each program that can be successfully integrated.

ASTHO is ideally positioned to convene national-level discussions with its affiliates around program integration. Moreover, ASTHO can coordinate discussions among CDC, HRSA, and SHOs about federal funding and requirements for these programs. Through these discussions, ASTHO will be able to develop a repository of best practices in integrating services and funding, and also share examples of how to make cuts that have a minimal impact on program activities.

## **Sufficient Financing and Reimbursement**

Not surprisingly, financing and reimbursement for all of the disease areas currently falls short, although several strategies could improve the situation.

The need for affordable medications is central to this issue, and this could be addressed by better negotiated prices for pharmaceuticals with greater flexibility in accessing these prices, in addition to guaranteed medication access for all infected patients. Comprehensive, integrated vaccine programs for prevention would also enhance prevention efforts. Another strategy would be establishing a database of best practices around Medicaid reimbursement and waivers for infectious disease prevention and treatment. Diverse funding and resources to address "non-medical" barriers to care would be another feature of an ideal system. SHOs can work with payers, including state Medicaid agencies, to define and expand diagnosis, treatment, and pharmacy benefits. In particular, SHOs can work with Medicaid to obtain waivers.

ASTHO's current fact sheets on "The State of Funding" can continue to provide updates on Medicaid support for these disease areas. ASTHO can also work with insurance companies to define insurance benefits and sustainable funding for diagnosis, treatment and prevention, in addition to more aggressive price negotiation for pharmaceuticals. ASTHO also will serve an important convening role to address

public health integrated systems funding, and will develop resources for fee-for-service revenue generation.

### **Contemporary Model Policies**

Policies are very powerful tools. However, sound scientific policies too often are not widely adopted. They are slow to reflect recent scientific advances, or are not passed due to political pressures or misunderstanding of existing legal frameworks.

A comprehensive system would be governed by national and state policies to effectively support prevention and treatment of the four disease areas. They would always reflect the most current advances in public health science, e.g., syringe exchange, early antiretroviral therapy (ART), treatment as prevention, and expedited partner therapy (EPT). Clear and operationally feasible reimbursement policies for public health activities and services would be widely known. Policies guiding midlevel health practitioners would enable them to effectively link prevention and clinical practices, particularly in underserved areas.

Public health research efforts would be buttressed by support for developing best practices into model policies that would be widely disseminated. All SHOs would have an understanding of the current legal framework in which they operate in order to understand gaps and opportunities for promising policies. The public components of prevention would be integrated with other partners, including policymakers, clinicians, and communities (rural towns, worksites, faith-based communities, schools, and service organizations like Kiwanis, Rotary, and Optimists).

The most effective role for a SHO in the policy arena is to educate policymakers on the adoption, and lead the implementation, of model policies in their state or territory. ASTHO presently supports this type of effort through the collection, synthesis, and dissemination of best practices, model policies, and model legislation. ASTHO will also assist with developing model policies based on public health science and best practices, and develop a compendium or toolkit of model policies and best practices.

### **Uniform Reporting Requirements**

Establishing uniform reporting requirements and ensuring the use of a reporting system by all entities involved in treatment and diagnosis of the four infectious disease areas are key components of a comprehensive system.

Sovereign nations, Veterans Health Administration system, military hospitals, and institutes of higher education would all be responsible for adhering to uniform reporting requirements. Disease reporting would be integrated into electronic health record systems, and universal laboratory-based reporting also would exist. Moreover, reporting would include country of origin information. Information from the reporting system would allow public health practitioners to geocode and focus prevention efforts on affected and high-risk populations and communities.

SHOs can identify opportunities to improve reporting as part of state health information exchange initiatives. Furthermore, they can establish guidelines for assessing high risk individuals and policies for reporting infectious diseases, in addition to maintaining the capacity to respond to requests for technical assistance. Going forward ASTHO can provide best practices, and develop a model reporting

policy document. ASTHO can also work with affiliates to facilitate discussions with key stakeholders about integrated or harmonized reporting requirements.

### **Education for New SHOs**

An important contextual factor for the state health agencies' work is the high turnover of SHOs. New SHOs should routinely be educated on global infectious disease issues, particularly TB and HIV, their potential impact on their state's population health and their agency's budget, and how to prioritize evidence-based interventions to optimize their impact.

SHOs can assist with education efforts by participating in peer-to-peer mentoring and otherwise share what they have learned with newly-appointed peers. ASTHO can develop a peer network for these purposes, and develop and provide educational materials.

### **Broad-Based Education**

The need for comprehensive education about global infectious diseases extends well beyond SHOs to include all health professions. Ideally, an introduction to global health would be added to medical school curricula, linking organism identification (in microbiology) with clinical treatment and public health regulations. Global health curricula would be incorporated for other key disciplines, such as nursing, pharmacy, and oral health professions. Education for current providers would be culturally competent with up-to-date information on therapies, and geographically disparate infectious disease clinical capacity would be linked with specialty and primary care.

To promote comprehensive education, SHOs can facilitate a dialogue between public health practitioners and other key disciplines to offer adequate discipline-specific public health training. ASTHO can facilitate similar dialogues at the national level, working with national educational organizations and other stakeholders.

### **System of Care**

The system of care provided by public health, healthcare providers and provider groups, corrections facilities, Medicaid, and higher education are the core of an ideal system to address the four infectious disease areas. In this system, everyone would have access to care when they need it. Diagnosis and treatment for the four disease areas would be a routine part of primary care and not restricted to specialized clinics or programs. All providers would adhere to the same standards of practice; they would receive consultation or refer complicated cases as needed and otherwise provide primary care. "Centers of excellence" would train clinicians on public health best practices and offer continuing medical education on a remote basis. Licensing requirements or required certificate courses would include epidemiologically-appropriate approaches to the four main infectious disease areas. Because it is unlikely that each state could have its own discrete system of care, a regional approach could be considered as appropriate, particularly for low-incidence states.

Although developing a comprehensive and fully functioning system of care is a significant undertaking, specific strategies undertaken by ASTHO and its members can make measurable progress toward this end. SHOs should articulate the core elements of a system that is appropriate to their jurisdiction and work with the leadership of statewide health professional and healthcare organizations to explore a new system of care. SHOs also can broker relationships across agency programs, state agencies, and provider



groups. ASTHO can work with the Infectious Disease Policy Committee to continue drafting an ideal system, with the support of affiliates, and also facilitate a national dialogue around appropriate systems with key stakeholder groups. ASTHO also can provide best practice resources for SHOs and convene discussions among states pursuing regionalization of care.

### **Clear Role of Public Health**

The role of public health with respect to any number of conditions can evolve over time by default, not by design, and the four infectious disease areas are no exception. The deliberate, well-defined role of public health in an enhanced system ideally would include the following:

- Performance measures that articulate a minimum level of infrastructure of state health agencies.
- Disease prevention, contact investigation, and expert consultation.
- Active community engagement to ensure consistent prevention messages and non-duplication of services.
- Clear regulatory authority, particularly over healthcare-associated infections.

Moreover, public health's role would be supported by stable and sustained funding from diverse sources, including private insurance and Medicaid waivers.

SHOs can move toward a more clearly defined role of public health by advocating for and implementing better coordination of public health services and primary care, based on a continuum of care approach with defined roles and reimbursement procedures. ASTHO can continue to facilitate discussions on core public health services in the context of changes to the healthcare system, in addition to brokering relationships with national organizations and educating Congress on the vital role of state health agencies in disease prevention.

### **CONCLUSION**

The result of the summit is an outline of a comprehensive system to integrate efforts to prevent and treat HIV, HCV, STDs and TB. The system comprises services, financing, policy, education, reporting, and clinical and public health practices. The summit also yielded specific strategies to be undertaken by ASTHO and SHOs to facilitate the movement toward a comprehensive and integrated system, including: integration of services, funding, and advocacy efforts; sufficient funding and reimbursement; contemporary model policies and practices; new SHO education; education for all providers; system of care; clear role of public health; and uniform reporting requirements. These products provide a robust foundation for future efforts.

## **APPENDIX A: ENVIRONMENTAL SCAN**

Participants engaged in a brainstorming activity to create an environmental scan of issues that affect how the four infectious disease areas are addressed. The following categories were created in the process of summarizing the report and are intended to reflect the general themes that were discussed. In several instances the individual items could be categorized in a different fashion.

### **Disease-Specific Issues**

- CDC/HRSA: funding for state health agencies for HIV is huge share of overall.
- HIV incidence holding steady.
- Fractured programs, policies, money for HCV.
- Unmet need for HIV care (diagnosed and untreated).
- Clinical setting transmission of HCV.
- Increased number of STDs (real and anticipated).
- TB is in its own silo.

### **Integration issues**

- Risky behavior tools aren't integrated—policy, clinical, population-based interventions.
- Constituencies may not know how to advocate for funding under broader umbrella.
- Chronic disease collaboration model—working with all groups, integrating advocacy.
- Program collaboration and service integration.
- Five percent rule.

### **Funding**

- No mechanism to prioritize investments—trying to “do everything with nothing.”
- Concern that aggregated funding = decreased funding.
- Issues with ability to bill.
- Medication pricing (federal government major purchaser).
- Medicaid waivers—need to know best practices, understand “ins and outs.”
- Certified public expenditures and sole community providers (matching funds).
- Potential for Medicaid—loss threshold—can do through Affordable Care Act (ACA).
- Shrinking federal dollars for TB, others.

### **Issues in Rural Areas**

- Maintaining needed capacity/regionalization.
- Rural health—technology difficulties (no internet, mobile connections, or they are very expensive).
- Communication technologies.
- Telemedicine strategies/venues for linking.
- Scopes of practice for mid-levels, especially rural (and includes EMS).

## **Other systems involved in reporting of the four diseases**

- Sovereign nations.
- Veterans Health Administration system—can decide whether to report.
- Workplaces.
- Military hospitals.
- Higher education.

## **Country of Origin Issues**

- Increasing number of immigrants.
- Migration patterns.
- Active cases.
- Drug-resistant strains.
- Cultural beliefs.
- Cross-border relationships.
- Reporting this in surveillance data.
- Undocumented.

## **Biomedical advances**

- TB 12 dose regimen.
- Treatment as prevention.
- Treatment, prevention, screening.
- QuantiFERON.

## **Policy Issues**

- Mandating clinical practice.
- Mechanisms for accountability: law, regulations, enforcement.
- Federal guidelines and regulations.
- State policies (access to syringes, decriminalization, etc.).
- Changes to the healthcare system.

## **Role of Public Health**

- Unknown future role of public health in treating, purchasing, etc.
- Public health doing things by default vs. by design.
- Need to refocus ability to “assure” instead of provide.
- Public health takes on a lot and needs to be more strategic.
  - Come back to primary role.
  - Clinical vs. other roles.
  - State health agency doesn’t regulate all clinical facilities and only responds to complaints.

## **Special Populations**

- “Myth” of prison health.
- Adolescents and their legal protections.
  - Fees/explanations of benefits.

## **Miscellaneous**

- Influence of “Hollywood”—impact of celebrity conditions/causes—need voice in this arena—bring more visibility.
- Turnover of SHOs—need to educate.

## **APPENDIX B: IDEAL SYSTEM COMPONENTS**

The following are affinity diagrams that reflect the ideal system components generated by workgroup participants. (Due to the nature of affinity diagrams, some of the individual bullets are repetitive and their relationship to the stated category may be indirect.)

### **Integration of Services, Funding, and Education Efforts**

- Coordination of initiatives within health departments and across sectors.
- Disseminate best practices on integrated case management for HIV, TB, and HCV in partnership with disease-specific organizations.
- Disseminate best practices on infectious diseases education, as opposed to disease-specific education.
- Integrated funding for TB, HIV, STDs, and HCV.
- Build HCV service system on framework of HIV service system.
- Integrated programs for the four areas.
- The health of individuals is considered as a whole simultaneously to HIV/hepatitis/STD and integrated at client level.
- Expanded screening, particularly for HCV and HIV and payment for routine screening.
- Comprehensive HCV funding, policies, and programs.
- Integrated (across diseases) prevention messages.
- Comprehensive approach to HIV/TB/Hep/STD rather than siloed individual approaches.

### **Sufficient Financing and Reimbursement**

- Defined person-based payment source for all care services.
- Better negotiated prices for pharmaceuticals with greater flexibility in accessing these prices.
- Diverse funding.
- Sharing of best practices around Medicaid reimbursement/waivers for infectious disease prevention and treatment.

- Comprehensive, integrated vaccine programs for prevention.
- Resources to address “non-medical” barriers to care (housing, language).
- Medication access for all infected patients.
- Best practices database of Medicaid waivers.

### **Contemporary Model Policies**

- National policy on syringe exchange, OTC syringe sales, and overdose protection.
- Environment where scientifically sound public health interventions can be supported (e.g., syringe exchange).
- State policies that enable/are consistent with advances in public health science (e.g. payment policies for early ART, treatment as prevention, EPT).
- Understanding of current legal framework to help identify gaps and promising policies.
- State laws/policies reflect state-of-science guidelines.
- Clear and operationally feasible reimbursement policies and procedures for public health/population activities and services.
- Public health practice research with clear dissemination tools and support for developing best practices into model policies.
- Utilize midlevel health practitioners effectively to link prevention and clinical practice particularly in underserved areas.
- Integration of public components of prevention with other partners including policymakers, clinicians, and the five spokes of communities: 1. rural towns, 2. worksites, 3. faith-based communities, 4. schools—stratified communities, and 5. other communities (Kiwanis, Optimists, Rotary, etc.).

### **Uniform Reporting Requirements**

- Disease reporting integrated into electronic health record systems.
- Country of origin reporting.
- Universal laboratory based reporting.
- Breakdowns of each disease entity by United States/non-U.S. country of birth (secondarily by specific country of birth).
- Access to reportable diseases/health information exchange/lab reporting system to geocode and focus prevention efforts on affected and high risk populations and areas (communities).
- Use of reporting system.
- Sovereign nations, higher education, VA, military all use the reporting system.

### **System of Care**

- Take public health best practices and develop “centers of excellence” that can train clinicians and develop continuing medical education that can be done remotely.
- Discuss licensing requirements and the need to include epidemiologically-appropriate requirements for licensing.
- Case management for optimal treatment and best outcomes.
- People receive treatment when they need it.
- Engage with healthcare provider groups.
- Engage with external agencies like corrections, Medicaid, and education.

- Promoting the theme of treatment as prevention across HIV, STD, and TB platforms.
- Diagnosis and treatment a routine part of primary care (not restricted to specialized clinics/programs).
- Standards of practice established regardless of care source.
- Access to quality reference lab services.
- Centralized expertise for consultation or referral of complicated cases and better primary care for taking care of the day to day.
- Training methodology for care givers/public health workers. Again, this has to emphasize the identification and treatment of the four main infectious diseases. Public health workers and physician extenders should be required to take certificate courses on infectious disease and treatment of these diseases.
- Expanded focus on treating latent TB infection, not just active TB.

## APPENDIX C: DRAFT WORK PLAN

The following charts capture the discussions held regarding ASTHO and state strategies to address each component of an ideal system. Participants were asked to identify measures of success for each component, but not for each individual strategy; measures of success have been aligned with strategies as appropriate.

Two overarching goals also were identified:

1. The work in all these categories should inform the Infectious Disease Policy Committee (IDPC)'s deliberation and strategic planning.
2. ASTHO members should begin to speak in more integrated terms about their departments and priorities.

These charts can serve as the basis of a comprehensive work plan to move toward an integrated system to address the four infectious diseases.

Integration of Services, Funding and Education Efforts			Measures of Success
ASTHO Strategy	Current activity (Planned)	1. Convene affiliates to begin discussing integration across programmatic areas.	Meetings took place and action plan has been developed and funded.
	New activity	2. Coordinate discussion among CDC, HRSA and SHOs regarding the integration of federal funding and requirements for HIV/STDs/TB/HCV.	Discussions are underway with principles developed among affiliates, stakeholders, and funders.
		3. Engage in discussions with affiliates and partners about need for integrated federal funding for HIV/STDs/TB/HCV.	
	Check with affiliates		
	Needs new funding	1. Develop repository of best practices in integrating services, funding and	Initial list of best practices developed and disseminated.

		policy.	
		2. Share examples of how to make cuts as funding declines.	
SHO Strategy	1. Evaluate internally for duplicity.		Tough decisions are made about how and what to cut as funding declines.
	2. Integrate HIV, TB, STD, HCV programs within agency.		Integrated systems are built by SHOs in their departments.

Sufficient Funding and Reimbursement			Measures of Success
ASTHO Strategy	Current activity	1. Continue writing/updating fact sheets on “the state of funding.”	
		2. With affiliates, SHOs, and other partners, communicate the need for sustainable funding for TB, HIV, HCV programs.	Meeting held with key stakeholders to start the discussion.
	New activity	1. Educate payers and providers about the nationwide need for defined insurance benefits for diagnosis, treatment, and prescriptions.	
		2. Work with pharma on more aggressive prices for pharmaceuticals for TB, HIV, STDs, and HCV at the federal level and greater flexibility in accessing these prices.	<ul style="list-style-type: none"> <li>List of preferred vendors for health agencies available.</li> <li>340B pricing available for “treatment as prevention” for STIs, TB, and HIV through state and local health departments, with flexibility to access these prices for “treatment as prevention” by state and local partners.</li> </ul>
		3. Figure out way to capture, analyze, and present Medicaid waiver	



		components relevant to public health.	
	Check with affiliates		
	Needs new funding	1. Develop billing guide based on ACA specific to infectious diseases.	
		2. Develop resources for fee for service (FFS) revenue generation with affiliates.	Playbook for FFS revenue.
		3. Think tank for public health integrated systems funding.	
SHO Strategy	1. Work with payers, including state Medicaid, to define/expand diagnosis, treatment, and pharmacy benefits.		
	2. Work with Medicaid for waivers.		

Contemporary Model Policies			Measures of Success
ASTHO Strategy	Current activity	1. Collect and synthesize model practices.	
		2. Disseminate best practices, model policies, model legislation.	
	New activity	1. Develop model policies based on evidence of best practices.	From model practices, synthesize a template to develop best practice infectious disease policies.
	Check with affiliate	1. Develop model state policies for TB screening and case management in partnership with TB organizations.	
	Needs new funding	1. Compendium or toolkit of model policies and state	

		best practices.	
SHO Strategy	1. Work toward the adoption and implementation of model policies in their state or territory.		

Uniform Reporting Requirements			Measures of Success
ASTHO Strategy	Current activity		
	New activity	1. Provide resources/best practices/examples.	<ul style="list-style-type: none"> <li>Established a resource guide.</li> <li>Highlighted 2-3 model systems.</li> <li>Initiated activity around cloud-based technology for syndromic surveillance.</li> <li>Development of integrated surveillance tools for these conditions as part of electronic medical record.</li> </ul>
		2. Develop model reporting/use policy document.	
	Check with affiliates	1. Facilitate discussion with key stakeholders about integrated/harmonized reporting requirements (federal, state, private, payers).	
	Needs new funding		
SHO Strategy	1. Establish guidelines for assessing high-risk individuals.		
	2. Establish policies for reporting infectious diseases.		
	3. Identify opportunities to improve reporting as part of state health information exchange initiatives.		
	4. Be able to respond to TA.		

Education for New SHOs			Measures of Success
ASTHO	Current activity		

Strategy	New activity	1. Coordinate peer-to-peer mentoring of new SHOs.	
		2. Educate new SHOs on regulations, treatments, new policies, and updates.	
		3. Develop educational materials such as a primer on infectious diseases, issue briefs, and curricula for SHO education and training.	<ul style="list-style-type: none"> <li>• Thirty-minute video/webinar production posted online for new SHOs.</li> <li>• Weekly text message with a “did you know?” message on infectious diseases.</li> <li>• All new SHOs complete infectious diseases orientation within six months of appointment.</li> </ul>
	Check with affiliates		
	Needs new funding		
SHO Strategy	1. Participate in peer-to-peer mentoring of new SHOs.		
	2. Participate in opportunities to share their knowledge with other SHOs.		

Broad-based Education			Measures of Success
ASTHO Strategy	Current activity	1. Establish tools for public awareness.	
	New activity	1. Convene and work with other national educational organizations to help educate the workforce (AAMC, ACGME, etc.).	Convened a meeting on workforce development on infectious diseases.
		2. Facilitate national dialogue on appropriate integration of discipline-specific public health training with appropriate stakeholders.	Convened a meeting of key stakeholders to discuss practical public health infectious disease curricula for key disciplines.
	Check with		

	affiliates		
	Needs new funding	1. Recommendations for medical school education.	
SHO Strategy	1. Facilitate dialogue between public health practitioners, schools, programs of public health education, and other key disciplines to offer adequate discipline-specific public health training.		

System of Care			Measures of Success
ASTHO Strategy	Current activity	1. Support IDPC in sketching out a draft of an ideal system of care for public health and clinical providers with the support of affiliates.	IDPC has completed the design of a system including clinical care and public health.
		2. Facilitate a national dialogue around appropriate “systems” with key stakeholder groups.	
	New activity	1. Establish best practices for systems of care.	
		2. Provide best practices as a resource for SHOs.	
	Check with affiliate		
	Needs new funding	1. Convene discussions around regionalization of care between states.	
SHO Strategy	1. Articulate core elements of system appropriate to their jurisdiction.		
	2. Work with current care providers and leadership of statewide health professional and healthcare organizations to explore a new system of care.		

	3. Act as broker for the development of integrated systems of care across agency programs, state agencies, and jurisdiction-specific provider groups.	
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Clear Role of Public Health			Measures of Success
ASTHO Strategy	Current activity	1. Facilitate discussion/agreement on core public health services as we move through healthcare reform.	Convened an initial meeting with key public health stakeholders to help define the unique mission of public health, as distinct from other healthcare providers and other disciplines, within six months.
		2. Broker relationships with national organizations.	
		3. Educate Congress on the vital roles played by state offices of public health in disease prevention.	Congressional/appropriations language begins to frame unique public health functions and roles.
	New activity		
	Check with affiliates		
	Needs new funding		
SHO Strategy	1. Advocate/implement better coordination of public health population services and primary care.		
	2. Development and dissemination of best practices.		
	3. Continuum of care approach with defined roles and reimbursement procedures.		